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How three policies aimed at increasing for-profit hospital care became an accepted method of reform in Ireland between 2000 and 2005

'How many ditches do you die on?'

How three policies aimed at increasing for-profit hospital care became an accepted method of reform in Ireland between 2000 and 2005

'How many ditches do you die on?'

A thesis submitted to Trinity College Dublin for the degree of Doctor of Philosophy in the Centre for Health Policy and Management, School of Medicine, Trinity College Dublin

2013

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Declaration

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Summary

This research set out to explore why three specific policies aimed at increasing private, for-profit hospital care became an accepted method of reform in Ireland between 2000 and 2005. It seeks to explain these three policy-making processes in order to understand more about how policy choices get made and what influenced these specific policy processes. I carried out this research using three policies as case studies:

1. The changes to the Finance Act in 2000 and 2001 which gave tax reliefs to build private for-profit hospitals.
2. The National Treatment Purchase Fund (NTPF), which was established in 2002.
3. The plan to co-locate private hospitals on the grounds of public hospitals, 2005.

I utilised qualitative methods of documentary analysis and in-depth interviews to explain and explore my research questions. Documents were gathered from many sources, including using Freedom of Information requests to gain access to previously unseen documents. Semi-structured, in-depth, elite interviews were carried out with 21 people involved in the three policy-making processes. Large amounts of data were gathered through these methods. The interviews were transcribed and coded in NVivo. All the data were then analysed using a conceptual framework that I developed for this research drawing on leading authors in this field.

The strongest finding to emerge from this research is the personalised and political nature of the three policy-making processes under scrutiny. While each policy process was different and resulted in different outcomes, the absence of the use of evidence – including the very limited use of learning from other countries – was an associated key finding in this research. Where evidence was used, it was used to justify a political decision that had already been made. There was also a lack of good – or in some instances any – information that would help guide the policy-making processes.

The role and impact of a few powerful people – politicians, consultants and/or private hospital owners – on the three policy-making processes is another one of the most robust results from this research. In particular, the role and influence of the political party the Progressive Democrats (PDs) and two senior politicians in these policy-making processes emerge as a central finding. This shows how particular personalities and politicians can have a powerful influence on the processes of making health policy, even when they are not the Minister for Health. This research also found how the broader political arena had more impact on these health policies than health system influences and demonstrates the impact Irish political institutions, in particular coalition governments, can have on policy choices. It also clearly shows the role of power in policy-making processes and how people in political and economically powerful positions wielded most influence in these three case studies.

Where it was possible to show lobbying took place, such as the changes to the Finance Act, that lobbying was very effective and led to policy change. It is harder to quantify the extent of the lobbying that took place in the other two policies. However, the research finds that private hospital owners and consultants benefited significantly from the two policies that were implemented and in some instances politicians represented the private sector interests in the policy making processes.

There was a strong degree of consensus among proponents of the three policies that the private sector could more easily solve the ills of public policy and that this was preferential to reforming the public sector. The failure of previous attempts to reform the public hospital system, and the health system overall, was a common theme amongst the interview findings. Closely associated with this from proponents of the policies was a firm belief that the private sector was a more efficient and effective provider of care. There was no evidence to support this viewpoint.

The three policies set out to increase access to public patients to either hospital beds or hospital treatment. While each policy was proposed on the basis that it would lead to an increased provision of private for-profit care, they were all promoted on the basis that they were in the interest of public patients. The continued long waits for public patients and the negligible increase in beds for public patients demonstrate that, apart from the public patients who received care under the NTPF, these policies did not benefit public patients. Instead, the policies benefited private patients and those who owned and worked in private hospitals, such as consultants. This research quantifies the amount of public money that was diverted to private for-profit hospital care under two out of the three policies that were implemented. This added up to €830 million.

The level of disagreement among the interviewees as to the causes of the problems is evident from the findings. This is apparent across the three cases. Implicit in these findings were ideological differences which influenced the differing assessments of the problems by different interviewees.

Another strong finding that emerges from the research is the failure to reform or invest in the public system, ie not building up public hospital bed capacity, not addressing the long waits in the public system for public patients, not getting rid of the perverse incentives that maintained the public private-mix. This inaction created a space from which these private initiatives could emerge and gain political and public approval.

Furthermore, the failure to take responsibility for private healthcare is contradictory to the Department of Health's simultaneous tolerance and promotion of a public-private mix of hospital care, even within the public hospital system. Each case raises questions about the capacity of the Department to develop and implement health policies. Another finding, evident in all three policies but most obvious in the case of the NTPF was how formal policy-making processes were undermined and ultimately overruled by informal processes. The research proposes a revised conceptual framework and a 'macro-dynamic' version of Kingdon's multiple streams (Kingdon, 1995).

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Glossary of terms

CSO – Central Statistics Office

DRGs – Diagnostic Related Groups

EU – European Commission

ECB – European Central Bank

FDI – Foreign Direct Investment

FOI – Freedom of Information

HIAI – Health Insurance Authority in Ireland

HIPE – Hospital In-Patient Enquiry

HSE – Health Service Executive

HSR – Health Services Research

HPSR – Health Policy and Systems Research

HSR – Health Service Research

IHAI – Independent Hospitals Association of Ireland

IHCA – Irish Hospital Consultants Association

IMF – International Monetary Fund

IMO – Irish Medical Organisation

MAC – Management Advisory Committee (in the Department of Health)

OECD – Organisation of Economic Co-operation and Development

PDs – Progressive Democrats

PPP – Public Private Partnership

tasc – Think Tank for Action on Social Change, a progressive Dublin based think tank

VHI – Voluntary Health Insurance

Chapter 1

Introduction

1.1 Introduction

This thesis seeks to explore three specific processes of health policy making in Ireland and to find out what influenced the formulation of health policies in the early 2000s. Specifically, it is concerned with three health policies that were adopted between 2000 and 2005, which sought to increase the provision of private, for-profit hospital care.

I became interested in this topic in summer 2008, when I set about researching and writing a book on health policy in Ireland (Burke, 2009). I knew that Ireland had a complicated, inequitable, public-private mix of hospital care. Unlike other countries with public and private provision, Ireland is unique in the extent to which it incentivises and rewards private care within the public hospital system (Barrington, 1987; Wren, 2003; Burke, 2009). My book sought to explain and highlight the inequities of the Irish health system, ultimately calling for a more equitable, universal system that does not discriminate against poorer, public patients (Burke, 2009). The public-private mix of healthcare in Ireland and the political and economic context in which this research was situated are explained in chapter two and detailed in chapter five.

I found that during the period under consideration in the book (1998 to 2008), a substantial effort was made to 'reform' without really improving or reforming the public health system, and there was a quadrupling of the health budget without any attempt to undo the inequitable provision of care that privileges private patients over public patients (Burke, 2009).

I discovered while researching and writing the book an even more complex healthcare system than I expected: a mix of public and private that the government and the Department of Health promoted yet failed to regulate, reform or take responsibility for. I also documented a proliferation of private, for-profit hospital care that up until then had not been revealed (Burke, 2009).

For example, when I looked for the number of beds in private hospitals, I found no such total was known. The Department of Health did not have it. The HSE did not keep any such figures: they were after all only responsible for the public system. There was no authority to regulate the private system, so no external regulator had those figures. Private health insurance companies must have them, but they refuse to share any information they collect, claiming that it is 'commercially sensitive'. Even the OECD, which collates such figures internationally, did not collect such data for Ireland. In order to find a total the number of private hospital beds for the book, I started to gather relevant information on private hospitals and new developments, which often appeared only in the business or property pages of the newspapers. I then rang up each private hospital asking them for their numbers of inpatient and day beds and published the figure in the book (Burke, 2009).

I looked to academic research to assist me to understand what had contributed to the growth of private, for-profit hospital care when it did not seem to be stated health policy. There was some academic research which examined private practice in public hospitals (Nolan and Wiley, 2000). However, there was no research that I was aware of that was looking at the role of private for-profit hospital care and what caused its proliferation during the mid-2000s. Neither could I unearth any scholarly work investigating or explaining the processes of recent Irish health policy making.

1.2 Researching health policy-making processes

This absence of scrutiny of health policy-making processes is observed internationally (Walt et al, 2008; Gilson et al, 2011; Gilson, 2012; Mills, 2012). There is limited international research on health policy making and specifically research that examines health policy-making processes that are politically driven and that strongly reflect the political economy of the country (Walt et al, 2008; Gilson et al, 2011).

Touhy's comparative work on the dynamics of change in the healthcare arenas in the United States, Britain and Canada situates health policy reform in political and institutional contexts (Touhy, 1999). Her work focuses on the evolution of healthcare systems in the countries researched. While their specific policy making processes are part of that, she finds the primary driver of health policy change is the broader political arena rather than health system dynamics.

More recent comparative analyses across eleven European countries sought to explain the 'juncture points in the history of a nation's health policy' (Oliver and Mossialos, 2005, Evans, 2005: 1). Their findings were inconclusive, that 'a single explanatory theory cannot account for all the health sector developments that have occurred within any individual country, let alone across many different countries with diverse cultures, histories, institutions and interests' (Oliver and Mossialos, 2005: 3). This research also concluded not that major reform is rare but it is hard as 'there may be too many historical influences, all overlaid on one another' (Evans, 2005: 273).

An Alliance for Health Policy and Systems Research was set up in 1998 to focus research efforts on this area (Alliance for Health Policy and Systems Research, 2004). A recent review of progress in this area of research found that 'within high income countries there is a burgeoning field of health services research' but that there remains limited analysis of policy-making processes and health-systems research (Mills, 2012: 2). However as pointed out above there have been efforts to compare health policy evolution across countries (Oliver and Mossialos, 2005, Evans, 2005) and within countries (Ham, 1999, Klein, 2006, Buse et al, 2007, Hakkinen and Lehto, 2005, Rochaix and Wilsford, 2005, Exworthy et al, 2012). However, much of the focus on policy analysis is on policy evolution and policy implementation, rather than policy making processes and/or the politics of health policy making.

John identifies the aim of research into public policy as 'to explain how public decision making works, why societies get the policies they do' (John, 2012: 1). Walt and Gilson's seminal work on

health-policy analysis in the 1990s called for a focus on the context and the actors, as well as the content of policy (Walt and Gilson, 1994). They also highlighted the need to pay attention to the role of power and the interaction between the above factors and between the state and the market. Walt and colleagues have subsequently advocated that in order to understand the whole health system there is a requirement to scrutinise the private as well as the public aspects of it (Walt and Gilson, 1994).

Kingdon's empirical research on agenda setting and formation of public policy in the USA during the 1970s and 1980s introduced the concept of different policy, problem and political streams, which, when they converged, opened up policy windows (Kingdon, 1995). These policy windows were taken advantage of by policy entrepreneurs, who influenced public policy-making processes (Kingdon, 1995). Touhy's comparative work across USA, Canada and Britain also examines the 'windows of opportunity' created by external factors, often independent of ideas in the health policy field (Touhy, 1999: 12) while an issue of Health Politics, Policy and Law compared health systems' evolution across eleven European countries (Oliver and Mossialos, 2005).

A particular issue highlighted in the recent literature on health-policy analysis is the need for rigorous methods and for grounding research in this area in relevant theories and conceptual frameworks (Gilson et al, 2008; Gilson et al, 2011; Mills, 2012). Detailed methods and relevant literature for this research are outlined in chapters three and four.

1.3 Researching Irish health policy-making processes

The primary academic text on health policy in Ireland ends in 1970 (Barrington, 1987). A health-policy reader published by UCD Press in 2006 had one section on health policy from a sociological perspective, assessing the main thrust of health-policy development in the 1990s as one of maintaining the status quo (Murray, 2006). Murray's sole identification of any new departure in health policy between 1990 and 2005 was the emphasis on strategic management (Murray, 2006). There is scarcely a mention of increased provision of private, for-profit hospital care in this text and the only chapter on policy processes focuses on the implementation of breastfeeding policy (McCluskey, 2006). The only reference cited among hundreds in the reader which dealt with health policy-making processes was Barrington's *Health, Medicine and Politics in Ireland, 1900-1970* (McCluskey, 2006).

A book, *The Politics of Healthcare,* drew on practitioners and managers in healthcare to tell their experiences of reform. One chapter by a former Secretary General of the Department of Health also focused on strategic management reform during the period between the mid-1990s and mid-2000s (Kelly, 2007). The book's editors note 'some observers would not seem out of place to regard strategic management of Irish health as maladroit, misaligned and misdirected' (McAuliffe and McKenzie, 2007: 2).

One chapter in the McAuliffe and McKenzie book outlines a particular (and successful) health policy-making process in Ireland: the smoking ban, which was introduced in 2004. They describe the policy-making process and the obstacles this policy had to overcome to become a reality (Howell and Alwright, 2007). Two general books on Irish health policy and the Irish health system were written by journalists, of whom I am one (Wren, 2003; Burke, 2009).

A recent publication on *Irish Governance in Crisis* examines the role the state and the political system had in contributing to the economic crisis (Hardiman, 2012). Hardiman finds that '"policy capacity" and "impartial government institutions" are among the most problematic issues in public life' (Hardiman, 2012: 5). The chapter on health considered the public-private mix in Irish healthcare and concludes it 'is a good example of policy evolution along unplanned lines, contradictory imperatives, where non decisions eventually become de facto decisions' (Finn and Hardiman, 2012: 129).

The analysis of policy making in Ireland that exists is usually descriptive rather than analytical or explanatory. Hardiman's recent examination of governance in Ireland is an exception to this, although it is more a critique of the policies and governance structures that led to the economic crisis than specific to policy-making processes. One of the chapters is on healthcare but, while its focus is on the public-private mix of healthcare and it references the growth of private, for-profit hospital care, it has neither the scope nor the space to seek to explain or explore those issues in more detail (Finn and Hardiman, 2012).

My search revealed no academic work that examined what influenced health policy-making processes in general and, in particular, those that led to increased private, for-profit hospital care in Ireland. As a result of the absence of much academic work in this area, when I enrolled in the Health Services Research (HSR) PhD programme with Trinity College Dublin in October 2008, I was interested in exploring these issues.

I wanted to investigate what influences policy-making processes and choices in Ireland and in particular what influenced the policy-making processes of three specific policies aimed at increasing the provision of for-profit hospital care. I was also interested in exploring what role politics and the political economy of the time played in influencing these policy processes. I wanted to test various propositions: were these policy processes a determined effort to 'privatise' hospital care? Did they happen by accident in the absence of any real reform of the public hospital system and the failure to provide equitable and universal access to hospital care? Were they the result of non-action or purposeful action? Were they merely a continuation of the Irish public-private mix of healthcare? These issues are teased out in chapter two and this thesis aims to address them through the analysis of three policy-making processes from chapter five onwards.

1.4 Research questions and case studies

The aim of this research is to find out how three policies aimed at increasing for-profit hospital care became an accepted method of reform in Ireland between 2000 and 2005.

My research questions are:

- What influenced the policy choices and processes aimed at increasing for-profit hospital care in Ireland between 2000 and 2005?
- How were these policy choices made or not made ('the unintended consequences of purposive social action')?
- What influenced these policy choices as the method of 'reform', how did they get on the agenda, and how did they become a political priority?
- Why were these policies adopted (ideology, pragmatism, power)?
- Who were the champions of these policies?
- How did these policy choices reflect the aims of health policy or of broader political economy policies of that time?

The three policies I am using as case studies are:

- The changes to the Finance Act in 2001 and 2002, which gave tax reliefs to developers to build private hospitals (Department of Finance, 2001 and 2002);
- The introduction of the National Treatment Purchase Fund (NTPF) in 2002 which was set up to buy private care in private hospitals for long waiting public patients (Department of Health and Children, 2002)
- The co-location policy announced in 2005, which planned to build private hospitals on the grounds of public hospitals and free up beds for public patients by 'migrating' the private patients in public hospitals to the newly built private hospitals (Department of Health and Children, 2005a).

This research is concerned with exploring these health policy-making processes and finding out what influenced three particular policy choices in Ireland in the years between 2000 and 2005.

1.5 Contribution to original knowledge

Policy making is an inherently messy process (Walt, 2008; Gilson et al, 2011). Irish health policy making has a tradition of being political and controversial (Barrington, 1987; Wren, 2003; Burke, 2009). This research aims to contribute to knowledge by gaining a greater understanding about what influenced these specific policy processes and choices. It is hoped that by doing so, it will contribute to more effective, policy making in the future, in Ireland and in other health systems.

This thesis sets out to explore what influenced three specific health-policy processes and choices in Ireland, where, as far as I am aware (as detailed above and in chapters two and four), there is little,

academic literature in this area. In particular, there is little if any study of the development of private, for-profit hospital care in Ireland. This thesis hopes to contribute to original knowledge by providing robust research on health policy-making processes in Ireland and in particular regarding the adoption of policies with the intention to increase private, for-profit hospital provision.

While the cases under examination are Irish, there may be some lessons for international health policy making, especially in small, high-income countries and in other post-colonial countries, where policy making has been found to be personalised and covert (Walt et al, 2008, Gilson 2012).

Kingdon's multiple-streams model was used as a mechanism for analysing the documents gathered for this research (Kingdon, 1995). From using Kingdon to analyse each of the policies, I make recommendations on how Kingdon's streams can be used to explain more than one policy. This development of a 'macro-dynamic Kingdon model' is a contribution to original knowledge.

A conceptual framework was developed uniquely for this research drawing on relevant literature on political science, public policy, power, political economy and health policy making (this literature is detailed in chapter four and reflected on in chapter 10). This was used for the analysis of the documents and interview data. Having reflected on the framework and how it worked for each of the cases and across the cases, I have developed a revised framework. It is hoped that this will be tested in future research on policy making thus contributing to original knowledge.

1.6 Outline of the thesis

This thesis is about exploring and explaining what influenced three health-policy choices and processes which intended to increase the provision of private, for-profit hospital care in Ireland between 2000 and 2005. This research situates these policy choices in the political, economic and social contexts in which they were made. It also places them in the broader health-policy context. These issues are outlined in chapter two. Terminology, especially terms used in relation to private care and public-private mix, is also dealt with in chapter two.

Through qualitative methods, including case studies, documentary analysis and semi-structured, in-depth, elite interviews, I investigated how these specific policy processes evolved and why these policy choices were made. The methods are detailed in chapter three.

The analysis of health policy making crosses many disciplines. These include public policy, political science, theories of power, political economy and specifically work in the area of health policy. Relevant literature is reviewed and from this a conceptual framework was developed through which the documents and interview data were analysed. This is outlined in chapter four. A more critical analysis of this literature and additional relevant literature are detailed in chapter ten.

Chapters five to 10 detail the analysis and key findings from this research. In chapter five, I detail extensive findings from the documentary analysis utilising Kingdon's multiple streams for each of the three cases. Chapters six, seven and eight outline the findings for each of the policies – the changes to the Finance Act; the NTPF; and co-location – in turn, using the conceptual framework to outline the key findings, drawing on the interview and documentary content. Chapter five specifies the documentary analysis separately to the combined documentary and interview analysis in chapters six, seven and eight as the detailed documentary analysis gave an in-depth description of the policies development, which informed the interviews which sought to explain the policy processes. These findings are in chapters six to eight.

Chapter nine is a discussion of key findings, which identifies key themes emerging across the three cases and the commonalities and differences between the cases.

Chapter 10 reflects on the literature detailed in chapter four and provides a more critical analysis of the literature and draws on other literature relevant to the findings. It deliberates on the conceptual framework developed specifically for this research and comes up with a proposal for an altered conceptual framework that could be tested on future work.

Chapter 11 summarises the key findings, assesses the generalisability of my findings and outlines my contribution to original knowledge.

Chapter 2

Economic, political and health policy context

2.1 Economic context 1997 to 2012

At the start of this research, in October 2008, Ireland was experiencing the beginning of the most severe economic collapse witnessed by any country since the Great Depression of the 1930s (Kirby, 2010). By 2010, Ireland recorded the worst annual government deficit in the history of post-war western Europe (Burke and Pentony, 2011). This economic crash of 2008 brought a sudden end to 15 years of soaring economic growth that had made Ireland a model for development in a globalising world (Kirby, 2010). In 2009, the International Monetary Fund (IMF) said Ireland 'was perhaps the most overheated of all advanced economies' (IMF, 2009).

During the 1990s and the early years of the new century, Ireland experienced growth rates of more than 7.5%, and in some years growth passed 10% (CSO, National Annual Accounts 2001-2011). Ireland was growing at three times the European average and was heralded as one of the most economically successful countries in the world (Kirby, 2010). Employment was up from 1.38 million people in 1993 to 2.25 million people employed by 2008 (CSO, 1994, CSO, 2009). Unemployment stayed below 5% continuously from 1999 to 2008 (Kirby, 2010).

Ireland's unsustainable growth was driven by a pro-cyclical economic policy, largely dependent on Foreign Direct Investment (FDI) and a property boom fuelled by government tax breaks (Kirby, 2010; Burke and Pentony, 2011; Kitchin et al, 2012). Banks were giving out loans for properties whose inflated value was unsustainable (Kitchin et al, 2012). This, combined with low interest rates predetermined by Ireland's eurozone membership, fed 'an orgy of borrowing and consumption' (Kirby, 2010: 4). Sustainable sources of tax revenue were eroded as capital gains and income taxes were cut (Burke and Pentony, 2011).

As long as the economy boomed, revenues were available to fund the increasingly high costs of social welfare, health and education services. When those revenues stopped – and they stopped suddenly in 2007/8 – Ireland had to borrow to maintain those services. By 2010, the borrowing rates were unsustainable and Ireland had to enter an EU/IMF/ECB bailout (Burke and Pentony, 2011).

2.2 Political context 1997-2012

The Fianna Fáil/PD coalition was in power from 1997 to 2007. Fianna Fáil, a 'republican' party, was the oldest, biggest party in Ireland since its formation in the early 1930s (Ferriter, 2004). Fianna Fáil was the dominant political power in Ireland and was in government for 19 out of the 31 governments formed since the foundation of the state in 1922 (Ferriter, 2004). For their first 14 times in government, they were in power alone, holding an overall majority. Since 1989, they have

been in coalition five times, most often with the Progressive Democrats (PDs) (Ferriter, 2004; Leahy, 2009).

The PDs formed in the 1980s after a small group split from Fianna Fáil. They pursued right-wing, economically conservative policies with a strong low-tax, pro-business/-enterprise bias, promoting privatisation and welfare reform (Collins, 2005).

All political parties ran for the general election in 1997 on a platform of cutting taxes (Gallagher and Marsh, 2008). The PDs controversially campaigned on a social-policy ticket, which included a promise to cut the public service workforce by 25,000 people (Gallagher and Marsh, 2008). No political party gained an overall majority in the 1997 election and Fianna Fáil went in to coalition with the PDs, with whom they remained in power until 2007 (Gallagher and Marsh, 2008).

The Fianna Fáil/PD government ruled during the time of greatest growth in Ireland's economy. Bertie Ahern, the Fianna Fáil leader, was Taoiseach (prime minister) for this decade and Mary Harney, the leader of the PDs, was Tánaiste (deputy prime minister) (Collins, 2005, Leahy, 2008). There were two Fianna Fáil ministers in the Department of Health. From 1997 to 2000, Brian Cowen, who went on to become Taoiseach in 2008, was the Minister for Health. From 2000 to 2004, Micheál Martin was the Minister for Health. From 1997 to 2004, Mary Harney was the Minister for Enterprise, Trade and Employment. In September 2004, she was appointed Minister for Health.

2.3 Irish health policy context

As outlined above the period 1997 to 2007 was one of rapid economic growth and political stability with the same two parties in coalition throughout this period (Burke, 2009). The economy was thriving and most people had more money, yet substantial quality-of-life issues were aggravating public discontent (Wren, 2003). High property prices resulted in many having to buy homes far from their networks of family and friends and their places of work. Over-priced property, long commutes, and expensive childcare were causing dissatisfaction (Burke, 2009).

In the run up to the 2000 local elections, frustration and unhappiness with the health system was named as the priority issue (Wren, 2003; Burke, 2009). There had been no health strategy since 1994 and there was widespread discontent with the health system (Wren, 2003; Burke, 2009). Extremely long waiting times for public patients and queues of people on trolleys in Accident and Emergency departments were bad press for politicians and unpopular with the public (Wren, 2003; Burke, 2009). The decision to develop a new health strategy was a response to this (Department of Health and Children, 2001a). During 2001, the Irish government embarked upon a wide-ranging consultation process to develop a new health strategy (Department of Health and Children, 2001c).

In December 2001, the government published their new health strategy, called 'Quality and Fairness – A Health System for You'. This outlined 121 actions in a seven- to 10-year programme of reform for the health system (Department of Health and Children, 2001a). Fianna Fáil and the PDs campaigned in the 2002 general election on the back of the economic success and appealed to the people to re-elect them and to give them four more years to reform the health system (Donnelly, 2002, Burke, 2009).

'Quality and Fairness' outlined a myriad of areas for reform but, critically, without many specific targets, timelines or estimated costs (Burke, 2009). The aim and content of 'Quality and Fairness' was primarily focused on the public health system, yet there are conflicting and unclear goals and objectives throughout the strategy, which reflect Ireland's complicated public-private mix (Burke, 2009). For example, the strategy promised 3,000 additional hospital beds but failed to specify where and by when (Department of Health and Children, 2001a). It indicated that a majority of new hospital beds would be provided in the public hospital system (it specified 450 of the 650 to be built in year one would be in the public sector). It also acknowledged that there was scope for an enhanced role for the private sector, through the recently introduced tax allowances, to the benefit of public patients – again without specifying how (Department of Health and Children, 2001a).

As Ireland's economy thrived in the early 2000s, public investment in health and social care quadrupled from €4 billion to €16 billion between 1997 and 2007 (Department of Health and Children, 2010b). However, Ireland traditionally spent well below the European or OECD average on healthcare. When examined over time (between 1995 and 2008), the country's spending on health places Ireland 17th out of 25 OECD countries in terms of health spend (McDonnell and McCarthy, 2010). This shows that the increase in health spend was making up for decades of neglect and for the cutbacks introduced in a previous economic crisis in the 1980s (Wren, 2003; Burke, 2009; OECD, 2012).

As public health spending increased under the stewardship of three different Fianna Fáil/PD health ministers, there were numerous attempts to reform the Irish health system – to improve quality, to make it more efficient, to transfer care from hospitals to primary and community care, to reorganise the public system – all with limited success (Tussing and Wren, 2005; McDaid et al, 2009; Burke, 2009).There was never an attempt to undo the inequality inherent in the system, to undo the public-private mix or to provide universal care (Tussing and Wren, 2005; Burke, 2009). During this time, there was also a proliferation of private, for-profit healthcare providers (Burke, 2009).

The Minister for Finance at the time, Charlie McCreevy, regularly referred to the Irish health system as a 'black hole' (Wren, 2003) and went public about his reluctance to give the Department of Health and the Minister for Health the money required to implement the health strategy, even before it was launched by the government (Kelly, 2007).

What followed after the publication of 'Quality and Fairness' was a short burst of spending to meet some of its commitments (Kelly, 2007). This coincided with the run up to the general election in 2002 (Tussing and Wren, 2005, Burke, 2009). The Labour Party ran for election in 2002 promoting a universal health-insurance model, while Sinn Féin and the Green Party both promoted a one-tiered, tax-funded universal health system (Wren, 2003).

When the Fianna Fáil/PD government was re-elected, there was a quick retraction of spending and, in particular, many of the main priorities in the strategy, such as delivering increased numbers of public hospital beds and the primary care strategy, never materialised (Tussing and Wren, 2005; Burke, 2009; McDaid, et al, 2009).

In the years after the publication of 'Quality and Fairness' a plethora of reports were commissioned and published. These included: a value for money audit of the health system; an audit of health structures – with a view to rationalising the myriad of health agencies in place; and a report of medical staffing to make recommendations on safe levels of staffing, as Ireland always had too few health- and social-care professionals (Department of Health and Children, 2003a, Department of Health and Children, 2003b, Department of Health and Children, 2003c). Interestingly, the first of these reviews on value for money was commissioned by the Department of Finance and published by the Department of Health. (Department of Health and Children, 2003a). The 2003 report on value for money in the health system found that

> *many of the problems [of the Irish health system] are fundamentally structural... we believe that just improving the systems of financial management and control will do little to improve the efficiency and effectiveness of health expenditure unless there is fundamental reform of how the health system is organised and managed* (Department of Health and Children, 2003a: 6).

The report went on to recommend the establishment of a national executive outside the structure of the Department of Health and Children to deliver health and social care (Department of Health and Children, 2003a). As a result of this recommendation, combined with other fundamental recommendations made in the other two reports, the Department of Health and Children announced the biggest ever 'reform' of the Irish health system – to disband the health boards and to establish a Health Service Executive (HSE) (Department of Health and Children, 2003d; Burke, 2009).

Up until then, for the previous 35 years, the health system was run by eight health boards (and, from 1999, 10 health boards, when Dublin was divided into three board areas), which were operated autonomously from the Department of Health (Barrington, 1987). The health boards were run by regional boards of local politicians, ministerial nominees and local health professionals (Wren, 2003). Each year, they received their budget from the Department of Health, which they were to spend in line with health policy (Wren, 2003).

However, the health boards were responsible for their own health budget and the provision of all public health and social care in their region (Government of Ireland, 1970). Every year they overspent their budget and often deviated from health policy, as local politics was often out of synch with national health policy (Wren, 2003; Burke, 2009). Some hospitals were health-board hospitals, while others were standalone voluntary hospitals which received direct funding from the Department of Health. By the time the HSE was introduced in 2005, everyone agreed that the outdated, independent fiefdoms of the health boards needed reform: what was not agreed was the type of reform required (Burke, 2009).

The establishment of the HSE was mired in conflict and confusion including a government cabinet reshuffle which resulted in a change of health minister just four months before the HSE was set up (Burke, 2009). In September 2004, the Tánaiste and PD leader, Mary Harney, became the Minister for Health and, despite warnings that the health system was not ready for the establishment of the HSE, the legislation was rushed through and it came into existence on the 1 January 2005 (Burke, 2009). This was the biggest public-sector organisation in the history of the country, imposing new structures on more than 110,000 staff providing health and social care for the whole population (HSE, 2006; Burke, 2009).

Yet, it was set up with no permanent chief executive and much confusion about its role and structures (Burke, 2009).The HSE has been marred by controversy and dysfunction since it was set up, with ever changing structures and management lines (Burke, 2009). The government elected in February 2011 committed to abolish the HSE in its Programme for Government (Government of Ireland, 2011).

2.4 The public-private mix in the Irish health system

The Irish health system is a complex mix of public, voluntary and private finance and providers (Barrington, 1987; Wren, 2003; Burke, 2009; McDaid et al, 2009). It is not a universal system and access to care is often restricted by ability to pay (Barrington, 1987; Wren, 2003; Burke, 2009; McDaid et al, 2009). The OECD describes the Irish system as a 'duplicate system' where private care (usually paid for through private health insurance) supplements and duplicates provision by and with the public system (OECD, 2004). A matrix of public and private finance and provision relevant to the cases is outlined on page 29.

Medical cards are issued to 40% of the population, based on means testing, usually those on the lowest incomes (Burke, 2009; HSE, 2012a). Five per cent of those who get medical cards get them on the basis of medical need (HSE, 2012a). Medical cards give people 'free' access to GP and public hospital care and drugs with a small charge per prescription item (McDaid et al, 2009). Sixty percent of the population pay out-of-pocket every time they see their GP, at a charge of €45-€60 (Burke, 2009; Thomas et al, 2008).

Everybody is entitled to public hospital care, with a maximum charge of €750 per year (Burke, 2009; McDaid et al, 2009). Both public and private care is provided in public hospitals and, critically, access to hospital care usually takes longer if you are a public patient (Burke, 2009; McDaid et al, 2009). Government policy since the 1990s has required that hospitals do not provide more than 20% private care, so that 80% of all hospital care is meant to be for public patients (Burke, 2009). However, this 80/20 public-private mix in public hospital care has never been achieved (HSE, 2012b).

The issues of the 'public-private mix' and the 80/20 ratio come up regularly in this research. The term the 'public-private mix' can be applied for all aspects of the Irish health system. However, it is used in this research to mean the public-private mix of care provided in public hospitals. The 80/20 ratio when mentioned in this research is used to refer to the government aspiration that 80% of all care in public hospitals is provided to public patients, while 20% is meant to be for private patients (Department of Health and Children, 2010a).

At the height of the economic boom in 2008, 52% the population had private health insurance (HIAI, 2011). This dropped to 46% in 2011 (HIAI, 2011). People take out private health insurance to gain faster access to public hospital treatment than public patients (Wren, 2003; McDaid et al, 2009; Burke, 2009).

The speedier access to public hospital care for private patients happens in two ways. Firstly, people who can afford to pay private fees can access an outpatient appointment more quickly (Burke, 2009). This first appointment with a specialist acts as a gate-keeping mechanism in to the public hospital system and recent figures show 16,000 public patients were waiting more than four years for an initial outpatient appointment in April 2012 (HSE, 2012b). After an initial assessment by a specialist, if a person is referred into the public hospital system, they are put on a waiting list for treatment. While it is government policy since 2008 that all patients, both public and private, are on a common waiting list, private patients still gain preferential treatment (Wren, 2003; Burke, 2009). Being privately insured when treated in the public hospital system also means people are more likely to get consultant-provided treatment (Wren, 2003; Tussing and Wren, 2005; Burke, 2009; Finn and Hardiman, 2012).

Private care in public hospitals is subsidised by public money in two ways (Department of Health and Children, 2003a; Thomas et al, 2006). Firstly, the majority of the cost of that care, apart from the consultant fee, is paid for with public money and individuals gain tax relief for their private health insurance (Department of Health and Children, 2010a).

A lot of the complexity of the public-private mix in the public hospital system is caused by perverse incentives within the system which have built up over time (Department of Health and Children, 2010a). These include the fact that doctors and hospitals are paid a fee for service on top of their public salary every time they treat a private patient in a public hospital. Doctors and

hospitals are paid their salary or annual funding no matter how many or how few public patients they treat (Department of Health and Children, 2010a). Only a very small proportion of hospitals' annual budgets are allocated on the basis of activity or patients seen (Department of Health and Children, 2010a).

The financial incentives in the system encourage more private patients than the stipulated 80/20 public-private ratio (Department of Health and Children, 2010a). As nearly half the population had private health insurance, hospitals were always under pressure to treat more than their 20% ratio. These pressures originate in the fact that the numbers of private patients who were referred in or who presented at Accident and Emergency departments exceeded the 20% ratio and hospitals and doctors were incentivised to treat private patients (HSE, 2012a; Thomas et al, 2006).

Even though about half the population have private health insurance, the vast majority of health system is financed out of public money (Department of Health, 2010a). Between 2000 and 2006, less than 10% of healthcare financing came from private health insurance, while between 8% and 10% came from out of pocket payments (Department of Health, 2010a).

2.5 Increased provision of private hospital care

Up to the late 1990s, most acute hospital care in Ireland was in the public or voluntary sector, although, as detailed above, a proportion of that care was private care provided in the public system (Nolan and Wiley, 2000; Wren, 2003; Burke, 2009; Department of Health and Children, 2010a).

Due to historical and cultural factors particular to Ireland, many hospitals and healthcare institutions were run by religious orders (Barrington, 1987). Some of these religious orders ran the large teaching hospitals, as well as private facilities such as nursing homes (Barrington, 1987). While they charged patients for their private facilities, they were run on a not-for-profit basis, with any profit usually invested in the public facilities they ran (Barrington, 1987). The 1980s saw the opening up of two private, for-profit hospitals (Wren, 2003).

Even though, government health policy was largely focused on the public system, there was a proliferation in the provision of private for-profit healthcare facilities in the early 2000s, often the unintended consequences of government policy and/or contrary to the national health policy (Burke, 2009; Department of Health and Children, 2010a). This was most evident in nursing homes, whose public/private provision shifted from two-thirds public to two-thirds private within a 10-year period between 1998 and 2008 (Burke, 2009; O'Reilly, 2011).

2.6 Context of private healthcare development and terminology used in this research

There is a vast literature on the privatisation of services across the world (Netter and Megginson, 2001). This literature was reviewed for this research and it informed this work, although is not included here in detail. Netter and Megginson define privatisation 'as the deliberate sale of state-owned enterprises or assets to private economic agents' (Netter and Megginson, 2001). State-owned assets are defined by the World Bank as 'government owned or government controlled economic entities that generate the bulk of their revenues from selling goods and services' (Shirley, 1992: 24). This definition emerged from a literature that is largely concerned with the state selling off state-owned services such as energy and transport to private entities.

The European Observatory on Health Systems and Policies defines privatisation as 'the transfer of ownership and governance functions from public to private bodies, which may consist of voluntary organisation, for-profit and not-for-profit' (Maarse, 2006: 988).

The practice of selling off previously state-owned and -run assets gained traction across the world during the 1980s as the then prime minister of Britain, Margaret Thatcher, and the then president of the USA, Ronald Regan, were leading proponents of the policy (Albrecht, 2009). During this time, the privatisation of aspects of healthcare became more frequent and it has remained a common feature of health policy across the world since then (Albrecht, 2009). Privatisation of healthcare provision was promoted by new public management and neo-liberal policies which became prominent in the 1980s and 1990s (Le Grand, 2010; Harvey, 2005). Albreht's review of the privatisation processes of healthcare in Europe assesses that privatisation 'is driven by the political agenda' and is 'often offered as the panacea for all sorts of problems' (Albreht, 2009: 449).

Saltman outlines the different ways the concept of privatisation can occur through the sale of shares on a stock exchange or through transfer of public assets to a not-for-profit foundation. He argues if this definition is kept to, it helps avoid confusion that often clouds 'privatisation' debates. Saltman's exploration of the melting boundaries between public and private in a European healthcare context, describing 'privatisation as 'amongst the most controversial and value laden terms in European health reform lexicography' (Saltman, 2003: 24).

Saltman notes that most European health systems have a mix of public, private, for-profit and not-for-profit providers with money flowing between them and many anomalies existing within such mixed systems. One example he gives is in England where GPs are private, for-profit business people who receive publicly funded pensions (Saltman, 2003).

In the international literature there is an emphasis on the increased blurring of boundaries between 'public' and 'private' providers in healthcare and the need to examine all providers and aspects if we are to better understand the overall health system (Maarse, 2006, Maarse and Normand, 2009).

This research is not concerned with the privatisation of hospital care in Ireland, as none of the policies transferred either ownership or governance of hospital care from the state to private providers. However each of the policies were introduced with a rationale of extending access and care for public and private patients by: increasing the availability of private for-profit hospital care (through tax breaks for developers under the Finance Acts – Case Study 1); contracting out care of public patients to the private sector (NTFP – Case Study 2); or attempting to transfer care from the public hospital sector to private providers (co-location – Case Study 3). Each of the policies intended to transfer public money to provide private, for-profit hospital care and to increase the provision of private for-profit hospital care. Two out of three of these policies were implemented. Both resulted in the increased provision of and significant public spending on private, for-profit hospital care.

International literature on the growth of the private sector differentiates between four different aspects of finance and provision in healthcare (Laing and Buisson, 1995, Touhy, 1999)

1. Publicly financed and publicly provided
2. Publicly financed and privately provided
3. Privately financed and publicly provided
4. Privately financed and privately provided,

As two out of the three cases here are a combination of public and private finances, the typology has been amended to take this into account with the three following categories:

1. Publicly financed and publicly provided
2. Publicly financed and privately provided
3. A combination of public and private finance and privately provided

Public and private finance and provision as related to the three cases

	Publicly financed and publicly provided	**Publicly financed and privately provided**	**A combination of public and private finance and privately provided**
The Finance Acts			✓
The NTPF	✓	✓	
Co-location			✓

Each of the three cases was a combination of different forms of public and private finance and provision.

The changes to the Finance Acts were a combination of public and private finance as the private developers were given tax breaks to build private hospitals.

The NTPF was the use of public health funds to buy care for long waiting patients in private and public hospitals. Although the majority of their care took place in private hospitals, some care was provided in public hospitals, often for patients with complex care needs who were been treated for an ongoing condition in that hospital.

The plan to co-locate private hospitals on the grounds of public hospitals was that these hospitals would be built out of private finance, although subsidised by public money through tax breaks and privately provided. However, different to other private hospitals, they would be built on a public hospital site where private patients would be transferred from the public hospital and some staff, in particular hospital specialists, would work in both the public and privately co-located hospital, thus taking away much of the risk involved in a standalone private hospital.

A brief timeline of events surrounding the three policies is in the next section 2.7. The methods used in this research are detailed in the next chapter and the findings are in chapters five to 10.

2.7 Timeline for period

Date	Policy or political development
June 1997	Fianna Fáil PD government elected, Brian Cowen appointed Minister for Health
January 2000	Micheál Martin appointed Minister for Health in cabinet reshuffle
June 2000	Local elections held; discontent with the health services was a major political issue
March 2001	Finance Act 2001 passed in parliament, giving tax breaks to developers to build private, not-for-profit hospitals
Throughout 2001	Extensive consultation process for the development of a new national health strategy 'Quality and Fairness' and ongoing development of 'Quality and Fairness'
September 2001	PDs announce idea for a Treatment Guarantee Fund
December 2001	'Quality and Fairness', the new national health strategy is published. It includes reference to the tax breaks announced in the Finance Act and the plan to establish a National Treatment Purchase Fund, as well as 170 other commitments, including a plan for 3,000 additional hospital beds
March 2002	Finance Act 2002 passed in parliament, giving tax breaks to developers to build private for-profit hospitals
April 2002	The National Treatment Purchase Fund is established

June 2002	There is a general election and Fianna Fáil/PD government is re-elected, having campaigned on the basis of needing four more years to reform the health system. Micheál Martin is kept on as Minister for Health
May 2003	Three major reports on the health system on value for money, an audit of structures and function and on medical staff/hospital reorganisation are published. (Department of Health and Children 2003a, 2003b, 2003c) Very little of the health strategy is implemented
June 2003	The plan to disband the health boards and to establish the Health Service Executive on 1 January 2005 is announced
June 2004	Local elections are held and local councillors are no longer appointed to their local health boards in preparation for the establishment of the HSE
September 2004	PD leader and Tánaiste Mary Harney is appointed Minister for Health
1 January 2005	HSE is established
July 2005	The plan to co-locate private hospitals on the grounds of public hospitals is announced by Mary Harney

Chapter 3

Methodology

3.1 Introduction and aims

This chapter details the methodology chosen to carry out this research, the rationale for choosing it, the data collection methods and how the data were analysed. A review of the relevant literature led to the development of a conceptual framework, against which the findings from the analysis were tested. The findings and analysis are outlined in chapters five to nine.

This PhD research uses as case studies three policies from Irish health policy between 2001 and 2005 to investigate what influenced the adoption of policies aimed at increasing the provision of for-profit hospital care in Ireland. The policies selected intended to increase the supply of for-profit hospital care and the spending of public money on for-profit hospital care by

- introducing tax breaks to build private hospitals
- buying hospital care for long waiting public patients usually in private hospitals but, in a small minority of cases, in public hospitals
- and co-locating private hospitals on the grounds of public hospitals.

This research is focused on finding out what shaped the selection and adoption of these policies and how these policy processes evolved.

Qualitative methods were chosen as this research primarily involves understanding the actors involved, the decisions that led to the adoption of these three policies, and the political, social and economic world in which these specific policy choices were made. The rationale for using qualitative methods is detailed in section 3.2 below.

Three specific policies were selected as case studies as the focus of this research. A definition of and the rationale for using case study are outlined in section 3.3. Specific methods used were documentary analysis and semi-structured in-depth interviews, as they enable the researcher to understand the what, why and how of policy-making processes.

Documents were analysed to understand what policy choices were made and when. The in-depth, semi-structured elite interviews were carried out to give a deeper understanding of why specific policy choices were made, or not made. The reasons for using documentary analysis and in-depth interview methods are outlined in sections 3.4 and 3.5.

As these case studies overlap different disciplines, a conceptual framework was developed drawing on theoretical literature from political science, health- and public-policy making, the role of power,

and political economy. The literature and development of the conceptual framework are outlined in chapter four.

Particular attention is paid to the role and position of the researcher in the research process. This is dealt with in section 3.7.

My research questions are as follows:

Primary research question:

- What influenced the policy choices and processes aimed at increasing for-profit hospital care in Ireland between 2000 and 2005?

Secondary research questions:

- How were these policy choices made or not made ('the unintended consequences of purposive social action')?
- What influenced these policy choices as the method of 'reform', how did they get on the agenda, and how did they become a political priority?
- Why were these policies adopted (ideology, pragmatism, power)?
- Who were the champions of these policies?
- How did these policy choices reflect the aims of health policy or the broader political economy of that time?

3.2 Research methods

3.2.1 Qualitative methods

Qualitative research methods were chosen as the best means to answer these research questions. The research questions are concerned with understanding what influences policy-making processes – the why and how of policy choices. It would be hard or even impossible to address these questions through purely quantitative means as the answers are complex, contextual and multifaceted, and not easily quantifiable.

In the past, the literature on research methods was polarised with quantitative research considered

- objective
- focused on numbers (quantifiable)
- deductive (whereby research is generated out of theory)
- positivist (applying the methods of natural science to understand and explain the world around us)
- and the findings were generalisable (Bryman, 2001).

In contrast, qualitative research was seen as

- subjective
- focused on words
- inductive (whereby theory is generated out of research or theory is tested)
- interpretivist (so that the reasons and meanings for a particular action or policy are explored)
- and the findings are not generalisable (Bryman, 2001).

Increasingly, there is dissent in the literature as to whether it can be categorised this simply (Silverman, 2011) (Holstein and Gubrium , 2004), especially with the common use of multi-methods and combining of qualitative and quantitative methods.

Even with more integration between qualitative and quantitative methods, and less polarisation in the methods literature, some general traits about qualitative research can be taken from the literature:

- its focus on words (Silverman, 2011)
- its ability to understand the social, political or economic world by exploring those worlds through its participants (Gubrium, 2004)
- its findings are often a result of studying the views of participants in those worlds (Bryman, 2001; Holstein and Gubrium, 2004)
- its particular value when researching in-depth and complex processes and exploring the where and why (Marshall and Rossman, 2011).

As Bryman states, 'Qualitative research is a research strategy that usually emphasises words rather than quantification in the collection and analysis of data' (Bryman, 2001: 264). Silverman has highlighted there are problems with considering qualitative research as a general approach when there are many different types of qualitative research, ranging from ethnography to discourse analysis. However, common to each of them are words 'that is, language in the form of extended text… The words based on observation, interviews or documents (or watching, asking, listening)' (Miles and Huberman, 1994: 9).

The strengths of qualitative research include its focus on 'naturally occurring events, ordinary events in natural settings' and, through its 'richness and holism', its 'strong potential for revealing complexity', that can go beyond 'snapshots' to 'understand why things happen as they do – even assess causality as it actually plays out in a particular setting' (Miles and Huberman, 1994: 10). It has also 'been advocated as the best strategy for discovery, exploring a new area, developing... and testing hypotheses' (Miles and Huberman, 1994: 10).

3.2.2 Limitations of qualitative research

A weakness of qualitative methods is how generalisable they are. Quantitative research, such as large-scale social surveys, allows generalisations about behaviour or traits, but it does not always explain causality, whereas qualitative research, like case studies, does not usually permit generalisations but can assist with understanding causality and motivation (Hammersley, Gomm and Foster, 2002; Miles, 1994; Silverman, 2011).

My bias and position is relevant to this research and these issues are dealt with in section 3.7. The methods selected and the conceptual framework I have developed place the case studies in the broader political, social and economic world in which they were chosen, each of which was influenced by people in those worlds. The limitations of case studies, interviews and documentary analysis are dealt with below. The selection of the case studies was driven by criteria outlined below. Although there will be limits to the generalisability of the findings, I am hopeful that the insights drawn from rich case studies are useful working hypotheses for further testing.

3.2.3 Qualitative research and policy making

As this thesis is concerned with what influences policy-making processes and/or adoption of health policy at a national governmental level, the methodologies selected are qualitative, as they allow the researcher to answer the research questions – to garner 'a rich texture' – a deeper understanding of the what, why and how of the policy processes (Walt et al, 2008).

Qualitative research allows the researcher to analyse and explain policy processes, as Gilson outlines:

> *Such research is essentially based on the understanding that the world around us is subject to human interpretation. Health policy and systems are therefore understood to be constructed and brought alive by social actors through the meaning they attach to their interpretations of their experiences* (Gilson et al, 2011: 2).

The conceptual framework for this research was drawn from literature on political science, public-policy making, health policy, role of power and political economy. Therefore adopting a qualitative approach was the natural course with which to proceed, as health-policy analysis focuses on 'what social and political processes, including power relations, influence them' (Gilson et al, 2011: 2).

Qualitative research is suitable for the analysis of health-policy formulation due to the specific characterisations and nature of health policy.

> *Health policies and systems are fundamentally shaped by political decision making whilst the routines of health systems are brought alive through relationships among actors involved... in essence health policies and systems are constructed through human behaviour and interpretation rather than existing independently of them. As relativist social science perspectives see all phenomena as at least partially constructed in this way,*

they have particular value in building methodological foundations of health policy research' (Gilson et al, 2011: 2).

Multiple qualitative methods of case study, documentary analysis and in-depth interviews allowed a deep exploration of the influences on health policy (Marshall and Rossman, 2011). There are multiple but concurrent stages to my methodology. These include

- case study methods
- documentary analysis
- in-depth semi structured elite interviews
- coding and analysis using my conceptual framework.

3.3 Case study

Case-study research is commonly used to qualitatively research in-depth specific 'cases' that are naturally occurring. Case-study research usually involves multi-methods where triangulation of evidence assists in making robust explanations of complex social phenomena (Yin, 2009).'Cases' could be people, events, institutions (Yin, 2009). Case-study research was chosen as a method that is very useful to answer the '"how" and "why" questions that are being asked, when the investigator has little control over events and the focus is on a contemporary phenomenon' (Yin, 2009: 2).

Central to this research is answering the how and why of the three cases adopted. As the researcher, I had no control over the 'events' that happened (or the policies that were made) although I was working in the health-policy field at the time (this issue is dealt with later in this chapter).

It is most useful in this research to explore why particular decisions were made or not made. According to Schramm 'the essence of a case study, the central tendency among all types of case study, is that it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented' (Schramm 1971 cited Yin, 2009: 17).

Case studies often employ similar techniques to historical analysis, such as documentary analysis, but add to historical analysis through other data-collection techniques, in this instance semi-structured, in-depth interviews with elites. 'Elite interview' is the term given to interviews 'with senior decision makers and representatives of powerful interest groups' (Buse et al, 2007: 187).

There is some disagreement in the literature as to whether case studies are a methodology, a strategy for enquiry (Yin, 2004) or merely a choice of what is to be studied (Stake, 1995). Yet there is convergence in relation to the use of case studies.

Case study is qualitative research in which the investigator explores a bounded system (case) or multiple bounded system (cases) over time in detailed, in-depth, data collection

involving multiple sources of information eg interviews, documents and reports" (Creswell, 2007: 73).

Case-study research usually has fewer rather than many cases and investigates them in 'considerable depth' (Hammersley and Gomm, 2000). They differ from experiments as the cases are selected from events, or, in this instance, policies, which have already been chosen rather than those that are created by the researcher. They differ from social surveys in the depth of information gathered (Hammersley and Gomm, 2000).

The case studies in this research are divided into exploratory, explanatory and descriptive qualitative case studies (Yin, 2004) and constitute a multiple case study, as there are three cases involved.

3.3.1 Strength of case study

The case study's 'unique strength is its ability to deal with a full variety of evidence, documents, artefacts, interviews and observations – beyond what might be available in a conventional historical study' (Yin, 2009: 11).

Yin elaborates:

> *A case study is an empirical enquiry that investigates a contemporary phenomenon in depth and with its real life context, especially when the boundaries that exist between phenomenon and context are not clearly defined* (Yin, 2009: 18).

They often allow the study of an expansive field of research through a particular circumstance or set of circumstances. They can provide unexpected explanations for often hard-to-answer questions (Yin, 2009).

Case studies are considered useful in building theories:

> *The argument for case studies as a means for building theories seems strongest in regard to precisely those phenomena with which the subfield of comparative politics is most associated: macro political phenomena, that is units of political study of considerable magnitude or complexity* (Eckstein, 2002: 102).

Both Becker and Platt highlight one of the advantages of case studies is that they allow the researcher to make surprising discoveries and consider different and connected relationships between trends examined (Becker, 1968; Platt, 1988).

There is much disagreement in the theoretical literature for the case study as to whether case studies explain causality at all, with some consensus that generalisations can be made only from multiple case studies, and even then with great caution (Hammersley et al, 2002).

The strengths of case studies are outlined above, ie they allow the research to carry out an in-depth analysis of why certain events or phenomena, or, in this instance, policy choices, were made or not made.

3.3.2 Limitations of case studies

There are also weaknesses identified with the case study method. One outlined by Yin is the 'lack of rigour of case study research', that case studies 'provide little basis for scientific generalisation' and that they fail to provide 'causal relationship' (Yin, 2009: 15/6). These limitations are addressed in this research through the adoption of a rigorous methodological approach, through the use of multiple cases and through an acknowledgement of the weaknesses of the methods.

I disagree with Yin's criticism when rigour and multiple cases are applied to the research. The aim of health-policy analysis is to find explanation and to suggest causality, which in the future can be tested. By placing the findings in my conceptual framework, drawing on relevant literature and utilising NVivo in my analysis, generalisations may emerge from this research for Irish policy making and health-policy making in general.

3.3.3 Case studies and policy making

This research is centred on understanding what influenced the adoption of the three specific policies under scrutiny. Through understanding those particular policy-making processes, I hope to develop a greater understanding of what influences policy-making processes, and therefore central to it is the 'how' and the 'why' of policy making (Miles and Huberman, 1994).

Policy making is a 'macro political phenomena' and this research hopes to contribute to theory building and methodological challenges in this area by analysing the data through the conceptual framework developed specifically for this work, and by testing and refining the conceptual framework.

> *Case study research is widely used in organisation and political science work, it supports 'thick descriptions' of the particular experiences situated within their context that allow an understanding and explanations of the phenomena of focus by reference to that context* (Gilson et al, 2011: 3).

In addition, multiple case studies, and systematic and deliberate cross-case comparison, support analytic generalisation (Gilson et al, 2011). They point out that the aim of such studies is not to

> *draw conclusions that can be statistically generalised to a wider study population that will hold across time and place. Instead analytical generalisation entails the development of general conclusions that although derived from a limited number of particular experiences, provide theoretical insights that can be put forward for consideration and testing in other similar situations* (Gilson et al, 2011: 3).

Walt et al (2008), when discussing the methodological challenges of health-policy analysis, specifically focus on the use of case studies for policy analysis (Walt et al, 2008: 312). These authors note how most policy analyses are case studies. They specify how it is important to clarify: cases of policy transfer and network influence or political influence; why it is useful to study these cases; and whether the cases are generalisable (Walt et al, 2008). This research seeks to answer each of these questions.

Gilson et al (2011) call for more rigorous use of case studies, while Reich, who has carried out extensive cross-country case-study analysis in the field of health policy, states:

> *Case studies do not constitute proof in social science. Three cases can however provide a persuasive argument, through the identification of commonalities and differences and through contextual analysis (and three cases are better than one or two)* (Reich, 1995: 69).

3.3.4 Selecting the cases for this research:

Ireland has a unique health system with an unorthodox mix of public and private care. Up to the late 1990s, most acute hospital care in Ireland was in the public/voluntary sector, although a substantial proportion of that care was private care provided for in the public system (Burke, 2009; Department of Health and Children, 2010a; Tussing and Wren, 2005; Wren, 2003).

The background to Ireland's health system and its public-private mix is detailed in chapter two. Until the early 2000s, the vast majority of Irish private hospital care was in the public and voluntary sector, most of which was in the not-for-profit sector, set up and run by religious orders. While Irish government health policy focused on the public system, there was a proliferation in the provision of private care in the early part of the first decade of the 21st century, often the unintended consequences of government policy and/or contrary to 'official' health policy (Burke, 2009; Department of Health and Children, 2010a; Tussing and Wren, 2005).

The following cases were chosen as they were the policy drivers for the increased provision and use of private, for-profit hospital care.

1. The changes to the Finance Acts in 2001 and 2002 which gave tax breaks to build private hospitals, nursing homes and healthcare parks;
2. The National Treatment Purchase Fund (NTPF), which was set up in 2002 to buy care for public patients who were waiting more than three months for elective treatment in a public hospital;
3. The plan, announced in 2005, to co-locate private hospitals on the grounds of public hospitals.

These policies were not the most important health policy developments during this time, In fact one of them, case study three, was never even implemented, However as detailed in chapter five, two

out of three of these policies resulted in significantly increased provision of private, largely for-profit, hospital care and use of private hospital care for public patients. The biggest health policy reform during the time period under consideration was the abolition of the health boards and the formation of the HSE (Tussing and Wren, 2005, Burke 2009).

The policies selected here were much less visible but had considerable impact on the landscape of healthcare and health policy. Also in order to understand the whole health system one needs to examine the private as well as the public aspects of healthcare policy and provision. While there is some analysis of Irish public health policy development and implementation, there was little academic scrutiny in the area of private health policy making processes in Ireland when this topic was embarked upon.

The three case studies chosen were introduced by the Fianna Fáil/Progressive Democrat government with a rationale of extending access and care for public and private patients by: increasing the availability of private for-profit hospital care (through tax breaks for developers under the Finance Acts); contracting out care to the private sector (NTFP) or attempting to transfer care from public hospitals to private providers (co-location). When announced, all policies were promoted on the basis that they would result in improvements in hospital care of public patients.

This research was carried out to gain a rigorous and in-depth understanding of how these policy processes emerged and why these policy choices were made.

3.4 Documentary Analysis

3.4.1. Data collection strategies

Detailed methods of data collection and analysis

The first stage of the data collection and analysis was to assemble all available documentary information on the three case studies/policy areas and to analyse them. The second stage was to carry out in-depth semi-structured interviews with elites involved in the policy-making processes. These methodologies are detailed. The analysis is detailed in section 3.6.1.

3.4.2 Documentary analysis:

Documentary analysis is a common social-research tool, used in both qualitative and quantitative analysis, but more commonly utilised in qualitative research.

Traditionally, documentary analysis has focused purely on the content of the documents, and most organisations, particularly official and government ones, produce inordinate numbers of documents such as monthly, quarterly and annual reports, memos, policies, mission statements, research findings (Prior, 2011).

Documentary analysis is used to understand the substance of the documents, putting them in context, explaining their significance and giving a summary (Atkinson and Coffey, 2004; Miles and Huberman, 1994).

> *Documents are social facts in that they are produced, shared and used in socially organised ways. They are not however transparent representations of organisational routine, decision-making processes, or professional practices. Documents construct particular kinds of representation... we cannot treat records – however 'official' – as firm evidence of what they report... We have to approach documents for that what they are and what they are used to accomplish.* (Atkinson and Coffey, 2011: 79).

According to Silverman, an 'interest solely in document content is rarely sufficient to understand what is going on, that it is always necessary to make some kind of connection between what be called the 'word' and the 'world', if we are to capture essential elements' (Prior, 2011: 96).

One method of dealing with large volumes of text, such as in the policy area, is to index or quantify the use of words in order to see how often they do or do not appear. Another is to look at themes in a document and 'text-mine' and produce concept clusters. This quantification is just an entry point.

> *To understand how the words in the documents connect to the world beyond the text – to the actions of the politicians and policy makers who produced the documents as well as to the audience for whom the documents were intended – we would need to use other sources of data such as interviews and other sources of text such as political speeches.* (Prior, 2011: 98).

Another way of analysing the documents is to look at the narrative, which in policy documents will give the 'official' policy line (Silverman, 2011).

3.4.3 Limitations of documentary analysis

A weakness of the official documents associated with the policies is that they tell the 'official' narrative, outlining what decisions were made or not made rather than why or how the decisions were made. In some instances they give the official explanation for the adoption of the policy, but they usually do not outline the opposition or arguments against them (Silverman, 2011).

The interviews raised the issue of the limitations of documents in the public domain relevant to the three policies under examination due to the impact of Freedom of Information. Freedom of Information (FoI) was introduced in Ireland in 1997. For the first time, it gave members of the public, the media and the research community extensive access to state papers, including cabinet deliberations, which were to be released after five years. Amendments to the FoI Act in 2003 significantly restricted the rights to access information that were granted by the original law, by increasing charges for making FoI requests and by making cabinet material inaccessible for 10 years (Department of Public Expenditure and Reform, 2010).

Another issue that arose repeatedly in the interviews when I asked where I could find documents to back up what was being said by an interviewee was that it would be hard to find it in the documents, because people limited what was put down on paper due to FoI Acts. Since the introduction of FoI, a practice of not writing things down, or using 'Post-its' which can be removed, has become common place across the public service. This was cited in five interviews.

This is an interesting finding in itself: that a policy designed to increase access to information has led to greater restrictions on it and more limited documentation of discussions that took place. These limitations of documentary analysis are addressed through taking a multi-methods approach and using in-depth interviews to supplement findings from documents.

Secondary documents were used to contextualise the primary documentary sources.

3.4.4 Sourcing the documents

The documents for this research have been gathered through an initial search from the reference list of relevant documents, by snowballing techniques. Snowball sampling 'identifies cases of interest from people (or documents) who know people (or refer to documents) who know what cases are information rich' (Marshall and Rossman, 2011: 111).

A weakness of the snowball sampling is that documents refer to or reference documents which support their position rather than getting an objective sample of documents on a specific topic (Marshall and Rossman, 2011).

As the policies selected are specific, there are limited numbers of 'official' documents associated with this formulation and therefore snowball sampling is an appropriate method of finding other relevant documents.

Further documents were sought after asking interviewees for literature used and developed during the development of the policies. Some documents were obtained through FoI requests, when it was not possible to get them from any other source. I put in an FoI request for all papers in the Department of Health in relation to tax exemptions in 2001 and 2002, which Wren referred to in her book (Wren, 2003). These were withheld from me due to changes introduced in 2003, but I got them from Wren and have utilised them extensively in this research.

I also put in FoI requests for the NTPF and co-location. For the NTPF, I was looking for early drafts of the health strategy. These were refused to me under various grounds: they did not exist, they were not accessible, they were protected by cabinet confidentiality. For co-location, I sought the documentation submitted to the Department of Health by the management consultancy firm Prospectus. This proved difficult to acquire as it is not in the public domain. After numerous requests, the draft policy-guidance directive to the Health Service Executive on the 'Development of private acute facilities on public hospital sites' Assessment Framework' was given to me

unofficially by someone in the health system after several FOI requests were rejected (Department of Health and Children, 2005a; Department of Health and Children/Prospectus, 2005).

Some documents mentioned in the interviews were not obtainable as they were refused under FoI and/or subject to cabinet confidentiality and the 10- or 30-year rule. This is a weakness of contemporaneous or recent historical documentary analysis that some information, especially that contained in cabinet documents, is not available (Marshall and Rossman, 2011).

Documents included in this research are:

- relevant policy documents – statements of the policy's intent
- relevant legislation
- documents produced during the policies' development, including press releases
- grey literature and unpublished reports on relevant policy issues
- communications between officials, memoranda and internal documents mostly obtained through FoIs
- relevant Dáil debates
- and some media coverage.

Together these documents provide a rich description of what influenced the policy choices in the three case studies.

Table 3.1 Key documents used to analyse the three case studies

Finance Act document names	*Source*	*Type*
1. Finance Act 2001, Irish Statute Book	Department of Finance, 2001	Legislation
2. Finance Bill, Second Stage Seanad debate, 27 March 2001	Seanad Éireann,	Seanad debate
3. Finance Act 2002, Irish Statute Book	Department of Finance, 2002	Legislation
4. FoI communication between Departments of Health and Finance about tax reliefs	Department of Health, 2001	Letters and emails
5. FoI communications between James Sheehan and Minister for Finance	Department of Health, 2001	Letters and emails
6. FoI communications between Michael Heavey of the IHAI and Dept of Health	Department of Health, 2002	Letters and emails
7. FoI communication between Ministers Martin and McCreevy	Department of Health, 2001/2	Letters and emails

8.	Direct communication with HSE re hospital bed numbers since 2005	Health Service Executive, 2012	Emails
9.	Committee Stage amendments to 2001 Finance Bill obtained under FoI	Department of Health, 2001	Drafts of Finance Bill
10.	Impact Assessment of legacy property reliefs	Department of Finance, 2010	Consultation report
11.	Revenue Commissioners Statistical Annual Reports 2004-2009	Revenue Commissioners, 2004-2009	Annual reports
NTPF document names			
12.	Report on Value for Money Examination, Department of Health	Comptroller and Auditor General, 2003	Report
13.	Annual Report of Comptroller General, 2004	Comptroller and Auditor General, 2004	Report
14.	PD plan to transform healthcare	Mary Harney, then leader of Progressive Democrats and Tánaiste, 2001	Opinion piece in the Irish Times
15.	Health Statistics, 1999	Department of Health, 1999	Report
16.	Monthly HSE Performance Report February 2011	Health Service Executive, 2011	Report
17.	NTPF annual reports 2003-2011	NTPF, 2003-2011	Annual reports
Co-location document names			
18.	Tánaiste announces plan for 1,000 new public hospital beds over five years	Department of Health, 2005	Press release
19.	Draft Policy Guidance Directive to the Health Service Executive. Development of private acute facilities on public hospital sites. Assessment Framework	Department of Health, 2005	Policy directive
20.	Letter to the HSE and assessment framework from Michael Scanlon, then Secretary General of the Department of Health	Department of Health, 2005	Letter
21.	Note on Hospital Consultants' Contract	Department of	Press release

	Health, 2005	
22. Tánaiste's Policy Initiative to free up bed capacity for public patients. Note for Editors	Department of Health, 2005	Press release
23. Development of private facilities on public hospital sites – memorandum on related policy issues.	By Prospectus for Department of Health, 2005	Memo obtained through personal communication
24. Co-location – a major policy initiative.	By Prospectus for Trinity MSc in health management	Presentation obtained through personal communication
25. Minutes of HSE board meeting 6 October 2005, 3 November 2005, 1 December 2005	Health Service Executive, 2005	Minutes of meetings on www.hse.ie
26. National Service Plan, 2006	Health Service Executive, 2006	Report
27. IMO Pre Budget Submissions 2005 and 2006	Irish Medical Organisation, 2005 and 2006	Pre-budget submissions
Documents used in all three cases		
28. Remarks by Mary Harney at a meeting of American Bar Association, 21 July 2000	Department of Enterprise, Trade and Employment	Press release of speech
29. Quality and Fairness – A Health System for You	Department of Health, 2001	Policy
30. Your views about health. Report of consultation. Quality and Fairness	Department of Health, 2001	Consultation process report
31. Report of Expert Group on Resource Allocation and Financing in the Health Sector	Department of Health, 2010	Research and policy report
32. Minister appoints head of the NTPF	Department of Health, 2002	Press release
33. OECD Health at a Glance 2011	Organisation for Economic Co-operation and Development, 2012	Database and report
34. Steering a policy course by Michael Kelly	McAuliffe and	Chapter in

	McKenzie (Eds) 2007	book
35. Dáil speech given by Mary Harney as Minister for Health	29 September 2004	Oireachtas

Table 3.2 Secondary documents drawn on for documentary analysis

Title and author	Year	Type
1. *Health Medicine and Politics in Ireland 1900-1970* by Ruth Barrington	1987	Book
2. *Public Expenditure Discussion Paper* by Tom McDonnell and Daragh McCarthy	2001	*tasc* research report
3. *Perceptions of the Quality of Healthcare in the Public and Private Sectors* by Dorothy Watson and James Williams	2001	ESRI research report
4. *Acute Hospital Bed Capacity. A National Review* by Mary Codd	2002	Department of Health report
5. *Unhealthy State, Anatomy of a Sick Society* by Maev-Ann Wren	2003	Book
6. *Health Insurance in Ireland: Issues and Challenges* by Brian Nolan	2004	ESRI report
7. *Breaking the mould. How the PDs changed Irish politics* by Stephen Collins	2005	Book
8. *How Ireland Cares. The case for healthcare reform* by Maev-Ann Wren and Dale Tussing	2005	Book
9. *Commission on Taxation Report* by Commission on Taxation	2009	Commission report
10. *Showtime. The Inside Story of Fianna Fáil in Power* by Pat Leahy	2009	Book
11. *Irish Apartheid. Healthcare Inequality in Ireland* by Sara Burke	2009	Book
12. *Celtic Tiger in Collapse, Explaining the Weaknesses of the Irish Model* by Peadar Kirby. Second Edition	2010	Book
13. *Health in Ireland. Key trends*. Department of Health and Children	2010	Report
14. Failed Design. Ireland's Finance Acts and their role in the crisis by tasc	2010	*tasc* report

15. *An Ombudsman Perspective on Health Policy* speech by Emily O'Reilly at Mater Hospital Health Policy conference	2011	Conference paper
16. *Government for National Recovery 2011-2016* by Fine Gael and the Labour Party	2011	Document
17. *The Challenge for Change. Putting Patients before Providers* by Brendan Drumm	2011	Book

3.4.5 Analysis of the documents

Drawing on my literature review and the development of a conceptual framework, the documentary analysis included:

1. An analysis of the content of the three policies including technical goals;
2. A timeline of the policies' development and adoption including the impacts of the policies;
3. The identification of the key actors involved in the policies' adoption and development;
4. An analysis of the political and economic context in which the choices were made;
5. An analysis of the key themes associated with the adoption of these policies;
6. An assessment of the use of evidence in the policy-making processes.

I used Kingdon's multiple-streams model to write up this analysis. These findings are in chapter five. The documents are written up separately to the interview content in chapter five in order to provide a descriptive and objective account from the documents. This content was then used in the interview process to explore and try to get the interviewees to explain what happened. This is written up in chapters six to eight. The documents and interviews are then combined to provide the analysis detailed in chapter nine.

3.5 Interviews

3.5.1 Semi-structured, in-depth, 'elite' interviews

Work carried out on documentary analyses provided an adequate description of the technical goals of the policies, the policy context in which these policies were made and, to a much lesser extent, explanations of why these policy choices were made.

Interviews are used as a way to supplement and elaborate on findings or themes identified in documents or from other methods such as focus groups (Kvale and Brinkmann, 2009). In this research, the in-depth interviews were used to discover and tease out explanations as to why these specific policy choices were made, or not made. No alternative method to semi-structured, in-depth interviews was considered given their strengths in eliciting quality content (Stephens, 2007).

Due to the breadth and depth of information garnered in the document analysis, the interviews were used as a sounding board to test the findings. Also if interviewees provided a contrary scenario, the documents were used extensively to substantiate or disprove an interviewees' stance.

For researchers, the primary aim of an interview is 'to generate data which give an authentic insight into people's experiences' (Miller and Glassner, 2011: 133). Whilst in the past there were efforts to carry out sterile, 'objective' interviews, there is recognition that this may not be feasible or desirable, that in fact what interviews do is 'elicit authentic accounts of subjective experiences' (Miller and Glassner , 2011: 131).

One concern of these interviews is whether they are in fact 'authentic accounts' or instead 'repetition of familiar cultural tales' (Miller and Glassner, 2011: 132). This is particularly true when the time under consideration is not recent and the subject's memory may be affected by commentary on the policy since then or they may have had a change in attitude. They may portray their current view as what they thought then. Also there may be some historical revisionism in order to preserve reputations.

A strength of semi-structured interviews mean the interview schedule is less formal, asking open-ended questions that allow the interviewee's experience and viewpoint to guide the direction of the interview (Patton, 2002).

3.5.2 Strengths of semi structured in-depth elite interviews

The benefit of in-depth semi-structured interviews is the depth of information and knowledge obtained. Interviews also allowed for clarification and follow up of both information gained from documentary analysis and of what arose in other interviews (Marshall and Rossman, 2011).

In-depth interviews are used as a method to enquire deeper. Qualitative in-depth interviews allow the 'construction site of knowledge' (Kvale and Brinkmann, 2009: 2). Kvale and Brinkman describe the interviewer as a miner, whose role it is to 'dig nuggets of knowledge out of subjects' pure experience' (Kvale and Brinkmann, 2009: 48), to probe and locate the interviewee's knowledge and get as much information and knowledge out of them as possible (Kvale and Brinkman, 2009). 'Information about social worlds is achievable through in-depth interviewing' (Silverman, 2011: 132).

Semi-structured in-depth interviews allow for an exploration of what, why and who influenced the agenda-setting, choice and adoption of these policies, what forces – political, economic, ideological, pragmatic – had most impact on the three policy-making processes (Holstein and Gubrium, 2004).

The semi-structured format allowed me to cover one or all of the three policy areas researched and also allowed interviewees to frame and structure their responses. The design also enabled me to ask follow up questions and request elaboration as appropriate, rather than follow a strict interview

protocol in structured interviews (Marshall and Rossman, 2011). According to Marshall and Rossman, 'the richness of the interview is heavily dependent on those follow up questions, often called probes' (Marshall and Rossman, 2011: 145).

3.5.3 Elite interviews

This research focuses on health policy and the role of political elites and those working in the private health sector in the policy-making process. The policy and political people interviewed were in senior positions in the Departments of Health and the health services. Those in the private sector are usually wealthy individuals who develop, own and run private, for-profit hospitals and whose hospitals availed of tax breaks, benefited from the NTPF or sought to participate in the 'co-location' project. Also, some senior medical professionals were interviewed about their involvement inside or outside the policy processes at that time.

All those interviewed for this research are or were people in positions of power and influence in the policy sphere. This specific type of interview is called an 'elite interview', given the status of the interviewees.

> *An interview with an 'elite' person is a specialised case of interviewing that focuses on a particular type of interview partner. Elite individuals are considered to be influential, prominent, and/or well-informed ... They are selected for interviews on the basis that their expertise in areas relevant to the research and for their perspectives on, for example, an organisation or a community or a specialised field such as the economy or health policy* (Marshall and Rossman, 2011: 155).

There are many benefits to interviewing members of elites as they usually have a long history in the organisation/area/policy in which they are involved and 'have a broad view of the development of a policy field or social science discipline' (Marshall and Rossman, 2011: 155).

Elites often respond best to more open-ended questions that allow them freedom to respond in their own way (Marshall and Rossman, 2011: 156). Such a flexible approach was adopted in this interviewing process.

3.5.4 Limitations of semi-structured in-depth interviews

A disadvantage of interviews is that good information is dependent on a high level of trust between the interviewee and interviewer (Marshall and Rossman, 2011). If this does not exist, the interviewee may be reluctant to be forthcoming with information or knowledge. This was a worry in advance of the interviews, as I have stated publicly my opinions on some of the policies and issues being discussed. This issue is dealt with later in the section on positionality.

Douglas synopsises four problems with interviews as a method, including 'misinformation, evasion, lies and fronts' (Douglas 1985 cited in Roulston, 2010: 203). These were dealt with by challenging interviewees on points if I felt they were giving me misinformation or lying. As stated

above the documents were used to validate or contradict what different interviewees said. Also people were reminded of the question if evading the answer, or asked why they thought a particular thing if they appeared to be putting on a front.

There can also be problems with recall or memory bias (Holstein and Gubrium , 2004). As the policies being researched were introduced between five to ten years before the interviews took place, interviewees may not remember accurately how events happened. The time delay may be seen as a positive in that more of them may have been willing to talk honestly about what influenced the policy choices or felt freer to talk about their opinion of them.

However, the time delay between the policy making and the interview can result in recall bias, meaning that interviewees may not remember what happened or they may reconstruct what happens with the wisdom or obstruction of hindsight (Silverman, 2012). Some interviewees said they 'could not remember exactly but…' or that they would need to refer back to notes. This was noted in the coding process.

With time and reputations to protect, the interviewees may skew their responses in self-interest to suit their particular take on events (Silverman, 2011). In some interviews, I strongly believed the interviewees were not telling the truth, for example, I had letters signed by subjects stating the contrary to what they were saying during an interview. In some instances I confronted them and in others I did not, depending on the circumstances.

To deal with this, interviewees were reminded of specific information sourced from the documents or were prompted and probed with what others said, for example, contradictory information from other interviewees. When claims were made in the interviews, interviewees were consistently asked to point towards documentary evidence to back up what was being said. While this was not always possible, recall or memory bias was dealt with by not depending on any one source, and if a single source is used, this is specified in findings/analysis section.

A drawback to elite interviewing is that the 'elites' tend to be busy people to whom it may be difficult to get access. Also, elite interviewees may be familiar with being interviewed and take control or charge of it to make the points they want to make (Marshall and Rossman, 2011). This may be more of an issue when there are significant differentials in status between the interviewee and the interviewer. As part of both my policy research and journalism work, prior to carrying out my PhD interviews, I was familiar with interviewing and questioning people in senior positions in academic, policy, political and business worlds. Most of those I interviewed knew me either directly through previous work or indirectly by reputation.

Triangulation of findings was used to mitigate recall bias and verify or dismiss claims made in the interviews and was central to dealing with recall and memory bias. One person's take on a

particular event was not be used unless it was substantiated by other interviewees or in the documents analysed (Marshall and Rossman, 2011).

3.5.5 Selecting the interviewees

The people who formulated these policy choices are the central source of information for the study. They include officials in government departments, government ministers, ministerial advisers, senior health-service officials (in former health boards and in the HSE), medical professionals and management consultants who advised on or were involved in the development of the policies, owners and managers in the for-profit, private healthcare market. As there were limited numbers of people working at senior decision-making levels involved in these case studies, these people were identified through purposive sampling (Holstein and Gubrium , 2004).

Purposive sampling is an informant selection tool, widely used in ethnography but also utilised in other qualitative research methods (Bernard, 2006). It is sometimes called 'judgment sampling' as the participants are selected for interview on the basis of their knowledge or experience relevant to the area under research (Bernard, 2006). Purposive sampling is commonly used when interviewing key informants, as is the case in this research.

The criteria for selection were:

- People involved in the development of one or more of the three policies/case studies utilised in this research
- People in relevant political and policy positions in government between 2001 and 2005
- People who owned or had investments in private healthcare/hospitals which availed of or benefited from policies selected
- Senior medical professionals who were involved in or spoke about (for and against) health-policy developments at the time.

A breakdown of interviewees is in table 3.3.

Snowball sampling was also used to supplement purposive sampling as each interviewee was asked about other potential interviewees. Purposive and snowball sampling were chosen methods as the policies researched are very specific and only a small pool of people were involved. The limited size of the pool means random sampling was not possible. A drawback of purposive and snowball sampling is that by their nature they are not representative and they do not cover the entire relevant cohort (Bryman, 2001).

Snowball sampling differs from purposive sampling as purposive sampling does not utilise interviewees as informants for other possible interviewees (Bernard, 2006). There is no lower or upper limit on the optimum size of a purposive sample, although five is considered a minimum for

data to be reliable (Bernard, 2006). Twenty-one people were interviewed for this research when it reached saturation point, ie when the interviews began to reveal little new information or themes.

It was important to minimise the bias of the interviewees. In order to do this, people who were proponents and critics of the policies were included. Also, other interviewees who may consider themselves 'neutral', such as civil servants, were probed during the interviews to get an understanding of their take on the policy. According to Bernard, despite the inherent bias in purposive sampling, the strength of the method lies in its intentional bias, ie the researcher is selecting the people who know most about a given area, in this instance the policy, as they were involved in its development or its opposition from an outsider perspective (Bernard, 2006).

3.5.6 Those who participated and those who refused to be interviewed

All of the potential interviewees were in senior policy, political and management positions between 2001 and 2005. Many of them no longer held those same posts by the time the interviews took place between January 2010 and spring 2011 – up to ten years after the first policy was introduced.

Table 3.3 Interviewees' roles, knowledge of three policy areas and whether still in their role

Position	Finance Acts	NTPF	Co-location	Still in role?
Senior departmental official	Yes	Yes	Yes	No
Senior health official (subsequently in the private sector and an adviser)	Yes	Yes	No	No
Senior health official, ex Department of Health	Yes	Yes	No	No
Private sector	Yes	Yes	Yes	Yes
Senior departmental official	Yes	Yes	Yes	Yes
Political person (politician or very senior adviser)	Yes	Yes	No	No
Senior health official	Yes	Yes	Yes	No
Medical representative	Yes	Yes	Yes	Yes
Senior health official	Yes	Yes	Yes	Yes
Private sector, ex Department of Health	Yes	Yes	Yes	Yes
Senior departmental official	Yes	Yes	Yes	No
Private sector	No	Yes	Yes	Yes
Medical representative	Yes	Yes	No	Yes
Medical representative	Yes	Yes	Yes	Yes
Private sector	Yes	Yes	Yes	Yes
Private sector	Yes	Yes	Yes	No
Private sector	Yes	Yes	Yes	No
Senior departmental official	Yes	Yes	Yes	No
Private sector	Yes	Yes	Yes	Yes
Political person	Yes	Yes	Yes	No
Political person	Yes	Yes	Yes	No

Interviewees included people from some of the most senior positions inside and outside of government, who were directly or indirectly (such as lobbying) involved in the policy-making process.

Table 3.4 Breakdown of interviewees by type and numbers

From which sector	*How many*	*Changed roles*
Private sector	7	One ex Department of Health official
Department of Health officials	4 (+2)	Six Department of Health officials were interviewed, two of whom changed roles
Senior health officials	4	One ex Department of Health official. Two went on to work in private health sector
Political people	3	None of them in office by time of interview due to change in government
Medical representatives	3	No change
Total	21	

Seven of the interviewees were from the private sector. Of these, six were directly involved in running or owning private hospitals, while one of them worked for a private management consultancy firm.

Six of the interviewees were senior officials in the Department of Health, although two of them had moved on to other roles by the time of the interviews and are categorised in their new roles. Three of four who remained in the Department of Health had retired by the time of the interviews.

Four of the interviewees were 'health officials'. I used this term to describe people who had been in a senior administrative position in the health boards or who were working in the HSE.

Three of the interviewees were 'political people'. I used this term to describe politicians or their political advisers. One of the political people was an ex Minister for Health.

Three of the interviewees were representatives of the medical profession working for either the Irish Medical Organisation (IMO) or the Irish Hospital Consultants Association (IHCA).

Most of the key architects involved in each of the policies' development were interviewed, however three central personnel from the political arena did not participate, and the key official from the Department of Finance was deceased by the time of the interviews.

Of the three political people I did not interview, one former minister was not contactable. I made several attempts to make contact, including writing to their home address and going through intermediaries, but got no response. Another senior politician turned me down, having initially verbally agreed to an interview. Eventually, after many written attempts to gain an interview, I got word through an intermediary that they would not do the interview.

Another senior political person refused to participate, citing my bias towards their policies as the reason. In my journalism work, I have been critical of health policies in which they were involved, in print and broadcast media and in a book I have written on the health system. This issue is addressed in the positionality section below. This person said they would give me an interview only if I publicly retracted previous criticism of government policy in which they had a role.

As these three people who did not agree to participate were very senior proponents of the policies under examination, their exclusion from the research is a weakness. However, their position is reflected in policy papers, press releases, political speeches and conference papers where they make their position clear on the arguments for the policies' adoption and implementation, and these are drawn on instead. Also other interviewees were asked about the opinions, motives and actions of the three with questions such as 'why did X support/drive this policy?' or 'what drove this policy?' Many of the interviewees worked closely with them and their impressions are included in the analysis.

Their absence also means there is a potential for bias in the findings. This is remedied as far as possible by drawing on the official documents that outline and support their position. Also, a broad selection of proponents of the policies were selected for the interviews in order to balance the potential bias in the interviewees who participated.

3.5.7 The interview process

A semi-structured interview protocol was developed in advance of the interviewees (see appendix I) and participants were given a participant information leaflet on the topic of the research in advance. Specific questions were not given before the interview (see appendix II). The semi-structured topical interview guide and participant information leaflet were developed for the ethics process I went through at the Trinity College Dublin School of Medicine as part of the PhD programme in autumn 2009.

Anonymity and confidentiality were assured so as to encourage interviewees to participate and to be as open as possible. Participants were sent a participant information leaflet in advance and asked to sign two copies of the informed consent form at the outset of the interview (see appendix III). They kept one copy of it and I have kept the other on record.

The interview guide was piloted with two interviewees and altered based on the piloting, in winter 2009. All interviews were recorded with the permission of the interviewee, transcribed and anonymised. Only I as the researcher and my two supervisors are aware of their identities and what they said. In the analysis, participants are numbered and categorised so as to ensure anonymity using terms such as 'senior policy maker', 'private hospital owner', 'politician' etc.

As there are three policy areas (case studies), at the beginning of the interviews, each interviewee was asked which policy/policies they were involved in and taken through the questions for each

policy in turn, as relevant. In line with semi-structured interviews, open-ended questions were used, for example, 'what influenced the development of this policy?' and 'why?'

Often questions were answered without having to specifically ask the questions. For example, instead of asking 'is this an example of policy transfer?' it would come up naturally as a response that 'this policy initiative was borrowed from Norway and England'.

Kvale and Brinkmann specify 'an interview is literally an *interview*, an inter change of views between two persons' (Kvale and Brinkmann, 2009: 2). However I tried not to respond to questions from the interviewee seeking my views in the interviews, and I constantly refocused the interviewees on their opinion or knowledge of relevant events, so that I minimised the potential of my opinions influencing what the interviewees said.

Sometimes dialogue was engaged in as a way of probing, testing and triangulating information obtained from other sources and interviews. For example, if one person gave a different account I would say 'another interviewee had a different take: they felt it was a diktat from on high not developed within the government department' in order to probe or elicit a response. When appropriate the interviewees were brought back to the topic or question being discussed. There was a strong tendency for interviewees to talk around the issue and avoid answering specific questions.

In all of the interviews, probes were used to remind or clarify events as they are recorded in the documents, and in many interviews claims made by previous interviewees were put to the current interviewee (Marshall and Rossman, 2011).

Securing and carrying out the interview was a relatively quick process. Interviewees were approached by email and a time and location agreed. Most interviews lasted about an hour, although some were up to two hours. Transcribing and coding were time consuming.

3.6 Analysis

3.6.1 Analysis of interviews

The content of the interviews were recorded, transcribed and imported into a software package called NVivo 9. The interview data in NVivo was analysed and written up using the codes, themes and sub-themes identified in the conceptual framework. Findings from the documentary analysis and interviews were analysed utilising the conceptual framework that is detailed in chapter five.

3.6.2 NVivo coding and analysing strategy

NVivo allows the researcher to organise and classify data (Bazeley, 2011). It facilitates working through data systematically so as to ensure rigorous justification for findings with evidence and an

audit trail of analysis and findings (Bazeley, 2011). It is particularly useful for large volumes of qualitative data such as that gained through in-depth interviews.

Each of the 21 interviews was imported in NVivo, after they were transcribed and formatted similarly.

There were six stages to coding the interviews:

1. Each interviewee was classified by type of interviewee and which policies they were involved in.

2. Open coding: each interview was coded into information on each policy type:
    a. Finance Act
    b. NTPF
    c. Co-location

3. Sub-coding: each interview was then coded into my headline thematic areas identified in the conceptual framework. These were:
    - policy characteristics
    - actor power
    - political ideology/institutions
    - random other themes emerging

4. The next stage of coding was sub-coding each of these areas. These were as follows:

Headline theme	**Sub theme**	**Relevant codes**
Policy characteristics	**Severity of the problem**	Public-private mix (of healthcare)
		Shortage of public hospital beds
		Insufficient public money
		Failure to reform public sector
		Incentives including perverse incentives
		Belief in private sector
	Ideas for intervention	Healthcare planning, quality and location
		Quality and Fairness policy content
		Oversight, or not, of private health care
		Evidence-based policy-making

		Policy transfer
		One policy to remedy another
		Unintended consequences of policy
Actor power	**Guiding institutions**	Role of the Department of Health
		Role of the Department of Finance
		Role of the Health Service Executive
		Role of civil servants
		Health service organisation, including hospitals and health boards
	The role of policy entrepreneurs	Role of ministers
		Role of political advisers
	Private sector interests	Role of developers and owners of private hospitals
		Influence of medical profession
		Lobbying
Political economy	**Political ideology/institutions**	Maintenance of the status quo
		Broader political economy of the time
		Coalition politics
		Political influence on decision making
		Use of tax breaks
	Policy process/window	Policy-making process
		Policy implementation, or not
Random other themes	**Other policy areas emerged as the interviews were being formatted and coded**	Methodology eg use of FoIs – change in documents
		My role/bias as a researcher
		Other policies – privatisation, Fair Deal, older people
		establishment of the HSE – set up as procurer not a provider
		terminology – private independent

5. Consolidating/distilling codes: the next coding stage was distilling, consolidating and merging codes. Some codes were empty while others have very little in them. Others found natural partners and were either let go or merged with variables under the three headline themes.

6. Writing up: the codes were then used as the basis for writing up each section, which followed the structure and framework developed in my conceptual framework. While there was substantial overlap between codes due to over-coding, these tended to work themselves out and find a natural place in the writing up of the analysis. NVivo allowed me to revisit quotes from interviews and check their context and which policy they were made in reference to.

Coding in NVivo was time-consuming, but when it came to analysis, it was useful to be able to search and check references quickly and also to be able to quantify some aspects of the interview eg 'Seventeen out of the 21 interviewees said…'

There was a lot of distilling and merging of themes and variables when writing up the analysis under the headline and sub themes identified in the conceptual framework. Initially I wrote up each policy under the categories and variables in my conceptual framework; these are the findings in chapters six to eight. I then wrote up the key themes, commonalities and differences across the three cases in chapter nine. In chapter ten, I reflect on the relevant literature and the conceptual framework. From this I propose a slightly altered conceptual framework for future testing.

3.7 Positionality

This research is concerned with both the processes and the actors which influenced the policy choices and involved judgment. As I have worked as a health-policy analyst and a journalist from 1997 to the present, I paid particular attention to any bias that I brought to this study at both the data-gathering and analysis stages.

Much of the literature on the role of the researcher and their position argues that 'previous knowledge is a crucial prerequisite of gaining understanding' (Bazeley, 2011).

> *Qualitative researchers who investigate a different form of social life always bring with them their own lenses and conceptual networks. They cannot drop them, for in this case, they would not be able to perceive, observe or describe meaningful events any longer, confronted with chaotic, meaningless and fragmented phenomena they would have to give up their scientific endeavour* (Kelle cited Bazeley, 2011: 23)

From 1992 to 1997, I worked as an outreach worker at Focus Point, a national charity working with homeless people based in Dublin. Between 1997 and 1999, I was a contract researcher on the health needs of young people at risk in the Department of Health and Children. In 1999/2000, I studied and completed a master's at the London School of Economics in social policy, majoring in health policy and social research methods. From 2000 to 2004, I was a policy analyst at the Institute of Public Health in Ireland, an all-Ireland non-governmental organisation working with governments North and South on strategies to reduce health inequalities.

From 2004 to 2006, I was managing editor at 'Village' magazine, a left-of-centre political magazine which took a critical view of government policy at the time. Since 2006, I have worked as a freelance journalist and independent health-policy analyst, where most of my worked has focused on the Irish health system, inequalities in health status, the structural defects in healthcare provision and the impact of the recession on the public health system. I wrote a book entitled *Irish Apartheid. Healthcare Inequality in Ireland*, which was published in 2009 (Burke, 2009).

Much of my journalism, writing and policy-analysis work has been critical of government health policy, of the failure to reform the public health system, of the increased privatisation of healthcare without any planning or regulation and of the unintended consequences of policy action in an Irish context. *Irish Apartheid. Healthcare Inequality in Ireland*, as the title states, is about the unfair and inequitable two-tier nature of the Irish health system, the growth in private care and the poor quality care experienced by public patients.

While writing the book, I became more aware of the importance of the private health system in Ireland, how it was largely undocumented and under-researched in an Irish context. In order to understand the whole health system better, I realised I had to understand the private as well as the public system. The three cases selected for this research led to or intended to bring about a significant increase in the provision of for-profit healthcare during the years under examination.

The content of my book, combined with print articles and a weekly radio segment on RTÉ Radio 1's 'Drivetime' programme (from October 2008 to present), means my opinions are in the public domain and it is likely that they are known to the interviewees.

My position and experience has led me to this specific research topic, yet I need to ensure my 'positionality does not preordain the findings of the research' (Marshall and Rossman, 2011: 63). At the outset of my PhD research, my supervisors were concerned that my 'public' profile and known opinions/commentary would discourage people from agreeing to be interviewed. Apart from the three interviewees from the political domain who did not agree to be interviewed (two refused and one did not respond to requests for an interview), this did not seem to be case. Many of those whom I have been critical of agreed to be interviewed. In particular some senior departmental officials and private-sector people seemed to welcome the opportunity to give me their perspective.

The benefit of my background and experience in doing the research is that most interviewees are familiar with my stance on particular issues and therefore I was not approaching them as a completely 'objective researcher' but rather as someone who has taken a position, sometimes even a strong one, on particular policies.

Interviewees were assured that for the interviews, I was leaving my opinions aside and I resisted engaging in dialogue, constantly reiterating I was there to hear their answers and opinions. As appropriate I challenged some of their opinions, thoughts and comments, if they were contrary to findings from the documents, the theoretical literature or other interviewees. Many of the interviews took place in the months around the time of a general election in February 2011, and so interviewees were often eager to discuss the election and its potential impact on health policy. I tried to resist such discussion at least until I had completed the interviews. With the private-sector personnel, I felt they viewed the interviews as an opportunity to try to share with me their thoughts on the benefits of private, for-profit healthcare.

To address my inherent biases, I kept reflective notes during the PhD processes, especially at the end of interviews. Also I discussed them at length with my supervisors. The literature on positionality recommends that rather than denying my 'position', I need to record and recognise it. This was done throughout this research through researcher identity memos and analytical memos, which were stored in NVivo (Bazeley, 2011).

Walt et al in their article on 'doing' health-policy analysis refer to the importance of 'positionality' in health-policy analysis. They specify the advantages and disadvantages to being both an 'insider' and an 'outsider' in health-policy analysis, how the 'situation' of health-policy analyst is critical 'to their ability to access the policy environment and conduct meaningful research, especially in policy analyses that require engaging policy elites and when investigating sensitive issues of high politics' (Walt et al, 2008: 314).

This research involves both 'policy elites' and 'high politics'. In my role as health-policy analyst I might be considered by those in the health-policy field both as an 'insider', when I worked in the Department of Health, and, in the past eight years in my role as journalist and health-policy analyst, as an 'outsider', especially those within political spheres or government departments, with whom I am often in press briefings, at opposite sides of the microphone.

Walt at al suggest greater reflexivity on the part of researchers that involves an analysis of their own institutional power, resources and position (in much the same way they would analyse actors in the policy process) and their role in defining research agendas and generating knowledge (rather than assuming themselves to be 'objective' and 'independent') (Walt et al, 2008: 315).

Being known, as both an insider and outsider, to the policy processes being examined has both hindered and helped me to gain access to people and documents for this research.

3.8 Reflections on my methods

Gilson and Raphaely, in their review of published literature of health-policy analysis in low- and middle-income countries, between 1994 and 2007, found that most research was analytically weak, lacked an explanatory focus and drew little on policy-analysis theory. They also identified that most research failed to take the role of power into consideration, and they encouraged more analysis 'for policy' than 'of policy' (Gilson and Raphaely, 2008).

Although this research involves analysis 'of' three policy-making processes in the past rather than analysis 'for' policy, it is hoped the lessons learnt can inform policy making in the future. I am confident that through my methods, through devising and revising a distinct conceptual framework, through explicit inclusion and exclusion criteria, I have addressed the weaknesses Gilson and Raphaely identified in much health-policy analysis (Gilson and Raphaely, 2008).

Their work also calls for 'more active engagement of analysts in the policy process, rather than examining it from the outside'. They want 'more deliberate engagement by health policy analysts in the processes of policy and health system change' (Gilson and Raphaely, 2008: 304). As a health-policy analyst and journalist, who straddles the insider/outsider status, this research is an example of my active and deliberate participation in rigorous and analytical policy processes and reform of the health system.

Chapter 4

Literature review and development of a conceptual framework

4.1 Introduction

This research is concerned with finding out how and why three policies, aimed at increasing for-profit hospital care, became the accepted method of reform in Ireland, between 2000 and 2005. As detailed in chapter one, the three cases are

1. The changes to the Finance Act in 2001 and 2002
2. The introduction of the National Treatment Purchase Fund in 2002
3. The plan to co-locate private hospitals on the grounds of public hospitals, announced in 2005.

Central to this research is gaining an understanding of what influenced the specific policy-making processes in the three cases.

> *Research on public policy seeks to explain how decision makers, working within or close to the machinery of government and other political institutions, produce public actions that are intended to have an impact outside the political system... Researchers of public policy aim to explain how public decision making works, why societies get the policies they do* (John, 2012: 1).

According to Walt et al, Gilson et al and John, policy making is not just about that decision, but a process of the continued interaction of institutions, ideas and interests (Walt at al, 2008; Gilson et al, 2011; John, 2012).

There are differing definitions of policy, public policy and health policy. 'Policy is often thought of as decisions taken by those with responsibility for a given area' (Buse et al, 2007: 5). It can be made at national, regional and local levels and people who make policy are known as policy makers. 'Public policy refers to government policy' (Buse et al, 2007: 5).

Health policy embraces 'courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system' (Buse, 2007: 5-6). Walt and Gilson highlight how there are different types of health policy, for example, public health policy might be most interested in how social, economic and environmental factors impact on population health, while health-service staff such as doctors and nurses are most concerned with how their services are resourced and provided, whereas a health economist devotes their time largely to how money is allocated and potentially rationed in the health system (Walt and Gilson, 1994).

Gilson and Raphaely identify how policy analysis can be broadly divided into analysis 'of policy' or analysis 'for policy' (Gilson and Raphaely, 2008). They find that most analyses want to

contribute to future policy rather than assist in policy making at that moment in time (Gilson and Raphaely, 2008). This is true for this research: it aims to inform more effective health policy making in the future.

John points out how a policy-oriented approach to political science scrutinises public decision making from the perspective of what tangible actions come out of the political sphere (John, 2012). Greenberg et al acknowledge that 'the task of investigating decision making in policy sectors is highly complex' (Grenberg in John, 2012: 7). Policy research tends to focus on what happens when decisions get made not on how or why those decisions got made in the first place (Gilson and Raphaely, 2008; Gilson, 2012). According to John, if the cause of the problem is not fully understood, then decision makers cannot know if their policies will be effective.

> *If reformers do not understand causation in public policy, they cannot know if their proposals for changes in decision making procedures will work out or not. Often the inability of policy makers to implement their policies stems from their failure to infer the correct causal model between what they decide to do and what is likely to happen on the ground and many of these links are as much about efficient policy making as about what happens in society and the economy. The failure of public policies may be due to feedback from the policy intervention to the decision making procedures themselves* (John, 2012: 8).

According to John, political science has failed to apply its rigorous methods and theoretical frameworks developed for analysis of electoral and party systems to policy studies (John, 2012).

Walt and Gilson see health policy as intrinsically linked to politics, the how, why, what and who of health-policy decision-making processes (Walt and Gilson, 1994). Health policy can also be what is not done, as much as what is purposively done (Walt and Gilson, 1994; John, 2012; Hardiman, 2012).

Mills' review of health policy and systems research finds that research into health services is much better developed and more common in high-income countries when compared with low income countries (Mills, 2012). While research into health services is broadly defined, Mills found that the research carried out in high-income countries under the banner of health-services research is largely focused on primary and hospital care, rather than on issues of public health and public policy (Mills, 2012). Mills also cites research that shows the vast majority of research funding does not go to health-services/-policy research, eg 1.6% of UK Medical Research Council funding and 0.5% of Welcome Trust funding went to health-service research, while 97% of grants awarded by the Bill Gates Foundation and the US National Institutes of Health went to the development of new technology (Mills, 2012: 6).

Mills clearly identifies the small quantity of health-policy research and analysis and, along with Walt, Touhy and Gilson, she makes the case for study on policy, as well as for and of policy (Walt, 1994, Touhy, 1999, Gilson, 2012, Mills, 2012).

This research is focused on national public policy making in Ireland as the cases are examples of public health policy, even though they relate to the development or provision of private hospital care.

4.2 Role of a conceptual framework

A conceptual framework allows the researcher to analyse what influenced the policy process in a systematic way. This is necessary given the complexity of the public policy-making process and the often large numbers of people usually involved (Sabatier, 2007). A framework allows the researcher to identify elements and the relationships between them. They do not by themselves explain or predict but rather allow for theory generation and more rigorous analysis (Walt et al, 2008).

A theory applies values to those variables and can assist in specifying how relationships may vary depending on the values of the variables (Sabatier, 2007: 6). Variables may be different, eg ministerial power and political ideology, but have a similar impact. Also variables may be closely related, so there is a need for a framework where variables interact and where the framework is dynamic (Sabatier, 2007).

Many researchers of public policy, especially those deriving their findings from secondary documents and interviews with key policy makers, do so without an explicit theoretical framework (John, 2012). A theoretical or conceptual framework allows the researcher to explain, not just describe, the policy process, thus overcoming weaknesses of previous studies (Sabatier, 2007; Gilson et al, 2008; John, 2012). John also acknowledges that although the 'goal of explanation is laudable, it is often difficult to test a causal model in the complex field of policy making' (John, 2012: 9).

4.3 Theoretical foundations for the conceptual framework

The study of public policy crosses many disciplines – political science, public policy, sociology, economics, history and public administration as well as specific policy studies such as health policy (Walt and Gilson, 1994). Therefore, there are many potential different sources from which to draw a conceptual framework.

Some of the frameworks and theories relevant to health policy making considered for this research are:

- Rational Comprehensive Planning (Lasswell, 1951)
- Incrementalism (Lindblom, 1959)
- Punctuated equilibrium model (Baumgartner and Jones, 1993)
- Power (Lukes, 2005).

These four were considered as they are the early theories that informed much health policy analysis over the past decades. There are a myriad of theories and frameworks that can be applied to policy analysis, from Marxism to rational choice. In order to limit the literature reviewed, the following criteria were used: Literature that

- is utilised in health-policy analysis literature
- has been applied to the role of the private sector in the public policy process
- is relevant to health policy making (rather than implementation)
- takes explicit consideration of the role of political institutions and ideology in policy process
- takes particular consideration of the role of policy elites/entrepreneurs.

The following frameworks were chosen, applying these specific criteria to a wide range of theories and framework:

- A policy-analysis framework triangle (Walt and Gilson, 1994)
- The multiple-stream theory (Kingdon, 1995)
- Political economy (Grindle and Thomas, 1991; Kirby, 2010)
- Political priority and agenda setting (Shiffman et al, 2004, Shiffman and Smith, 2007)

Each of these is reviewed here briefly, particularly drawing on how they are relevant to the analysis of my case studies. They are reflected upon and more critically analysed in chapter ten. Some other relevant literature is also included in chapter ten which was not part of the initial literature review.

4.3.1 Rational Comprehensive Planning

Rational Comprehensive Planning was the earliest model developed in public policy. It is also known as the linear, heuristic or stages model whereby the problem is identified, different solutions considered, the benefits and costs outlined, and the most rational decision is identified and implemented to solve the problem and then evaluated (Laswell, 1951). This model sees policy formulation and implementation as an objective, straightforward, rational process. It was considered useful as it allows the researcher to breakdown policy making and implementation into different stages (Sabatier, 2007).

It was critiqued by Lindblom as over-simplified, failing to take into account the complexity of policy, and ignoring potential conflict in the process and values or ideologies which may influence policy choices (Lindblom, 1959). The linear model views policy making as solely in the hands of policy elites and is criticised for this as unrealistic, as often external forces are involved in the policy process (Neilson, 2001). It has also been criticised for avoiding the political nature of policy making and decisions (Sutton, 1999).

4.3.2 Incrementalism

Incrementalism was developed as a concept by Lindblom, who wrote about policy as 'the science of muddling through' (1959). Lindblom argues that policy makers operate in environments of uncertainty with limited resources. The finite resources impact upon what choices are made so decisions are made incrementally and policy change takes place at the margins, allowing policies to be amended as they are implemented (Lindblom, 1959).

Incrementalism was introduced as a way of overcoming the linear model in order to explain how decision makers, 'when confronted with the need to change policy, attempt to reduce uncertainty, conflict and complexity by making incremental or marginal changes over time' (Grindle and Thomas, 1991: 238). According to the model, the more uncertainty exists in a given decision situation, the more incremental strategies will be adopted (Grindle and Thomas, 1991).

This model is criticised as it fails to take account of the fact that sometimes big policy change occurs and is adopted by government. This is particularly true as a response to a crisis where significant policy change can be developed and implemented as a response to that crisis (Grindle and Thomas, 1991). Also, it fails to show how ideas are selected or get on the agenda (Kingdon, 1995), how external factors may influence policy choices (Grindle and Thomas, 1991) or how specific policies become a political priority (Shiffman, 2004).

4.3.3 Punctuated equilibrium model

The punctuated equilibrium model draws on the punctuated equilibrium theory of evolutionary biology that says all social systems have long periods of no change followed by sudden change. When applied to policy, it means that most policy is incremental and that radical policy change is unusual and only occurs when there is a significant change in understanding of a particular problem (Baumgartner and Jones, 1993).

Punctuated equilibrium draws on political science and the role of political institutions in decision making, how most institutions are more likely to maintain the status quo than to change and, when combined with vested interests, major policy change is restricted. It is only when there is a major shift, such as a change in government or a crisis, that periods of no change are interrupted by disequilibrium (Baumgartner and Jones, 1993).

It is often applied in historical institutionalism in which the reluctance to change is caused by institutions, vested interested and individuals. Baumgartner and Jones 1993 draw on the experience of the USA to show that the American political system is set up to be conservative and to resist change. This model is considered useful as it allows policy making to be understood in the context of the interaction between political institutions and interests. Criticisms of punctuated equilibrium as applied to the USA include that it is a top-down model that is overly dependent on federalism and ignores the powerful role of the president and Congress in policy making in the USA (Schlager, 2007). As such, Schlager maintains that it is less applicable to European countries as their analysis is dependent on congressional procedures (Schlager, 2007).

4.3.4 Power

Power is central to any policy analysis, yet it is a contested concept and open to differing interpretation depending on where one resides in the power structure (Walt et al, 2008).

There is much written in the policy literature on the role of power in policymaking and implementation. This includes examination of the role of elites and networks in the policy making process. Different dimensions of power examined in the policy process are: power as decision making, as articulated by Robert Dahl's classic study in the 1960s; power as decision making or non-decision making, which was expressed by Bachrach and Baratz in a critique to Dahl's work; and power as thought-control, as conceptualised by Steven Lukes (Lukes, 2005).

Each of these aspects of power are influenced by the type of society and political structures in place: is a country ruled by an elite who determine the political and policy choices that are preferential to them, or is it a pluralist society where power is more widely distributed throughout society? Lukes outlines how 'we need to attend to those aspects of power that are least accessible to observation: that ... power is at its most effective when least observable' (Lukes, 2005: 1).

Lukes's multidimensional view of power focuses on: a) decision-making and control over political agenda (not necessarily through decisions); b) issues and potential issues; c) observable (overt or covert) and latent conflict; and d) subjective and real interests (Lukes, 2005).

As stated above, the concept of power is contested and, even if agreed upon, hard to measure. However, this research is focused on three very specific policies in which a small number of people had particular power and influence over the policy choices, therefore power must be a part of the framework for analysis.

4.4 Literature that contributed to conceptual framework

4.4.1 A policy analysis framework/triangle

Walt and Gilson's seminal work on the role of policy analysis advocated paying attention to the process and context in which policies get made, not just their content. Doing this requires an examination of the actors involved and the role of power in the process (see diagram 4.1 below) (Walt and Gilson, 1994; Walt, et al, 2008). Their work was grounded in political economy and focused on the interaction between these factors, as well as the relationship between the state and the market (Walt and Gilson, 1994).

Walt and Gilson are keen to point out that the triangle is a simplified model of 'an extremely complex set of interrelationships', and that no one factor can be considered individually as they affect each other (Walt and Gilson, 1994: 355). Critically they argue that the focus on policy content ignores the vital importance of who makes and implements the policy, the context in which it is chosen and enacted, and the process through which it is developed (Walt and Gilson, 1994: 355).

In their review of the changing context of health-policy analysis, they highlight how ideology, such as neo-liberal policies that emerged in the 1980s, need to be taken into consideration alongside 'a context in which market values dominate' (Walt and Gilson, 1994: 356). They specify how neo-liberal policies led to increased tensions in health policy, where in high-income countries 'there was increasing emphasis on cost containment and efficiency improvement, leading to concepts of an internal market and separation between providers and purchasers and a controversial emphasis on the virtues of competition' (Walt and Gilson, 1994: 357).

They produce a model of analysis drawing heavily on political economy approaches, particularly drawing on the disciplines of politics and economics. Such a model takes a dynamic approach to policy analysis that realises policy choices should be preceded by analysis rather than vice versa, and that when that occurs policy has a greater chance of effective implementation (Walt and Gilson, 1994: 360).

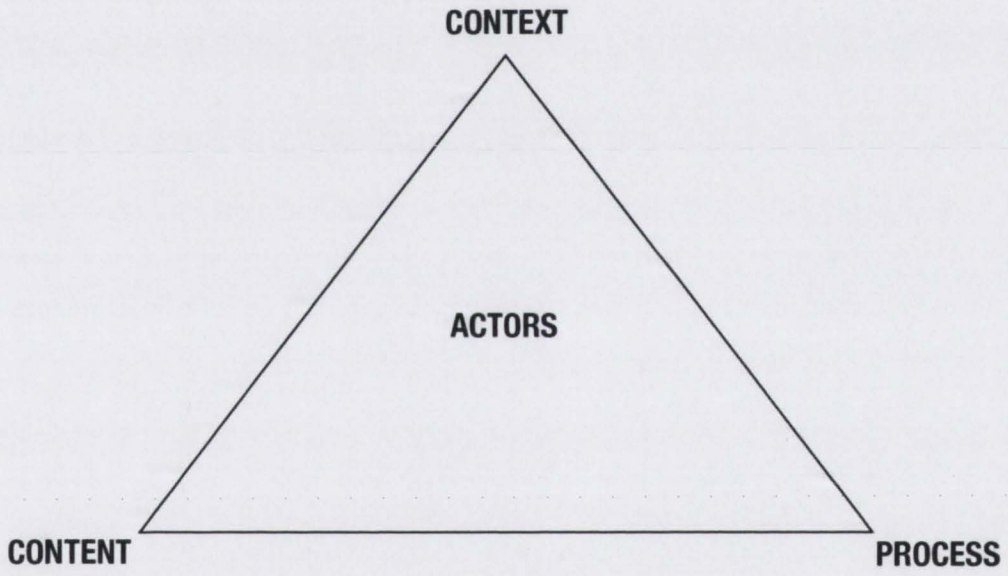
Walt and Gilson also examine the role of the state and the market, very much drawing on political economy, making the point that the belief of the policy makers or government on this matter plays a central role in policy making.

The triangle also places an important emphasis on actors, be they groups, organisations or individuals and how they interact with each other and Walt and Gilson place them at the centre of the triangle (Walt and Gilson, 1994). Central to the role of different actors in any policy process is power (Walt and Gilson, 1994) and power can be determined by money, access to resources and information, political office, position or authority, organisations and structures (Buse et al, 2007).

A 2008 article highlights how health policy has changed over the decade since Walt and Gilson's previous article and needs to include a much wider array of actors, 'including for-profit and not-for-profit private sector interests' (Walt et al. 2008: 309). This article also acknowledges the increasing role of global policy and international organisations. This is true in the developing world, especially around funding for HIV and anti-malaria work. In higher-income countries, it is true, too, as all governments struggle with how to meet increasing demand for health services by an ageing population, with a higher burden of chronic diseases within a limited budget and the rising costs of improved medical care (Walt et al, 2008, Gilson and Raphaely, 2008).

They also point out how in the literature on developing countries that certain peculiarities among post-colonial countries can influence the policy process and policy choices. Among these are the personalised and covert nature of policy making, plus the role of 'elites' such as doctors and health professionals, influencing health policy (Walt et al, 2008).

Figure 4. 1 Walt and Gilson's policy triangle (1994)



Walt and Gilson's policy triangle allows the researcher to enquire as to 'what explains what happened' as opposed to 'what happened', although they contend that much health-policy analysis between 1994 and 2008 remained descriptive rather than analytical (Walt et al, 2008). The authors acknowledge 'a shift in the nature of policy making which points to the involvement of a much larger array of actors in the policy process, 'including the private sector, for-profit and not-for-profit organisations' (Walt et al, 2008: 310).

Later work by Gilson and colleagues developed their thinking on health-policy analysis which allows 'an understanding of the policy making process that is a process of continued interaction

among institutions, interests and ideas', an analytical paradigm that integrates politics, power and processes (Gilson et al, 2008: 291). 'It can help explain why certain issues receive political attention, and others do not, by enabling identification of which stakeholders may support or resist policy reforms and why. It can also identify the perverse and unintended consequences of policy decisions' (Gilson et al, 2008: 291).

Specifically, Walt et al note the absence of explicit conceptual frameworks, little detail on the methods or design of policy research and an over-reliance on single case studies in health-policy analysis (Walt et al, 2008: 309). In particular they point out the 'limited use of relevant theory to underpin analysis and the paucity of attempts to provide an explicit explanatory focus' (Walt et al, 2008: 309). In order to address this, they recommend using 'existing frameworks and theories of public policy process more extensively, making research design an explicit concern and paying greater attention to how the researchers' own power and positions influence the knowledge they generate' (Walt et al. 2008: 308).

The policy triangle is widely used in policy research to assist thinking systematically about all the different factors that might affect policy, both retrospectively and prospectively (Walt et al, 2008). Its strength lies in the fact that the policy triangle allows the policy process to be situated in political and power structures that surround it and in the inter-related nature of the factors involved.

A criticism of the triangle is its broad approach, that it is not dynamic and does not go into the specific detail of what has happened to explain in detail the policy process. 'It's like a map that shows the main roads but has yet to have contours, rivers, forests, paths and dwellings added to it' (Buse et al, 2005; 9).

Although not used specifically, the elements of the Walt and Gilson policy triangle inform the development of a conceptual framework for this research.

Walt et al's 2008 work highlights how processes of health policy making are not clearly bounded and decisions emerge rather than taking place at a particular moment in time (Walt et al, 2008: 310). Exworthy, whose work was published in the same special issue of *Health Policy and Planning*, notes how policy decisions can be hard to observe, unpack and explain, and obtaining relevant documents may be hard (Exworthy, 2008).

4.4.2 Kingdon's multiple stream theory

Kingdon's classic work on why policy issues rise and fall on government's agendas has influenced a more nuanced approach to policy analysis. His research, situated in the USA in the 1970s and 1980s, was concerned with understanding agenda setting: discovering why some public policies get on the agenda and acted upon and others do not. His research was carried out over many years,

interviewing 247 people involved in agenda setting and decision making in health and transport policy.

Kingdon defines public policy making as a 'set of processes, including at least 1) the setting of an agenda, 2) the specification of alternatives from which a choice is to be made, 3) an authoritative choice among specified alternatives and 4) the implementation of a decision' (Kingdon, 1995: 2-3). He cautions that success in one process will not guarantee it in another. He also raises the question of why some areas gain huge attention and others do not. For example, in his interviews on healthcare, 80% brought up the issue of the cost of healthcare but mental health rarely got a mention.

Kingdon drew on the work of Olsen, Cohen and March to develop their 'garbage can' model into the multiple-streams model (Olsen, 1965). His multiple-streams model of agenda setting outlines the random nature of the policy-making process, similar to a rubbish bin in which the different streams are independent and interact with each other at accidental moments, which in turn creates windows of opportunity where certain issues become the priority and policy choices get made (Kingdon, 1995).

Olsen was an early observer of the fact that it was often the policies which tried to redistribute to the poor that became the most politically contentious (Olsen, 1996).

Given that politics is central to making health policy, it requires going beyond a linear concept of policy making from problem identification to issue recognition to policy formulation and implementation. 'Health policy is synonymous with politics and deals explicitly with who influences policy making, how they exercise that influence and under what conditions' (Walt and Gilson, 1994). It requires going beyond an exploration of the 'what' of policy-making process to exploring how an issue got on the agenda and the 'who', 'why', 'when' and 'how' behind such policy choices getting made (Kingdon, 1995, Buse et al, 2005).

Kingdon's research 'explores how problems are recognised and defined, how policy proposals are developed, how political events enter in, and how these things become joined at critical junctures' (Kingdon, 1995: xvii). He makes the point that this is not an easy area of research as it is particularly untidy, 'a labyrinth of policy formulation' (Kingdon, 1995: 18). He describes the process by which agendas get set, how alternatives are specified and decisions get made as a game. His research is about understanding more about that game: 'a formidable array of puzzles' (Kingdon, 1995: 18). His research finds that policy alternatives are often as important – if not more important – than the agenda set by political leaders. Alternatives are usually set by 'staffers' ie permanent administrators or civil servants (Kingdon, 1995: 27).

Kingdon defines his streams as follows:

Problem stream – refers to when an issue becomes a public matter requiring action, that has indicators of scale and significance, which in turn give it prominence (Kingdon, 1995). Kingdon's work uses examples from health and transport policy to show how indicators are used to make the case for policy developments. These indicators, which detail the scale and depth of a certain problem, help issues get noticed in the public and political domains. However, sometimes indicators are ignored and issues get on the policy agenda for other reasons, eg due to a crisis or the personal experience of a politician (Kingdon, 1995: 100).

Policy stream – refers to the analysis of problems and possible policy solutions or alternatives developed by experts, politicians, bureaucrats, interest groups and researchers. According to Kingdon, the selection of a policy takes place in the policy stream, which he calls the 'policy primeval soup', where many possibilities are combined to find a solution (Kingdon, 1995: 123). Kingdon's research finds that linking a policy proposal to a problem can enhance a policy's prospect of moving up the agenda and getting selected (Kingdon, 1995). Often proposals gain a solid position only when a viable alternative is proposed and alternatives which respond to new political situations can change the policy agenda.

Politics stream – refers to political events such as shifts in national mood or public opinion, elections, changes in government, uprisings, demonstrations, campaigns, pressure groups, and the ideological make up of government (Kingdon, 1995). When a policy stream or solution is adopted politically, it becomes part of the political stream. There are three aspects of the political stream – the national mood; organised political interests; and government. Kingdon's research found that consensus was reached in the political stream through bargaining.

Policy window – is a point in time when 'the separate streams of problems, policies and politics come to together at certain critical times… this coupling is most likely when policy windows – opportunities for pushing pet proposals or conceptions of problems – are open' (Kingdon, 1995: 165). Kingdon outlines how the policy window comes about when the opportunity arises for a problem to come on to the policy agenda, to be taken seriously by politicians or government with a view to action (Kingdon, 1995: 20). The point when policy streams come together and intersect cannot be easily engineered or predicted. Policy windows usually occur when there are 'compelling problems' or due to changes in the politics stream, and windows tend not to be open for long (Kingdon, 1995: 20). Kingdon identifies how a changeover in administration, ie in government or in political actors, is the most likely cause of a policy window (Kingdon, 1995: 168). He also finds that 'problem windows and the political windows are related. When a window opens because a problem is pressing, the alternatives generated as solutions to the problem fare better if they also meet the tests of political acceptability' (Kingdon, 1995: 175).

Policy entrepreneurs – refer to those inside and outside of government processes who take advantage of a policy window to get a policy on a government's formal agenda. Kingdon defines

them as 'advocates who are willing to invest their resources – time, energy, reputation, money – to promote a position, in return for anticipated future gain' (Kingdon, 1995: 179). He identifies how policy entrepreneurs do not just push policies or solutions through: 'they also lie in wait for a window to open' (Kingdon, 1995: 190). He compares them to surfers, lying in wait for the big wave: 'if you are not ready to paddle, when the big wave comes along, you are not going to ride it' (Kingdon, 1995: 173). He also makes the point that policy entrepreneurs 'are responsible not only for prompting important people to pay attention, but also for coupling solutions to problems and for coupling both problems and solutions to politics (Kingdon, 1995: 18). Policy entrepreneurs can play a key role in bringing the Kingdon streams together. Zahariadis has described Kingdon's policy entrepreneurs as 'goal intended manipulators' (Zahariadis, 2007: 70).

Kingdon identifies three critical qualities in policy entrepreneurs:

- to have 'expertise, an ability to speak for others, as in the case of a leader of an interest group, or an authoritative decision making position' (Kingdon, 1995: 189);
- to be known for their 'political connections or negotiating skill' (Kingdon, 1995: 189);
- and to be 'persistent': 'many potentially influential people might have expertise and political skill, but sheer tenacity pays off' (Kingdon, 1995: 190).

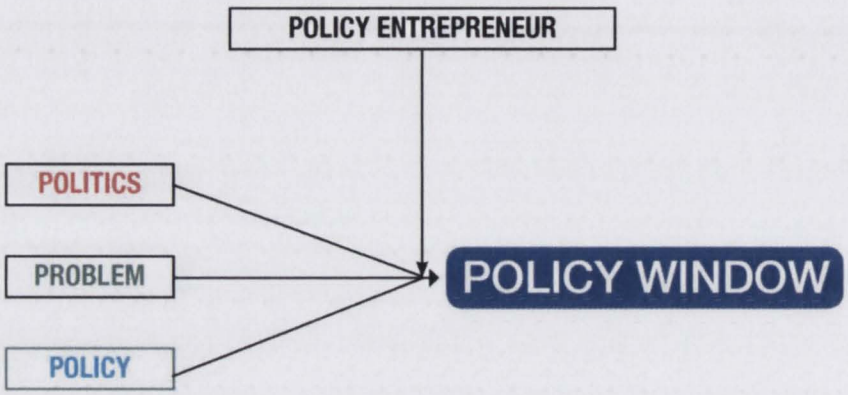
The policy entrepreneur is central to the whole process as they match a problem with a solution and get it on the political agenda. He also points out that no single formal or informal position or place in the political system has a monopoly on policy entrepreneurs: they could be a cabinet secretary, a minister, a lobbyist, an academic, a career civil servant (Kingdon, 1995: 181). Critically, without an entrepreneur, the coupling or convergence of the streams may not take place.

Visible and invisible participants – Kingdon outlines how visible participants may be a recently appointed minister, who may be given benefit of the doubt by electorate. Invisible participants may be 'specialists in the field, researchers, academics, and consultants who work predominantly in the policy stream, developing and proposing options for solving problems which got on the agenda' (Buse et al, 2005: 69). According to Kingdon, the visible clusters of participants tend to be more influential and 'the administration', meaning a leader and senior officials, are the most usual visible cluster. The administration tends to set the agenda, although invisible actors can control alternatives (Kingdon, 1995).

The Kingdon multiple streams have been used to explain rather than describe (Reich, 1995) and therefore they are useful for this research as 'the model suggests that characteristics of issues combine with the features of political institutions and circumstances, together with the development of policy solutions, in a process that can lead to the opening and closing of windows of opportunity to shift an issue on to the agenda' (Buse et al, 2005: 68). Also it is useful as it allows

the researcher to identify the ways in which a decision emerges rather than it taking place at a particular moment in time (Exworthy, 2008).

Figure 4. 2 Adaptation of Kingdon's streams by Kingdon (1995)



Kingdon's streams have been described as 'a lens, perspective, framework… that explains how policies are made by national governments under conditions of ambiguity' (Zahariadis, 2007: 65). Zahariadis considers the Kingdon streams useful as they allow a 'temporal order ie the adoption of specific alternatives depends on when policies are made – and by proposing a theory of political manipulation' (Zahariadis, 2007: 67). They also allow for residual amounts of randomness and assist in answering the question: 'why do some policy makers adopt some policies and others do not?' (Zahariadis, 2007: 80).

Zahardiadis, who applied Kingdon's model to privatisation of telecommunications in Britain and France, found that the model outcomes can be unpredictable. For example he found that a crisis could open a policy window (Zahariadis, 1992). Dunn points out that the nature of the problem has to be identified and Kingdon implies that there is consensus on the nature of the problem (Dunn, 2003). Brunsson and Olsen view privatisation and government reform as good candidates to which to apply Kingdon's multiple streams (Brunnson and Olsen, 1993).

4.4.3 Political economy

The work of Walt, Gilson and Kingdon directed me towards Grindle and Thomas, whose work was prompted by the absence of insights into the process of policy choices in political economy and political science literature. Grindle and Thomas drew on their research experience in a range of

developing countries to make some broad generalisations on the political economy of reform, proposing a framework for analysis.

Similar to Kingdon, their work took place in the 1980s, situated in the developing world, which was going through substantial change as the state was no longer viewed as the principal force of achieving economic growth and social development. Their work placed public policy choices in a political-economy framework, in particular focusing on the shift of power from the state to the market. They centre their attention on the role of decision makers and policy makers, the choices they make and the factors that influence those choices (Grindle and Thomas, 1991: 2).

Grindle and Thomas argue how there is little theory to explain how issues of reform get on the agenda, the role of policy elites, how political views influence such reform, how economic and political pressures alter policies. Their work challenges Marxism, historical institutionalism, pluralist and public choice theories that view policy and decision makers as self-interested people who are formed by their class, society or the institutions they represent. They find that not all decision makers coalesce with vested interests and find 'policy elites – those formally charged with making authoritative decisions in government – have considerable scope to identify problems, articulate goals, define solutions and think strategically about their implementation' (Grindle and Thomas, 1991: 19). They propose that policy elites often initiate reform by placing issues on the policy agenda (Grindle and Thomas, 1991: 32). However, they also identify that it is often the powerful and those who are rich and influential who influence policy choices.

Grindle and Thomas also found that policy elites worked in environments where decision making was closed and centralised, with poor information; where there were informal processes of 'interest representation'; and where 'regimes' tend to be vulnerable. They found that these factors isolate these environments from societal preferences, which all influence the belief systems of policy elites, who they identify as 'critical political variables in decision making contexts' (Grindle and Thomas, 1991: 67).

They emphasise the importance of placing all decision-making processes in their political, economic, cultural and social contexts, in particular identifying whether policy is being made in 'a politics as usual' time or in a time of crisis or real change, and how this timing may affect the decisions made. They found that times of crisis often provide elites with greater autonomy to make choices and that 'non-crisis' situations generate much less impetus for reform (Grindle and Thomas, 1991: 83).

Similar to Walt, Gilson and Kingdon, they find policy-making processes are messy: 'policy choices do not result from autonomous action of decision makers but neither are they mere reflections of the power of societal groups' (Grindle and Thomas, 1991: 120).

From their extensive research with policy makers investigating how decision get made (or not made), they outline how when investigating policy decision making within government, one needs to:

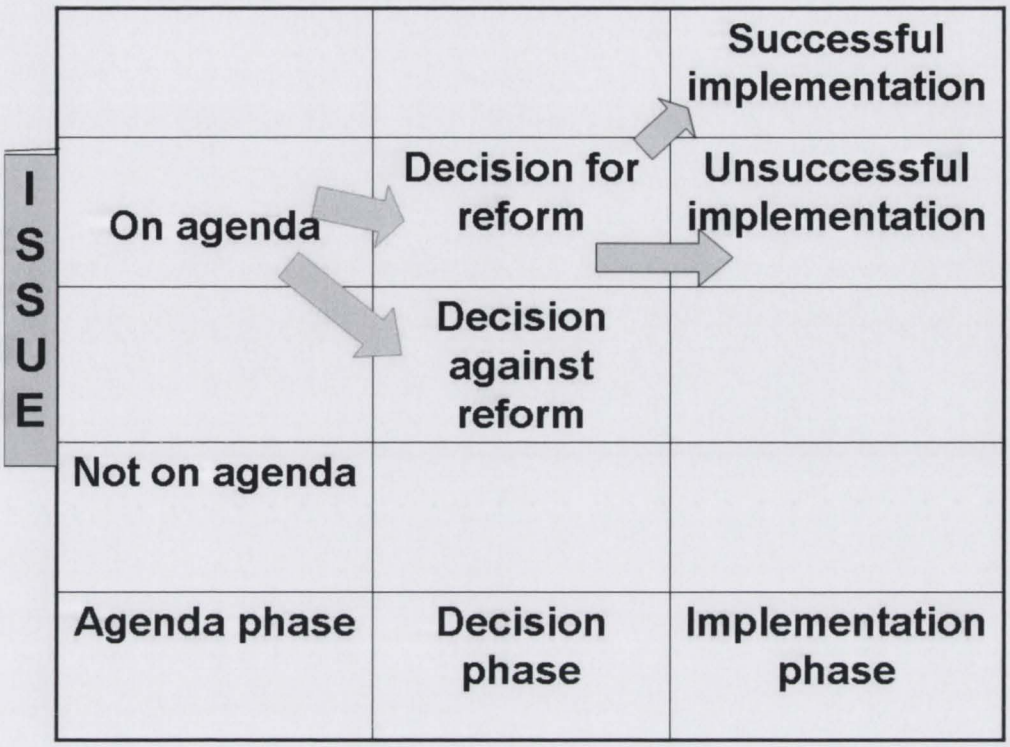
- explain systematically the perception and behaviour (and role) of policy elites
- explain the historical, political and institutional context within which they operate – contextual factors loom large in the process of agenda setting and decision making
- explain factors unique to particular policy initiatives and how they affect the dynamics and process of decision making among policy elites – is it a response to a crisis or politics as usual? – if it is a crisis, policy elites may believe that they must do something about it and this raises the political stakes – how a policy gets on the policy agenda and is deliberated on within government?
- Explain how characteristics of reform may influence conflict or opposition to policy change such as costs, benefits, technical change required, administrative intensity, short-/long-term impacts, resource implications in terms of costs but also policy.

Grindle and Thomas ask three key questions:

1. How did this issue of reform get on the agenda of government decision making?
2. What decision criteria – political, bureaucratic, technical, ideological – were important in promoting or inhibiting the process for change?
3. What factors led to the sustainability or abandonment of reform initiatives?

They develop an analytical framework that specifies different stages and routes through which policies get made and implemented, or not, and identify different phases of the policy process as below.

Figure 4. 3 Phases of the policy process



Grindle and Thomas, 1991 – Phases of the policy process

They find that 'decision makers play important roles in shaping policy and institutional outcomes and that the process through which issues get on the reform agenda, through which they are deliberated within government, and through which they are pursued and sustained, is critical to understanding how, why and when change occurs' (Grindle and Thomas, 1991: 32).

Political economy literature is relevant to this research as it situates the policy decisions in the context of economic as well as political and social policy choices.

There is a small and growing literature on Ireland from a political-economy perspective, but while some of this relates to welfare, none of it relates to health policy. Kirby, whose work is focused on the impact of economic policies, outlines how a critical-theory approach to political economy 'seeks to examine the interaction of political power and economic outcomes, which devotes central attention to the links between state and market' (Kirby, 2010: 97). Political economy contextualises the Irish decisions within European and global trends towards increased marketisation and privatisation of aspects of healthcare provision, as well as acknowledging the complexity and the blurring of lines between public and private (Maarse and Normand, 2009).

Kirby's work assesses 'the theoretical lens through which the Irish [economic model] case is being interpreted and outlines an alternative theoretical approach' (Kirby, 2010: 123). Kirby describes adequate theory as 'the ability of a theoretical framework to guide an examination of the subject so

that insight might be offered into its nature and causes, thus maximising its explanatory power. In doing this, it clarifies whose interests it serves and for what purpose' (Kirby, 2010: 123).

Similar to Walt and Gilson, Kirby advocates a multi-disciplinary approach straddling political science, economics, sociology, development theory and political economy, which combines rigorous problem solving and quantifying approaches to these disciplines with broader explanatory power. The 'framework needs to be able not just to examine the nature and extent of economic change in Ireland but to link this in a robust way with social [policy] outcomes, identifying in a detailed and rigorous way how the former is shaping the latter' (Kirby, 2010: 134).

Kirby's work critiques assessments of Ireland as a developmental and a competition state and argues

> *the reality to be much more complex. Indeed, the state has been the central actor in the development of the market, without which the levels of development reached by Ireland would not have been possible. Yet the state has also been profoundly implicated in the lop-sided outcomes achieved, particularly dramatically as a result of the Celtic Tiger boom – both in terms of the dualistic nature of the productive economy and also in terms of the deep polarisation that has been entrenched* (Kirby, 2010: 145).

Kirby argues that the Irish state is central to the Irish model of development and as its development (like developing countries as outlined in Grindle and Thomas) depended on actions of the state but also because the state has configured the market economy in Ireland 'in peculiar and distinctive ways' (Kirby, 2010: 145).

In this context Kirby recommends further enquiry in an Irish context of its peculiar relationship between the state and the market. He suggests that doing this for specific sectors and examining how specific policy choices are made can inform the development of a more sustainable, equitable model in the future. Kirby makes the case for situating exploration of Ireland's political and policy processes in an international political-economy framework, saying that it 'helps to overcome the parochialism that characterises much of the Celtic Tiger literature and seeks to offer a more critical and well grounded analysis of the Irish case' (Kirby, 2012: 123).

4.4.4 Shiffman – political priority

Due to the political nature of the policy making in the three cases, I looked to literature on political influences and political priority in making health policy. Shiffman has developed a framework on the determinants of political priority for health-policy choices at national and global level and the interactions between these levels in developing countries (Shiffman et al, 2004). In particular, Shiffman was interested in what generated political support for health-policy goals. His work took place in the early 2000s, when there was a substantial push for national countries to achieve goals set internationally, such as the Millennium Development Goals. Despite significant funding for

such goals, national government did not always prioritise them, and Shiffman wanted to find out why.

Shiffman drew on the political-science literature of 'agenda setting' (such as Kingdon) and 'political priority' and adapted it for analysis of health policy. Shiffman studied agenda setting at both these levels, defining agenda setting as 'that stage in the public policy process during which certain issues rise to prominence and others are neglected' (Shiffman et al, 2004: 383). According to Shiffman agenda setting comes before 'policy formulation, the enactment of authoritative decisions and policy implementation' (Shiffman et al, 2004: 383). Shiffman found that political attention happened in an irregular way rather than in an incremental or rational way (Shiffman et al, 2004).

Shiffman followed up his work on national initiatives in Honduras, India, Indonesia and Nigeria between 2005 and 2007 with a cross-country comparison to assess which global health initiatives gain political priority from international and national leaders and which do not. For this work, he developed the following framework with four key areas and many sub-areas – these are detailed below as they were also drawn on for my conceptual framework:

1. The strength of the actors involved
2. The power of the ideas used to frame the policy
3. The nature of the political contexts in which they operate
4. Characteristics of the issue itself.

Table 4.1 Shiffman's framework on determinants of political priority

Category	Description	Factors shaping political priority
Actor power	The strength of the individuals and organisations concerned with the issue	1. Policy community cohesion: The degree of coalescence among the network of individuals and organisations centrally involved with the issue at global level 2. Leadership: The presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause 3. Guiding institutions: The effectiveness of organisations or co-ordinating mechanisms with a mandate to lead the initiative 4. Civil society mobilisation: The extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level
Ideas	The ways in which actors understand and portray the issue	5. Internal frame: The degree to which the policy community agrees on the definition of, causes of and solutions to the problem 6. External frame: Public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environments in which actors operate	7. Policy windows: Political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decision-makers 8. Global governance structure: The degree to which norms and institutions operating in a sector provide a platform for effective collective action
Issue characteristics	Features of the problem	9. Credible indicators: Clear measures that demonstrate the severity of the problem and that can be used to monitor progress 10. Severity: The size of the burden relative to other problems, as indicated by objective measures such as

		mortality levels 11. Effective interventions: The extent to which proposed means of addressing the problem are clearly explained, cost-effective, backed by scientific evidence, simple to implement, and inexpensive

(Shiffman and Smith, 2007)

While there are aspects of Shiffman and Smith's work that are not relevant to my research, such as the focus on international organisations and donor agencies, the core categories and many of the sub-components are. In particular, I have drawn on those factors which are most relevant to national policy making in a higher-income country and where there is overlap with previous literature reviewed. These include the role of guiding institutions, the extent and level of consensus around a problem, the degree of consensus on a policy solution, the role of political entrepreneurs and the policy windows.

4.5 Developing a conceptual framework

There are strong correlations between the work of Walt and Gilson, Kingdon's streams and the questions and frameworks outlined by Grindle and Thomas, Kirby and Shiffman. Each of these have aspects which are relevant to my research on how and why three policies, aimed at increasing for-profit hospital care, became the accepted method of reform in Ireland between 2001 and 2006.

This conceptual framework was devised by merging and combining various aspects of frameworks developed by the researchers reviewed above, combined with themes emerging from my interview coding. The coding below was developed after reviewing the literature. They informed the development of my interview schedule as detailed in appendix I.

4.5.1 Coding

Twenty-one interviews were carried out with people inside and outside of the three policy processes (see chapter three for details). Each interview was transcribed and coded. There were four different levels of coding, with the headline and sub-coding themes devised before analysis began. These are detailed in chapter three. There were various stages to the coding, also detailed in chapter three. After the coding I then began analysis using this conceptual framework. Table 4.2 outlines the headline themes for analysis as categories, the variables and source of the idea, an explanation for the variable and how they linked to the codes outlined in 3.6.2.

In the table Walt and Gilson are cited as (W&G), Kingdon is cited as (K), Grindle and Thomas as (G&T), Shiffman and Smith as (S&S). When adapted by me, it is cited as (adapted by SB).

Table 4.2 Conceptual framework developed for this research

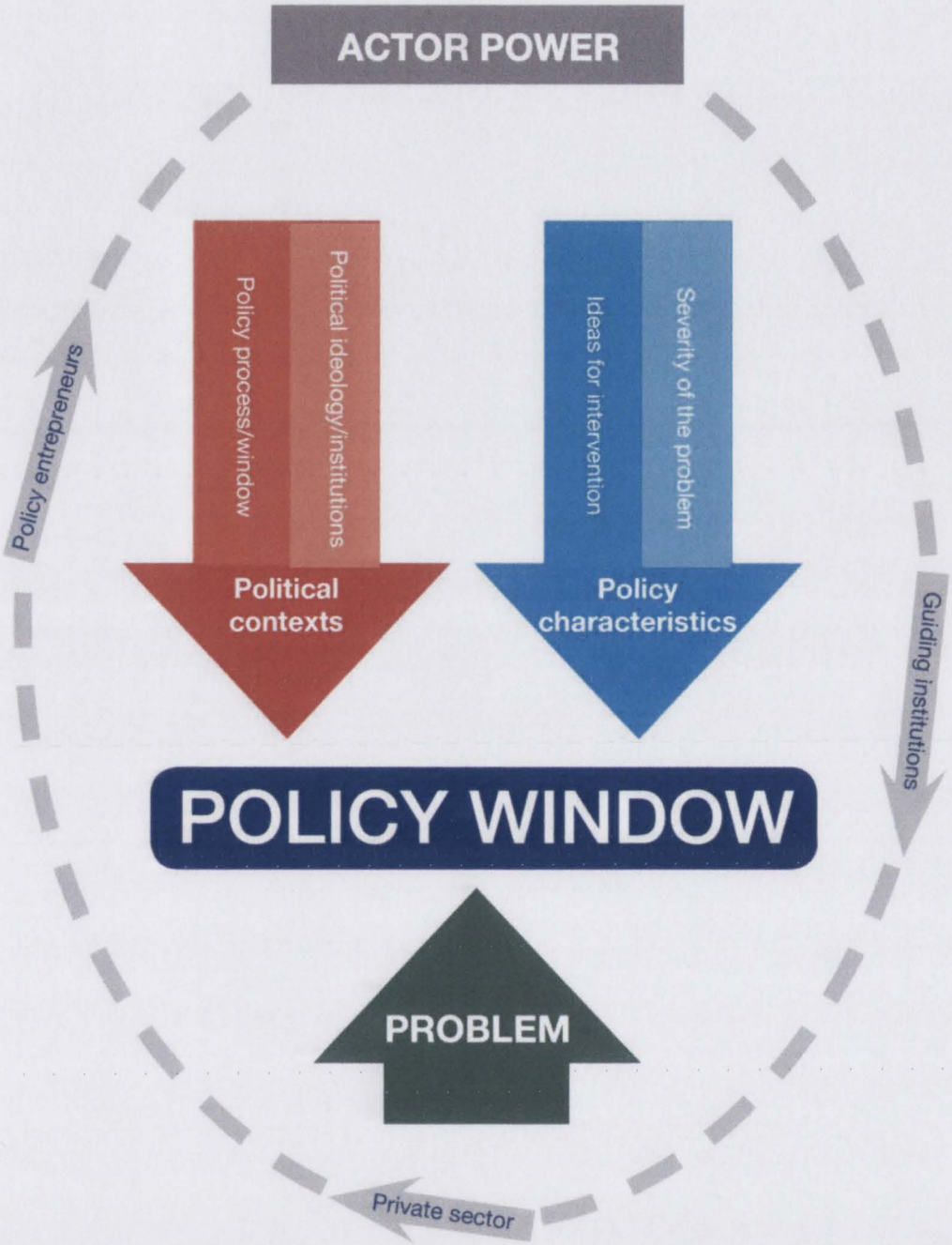
Category	*Variable and Source*	*Explanation of variable*
Policy characteristic	***Severity of problem*** (K, G&T, S&S, adapted by SB)	Clear measures to show the extent and level of the problem
	Ideas for intervention (W&G, K, G&T, S&S, adapted by SB)	The proposed policy solution, the degree of agreement on solution, origins of solution including policy transfer, opposition and alternative solutions to problem
Actor power	***Guiding institutions*** (S&S)	The degree of priority given to the issue, role of government departments
	The role of policy entrepreneurs (K, G&T, S&S, adapted by SB)	The role and influence of policy entrepreneurs, particularly strong champions for the policy in the policy-making process
	Private sector interests (W&G)	The degree of influence of private sector interests and lobbying
Political contexts	***Political ideology/ institutions*** (K, G&T, adapted by SB)	The degree that contextual (historical, economic & political) and political institutions influence the policy choices
	Policy process/windows (W&G, K, S&T, adapted by SB)	The moment when policy, political and problem stream come together

From reviewing the literature and my methods, I developed the following four stages of analysis for my research:

1. Utilising Kingdon's multiple streams to explain the case studies, drawing on the documents and literature relevant to each policy-making process. This is the content of chapter five.
2. Analysing each of the case studies through a conceptual framework developed above, drawing on the coding of the interviews and the documentary analysis. This is detailed in chapters six, seven and eight.
3. Comparing and contrasting the findings from the three case studies through the conceptual framework developed for stage three of the analysis. This is the content of chapter nine.
4. Reflecting on Kingdon's streams and my conceptual framework. This is the content of chapter ten.

Figure 4.4 is a visual version of the conceptual framework, drawing on categories and variables. It was devised in advance of doing the analysis.

Figure 4. 4 Conceptual framework for analysing the policy process



The documentary analysis and the interview content are analysed using the conceptual framework in chapters six, seven, eight and nine. In chapter ten, I reflect on this and propose a revised framework for analysis.

Chapter 5

The three cases drawing on documentary analysis: Using Kingdon's streams to explain three case studies

5.1 Introduction

This chapter is the first stage of the analysis in this research. It draws on Kingdon's seminal work on agenda setting and policy process, seeking to explain why and how some policies get adopted and others do not. Kingdon developed a multiple-streams model and these streams are used to analyse the documentary evidence gathered for the three cases.

The documents used in this research were outlined in section 3.1 and 3.2. Documents obtained under Freedom of Information requests are detailed in appendix V.

Kingdon's work focuses on exploring how problems were recognised and identified, how policy gets made and how politics plays a role in the policy choice. It is therefore particularly appropriate for this research, which explores how these three cases were chosen as policies between 2000 and 2005. Kingdon's streams are as follows:

Problem stream: Kingdon's 'problem stream' refers to when an issue becomes a public matter requiring action, which has indicators of scale and significance, which in turn help issues get noticed in the public and political domains (Kingdon, 1995).

Policy Stream: Kingdon's policy stream refers to the analysis of problems and possible policy solutions or alternatives developed by experts, politicians, bureaucrats, interest groups and researchers (Kingdon, 1995).

Politics stream: The politics stream is when political events, such as elections, changes in government, public opinion and the political make up of government, influence the policy choices. When a policy stream or solution is adopted politically, it becomes part of the political stream (Kingdon, 1995).

Policy window of opportunity: The policy window is the moment when the problem, policy and political streams come together to influence the policy choice/outcome (Kingdon, 1995).

Policy entrepreneurs: Kingdon describes policy entrepreneurs 'as advocates who are willing to invest their resources – time energy, reputation, money – to promote a position in return for anticipated future gain in the form of material, purposive or solidarity benefits' (Kingdon, 1995: 179). His research shows how policy entrepreneurs can be found in different locations, how 'no single formal

position or even informal place in the political system has a monopoly on them. For one case study, the entrepreneur might be a cabinet secretary; for another a senator or member of the house; for others, a lobbyist, academic' (Kingdon, 1995: 180). Each of the three cases is detailed in this chapter following Kingdon's streams. More detail on Kingdon was outlined in section 4.4.2

5.2 Case Study 1: Changes to the Finance Act 2001 and 2002

What follows is an outline of the changes to the Finance Acts in 2001 and 2002, which gave capital allowances (tax breaks) to developers to build and/or refurbish private hospitals, which led to significant increases in the numbers of private for-profit hospital beds.

5.2.1 Case Study 1: problem stream

The shortage of public beds was an ongoing political and public-policy issue throughout the 1990s and in the early years of the new century (Department of Health and Children, 2001a; Wren, 2003). Public patients had to wait a long time for treatment in public hospitals, while growing numbers of those covered by private health insurance did not have much choice of private acute hospital facilities (Department of Health and Children, 2001a; Wren, 2003).

There was also public and political dissatisfaction with significant increases in the health budget since 1997 without any perceived associated improvement in health services (Department of Health and Children, 2001a; Wren, 2003). Between 1990 and 2001, there was a tripling of the health spend (Department of Health and Children, 2001a: 43) yet only after 2000 did Ireland's health spend exceed the EU average, eg in the late 1980s and early 1990s, it was 60% of the EU average (Department of Health and Children, 2001a: 43).

Comparative health spending figures show significant increases since then, however when Ireland is compared with OECD countries over time, it is ranked 17th out of 25 countries, spending on average 6.1% of GDP on health between 1995 and 2008 (McDonnell and MacCarthy, 2010). By 2000, 95% of the population wanted the government to spend more on health to reduce waiting lists (Watson and Williams, 2001).

In line with international trends, there was a decrease in overall numbers of inpatient hospital beds, as new technology and medical science facilitated an increased use of day cases and shorter lengths of stay (Codd, 2002). As a response to the economic crisis in the 1980s in Ireland, huge cuts to the health budget resulted in the closure of thousands of hospital beds, on what was often assumed to be a temporary basis. Many of them remained closed nearly two decades later (Codd, 2002). And despite an increasing health budget in the years up to 2000, no additional public hospital beds were added to

the public bed stock. 'The number of acute hospital beds in [the year] 2000 (11,832) is approximately 6,000 lower than the number in 1980 (17,665)' (Codd, 2002: 9).

The shortage of acute hospital beds manifested itself in long waits for all patients in emergency departments, as there were insufficient beds available for admissions. It also resulted in extremely long waiting lists for the diagnosis and treatment of public patients in public hospitals. (Department of Health and Children, 2001a and 2001c; Wren, 2003).

There were other reasons for long waits treatment of public patients in public hospitals including the fact that there was an increasing proportion of the population with private health insurance, with private patients in many public hospitals accounting for well over the 20% limit, as stipulated by government (Department of Health and Children, 2001a and 2010a). For example, while the public-private mix in public hospitals was designated to be 80/20, in 2002, 25% of both inpatient and day-case discharges were private, with certain hospitals far exceeding the 20% private-patient limit by regularly providing care for 40-50% private patients (Brick et al, 2010: 226).

The bulk of the cost of care of private patients in public hospitals was being subsidised by public money, therefore diverting much needed public funds for public patients to private patients in public hospitals (Department of Health and Children, 2001a and 2010a; Wren, 2003)

Furthermore, the numbers of private hospitals beds did not increase in line with the proportion of those covered by insurance. By 2007, 35% of hospital beds were private (in both public and private hospitals), an increase of 34% between 2002 and 2010 (Department of Health and Children, 2010a; Nolan, 2004). Despite the fact that half the population had health insurance by 2007, from 2000 to 2007, private health insurance contributed less than 10% of all healthcare financing (Thomas et al, 2008, Department of Health and Children, 2010a).

5.2.2 Case Study 1: policy stream

There were various Department of Health initiatives to address the manifestations of shortages of public hospital beds in the 1990s with little real effect. An example of this is the Waiting List Initiative which is outlined in the next section in this chapter on the NTPF. By the year 2000, thousands of public patients were still facing very long waits for treatment (Comptroller and Auditor General, 2003; Department of Health and Children, 2001a).

In 2001, significant public, political and policy attention was paid to the development of a new health strategy (Department of Health and Children, 2001a, Department of Health and Children, 2001c). The government in power since 1997, a Fianna Fáil/Progressive Democrats coalition, embarked on an extensive consultation process to develop a new health strategy for the new century (Department of Health and Children, 2001c). As part of the consultation process for the new health strategy with the

public and with health system staff, the issues of long waiting times and the shortage of public hospital beds were paramount (Department of Health and Children, 2001c).

Meanwhile, the annual Finance Act, the primary legislation that brings the provisions from the national budget into effect, and the embodiment of the government's economic policy, was being developed by the Department of Finance (*tasc*, 2010). Included in the Finance Acts are capital allowances. In the years leading up to the early 2000s, certain capital allowances gave tax breaks to developers to build specific types of units (hotels, housing estates, apartments, car parks).The tax reliefs were a central plank of government policy, which fuelled the economy and a construction industry 'boom' (Department of Finance, 2011).

Tax breaks or reliefs are known officially as tax expenditures. They are defined as 'a transfer of public resources that is achieved by reducing tax obligations with respect to a benchmark tax, rather than by direct expenditure' (Commission on Taxation, 2009: 239). They allow individuals or businesses to pay less tax due to the 'reliefs'. They benefit higher-income groups, are considered regressive and were a used prolifically by the Fianna Fáil/PD coalition government (Commission on Taxation, 2009; *tasc*, 2010). The Commission on Taxation was established in February 2008 to review the structure, efficiency and appropriateness of the Irish taxation system. Its report found 245 such expenditures, way above any other OECD country. A review of tax expenditures by the independent think-tank *tasc* found them inefficient and inequitable and said they cost the exchequer a total of €7.4 billion in 2009 (*tasc*, 2010).

Communications between the Department of Health and the Department of Finance at the time reveal that both the Department of Health and the Department of Finance were advising against capital allowances for hospitals. The Department of Health had concerns about the proposed changes, including that they were contrary to its health policy, which was rationalising the numbers of hospitals and centralising specialities (FoI 2 and 3). Government officials also warned that hospitals could be built where a developer or investor decided to build them rather than where the need for the health service existed (FoI 2 and 3). The Department of Finance concerns were focused around not knowing how much it would cost as they could not control how many would take up the tax breaks (FoI 3).

In one communication, obtained for this research under Freedom of Information, between the Department of Finance and the Department of Health, a finance official said:

> *There are strong arguments against introducing a tax based scheme to support the creation of hospitals. For example, it would be difficult to secure the orderly development of hospital facilities in appropriate locations within each region if the relief were open ended* (FoI 2, Department of Finance, 5 October 2000).

In response, a Department of Health official said:

> *I agree with your arguments against introducing a tax based scheme to support the creation of hospitals. Such a scheme would be totally contrary to 'the orderly development of hospital facilities'. It might also create excess capacity which would be inflationary from the point of view of insurers. It would also reduce the possibility of more efficiencies in the hospital sector* (FOI 3, Department of Health, 1 November 2000).

This communication took place as the health strategy was being developed during 2000. A central plank of the new health strategy was quality care. This resulted in an emphasis on providing acute and complex care in specialist centres, resulting in the centralising of some services eg cancer and trauma (Department of Health and Children, 2003c).

Action 78 of the 121 actions in the health strategy committed to the introduction of an additional 3,000 hospital beds over the lifetime of the strategy:

> *Over the next ten years, a total of 3,000 acute beds will be added to the system. This represented the largest ever concentrated expansion of acute hospital capacity in Ireland, specifying 650 of the extra beds will be provided by the end of 2002, of which 450 will be in the public system* (Department of Health and Children, 2001a)

The health strategy also specified one of the six roles of a yet to be established National Hospitals Agency would be 'to develop a strategic relationship with the private hospital sector' making particular reference to the capital allowances in the Finance Act (Department of Health and Children, 2001a: 102).

> *The government recognises the scope for a significantly enhanced role for the private sector. In this regard, the Finance Act 2001 provides for significant tax allowances for the establishment of private hospital facilities under conditions which will also benefit public patients* (Department of Health and Children, 2001a: 103)

The Finance Act amendments pursued a contrary route to the Department of Health's new strategy published in December 2001. In 2001 and 2002, two amendments to the Finance Act opened up capital allowances to private hospitals for the first time (Department of Finance, 2001, 2002). The 2001 Finance Act introduced measures that allowed tax relief for hospitals run as private charitable foundations (Department of Finance, 2001). In 2002, the capital allowances were extended to for-profit operators, and the qualifying size of the hospitals for the reliefs was reduced from 100 to 70 beds (Department of Finance, 2002). The 2002 Finance also included a specific provision for a sports clinic.

The wording in the Finance Act specified that the

> *extra beds will be matched by the Minister for Health and Children designating a corresponding reduction in private beds in public hospitals thus adding to capacity for public health patients in public hospitals* (FoI 8, Seanad Éireann, March 2001).

This correspondence reflects the blurring of the lines between public and private finance and provision. It shows the government was willing to give tax breaks for private, for-profit hospitals. There was in intention that this would benefit public patients although this was doubted by health officials at the time and their forecast was proved correct as no such redesgination of private beds in public hospitals took place despite an increase in private beds (FoI 11).

Communications from the Department of Health obtained for this research clearly show that the then Minister for Health, Micheál Martin, distanced himself from the changes to the Finance Act.

> *The minister has asked me to explain that this legalisation was sponsored by the Minister for Finance... the Minister for Health has no function in the matter...* (FoI 13, Department of Health, 17 May 2001).

These communications also show a stand-off between the then Minister for Finance, Charlie McCreevy, and Minister for Health, Michael Martin, specifically in relation to the redesignation of beds.

5.2.3 Case Study 1: politics stream

The politics of the period under examination was one of continuity, not change, with the Fianna Fáil-led government in power from 1997 to 2011, first in coalition with the PDs, then, after 2007, with the Green Party.

From 1997 to 2002, the government was made up of Fianna Fáil, which historically was always the largest party in the state, and the PDs, which was categorised as a small, right-wing, pro-enterprise party, consistently thought to have much more influence than its small party size represented (Collins, 2005; Leahy, 2009). The Minister for Finance, Charlie McCreevy, was a senior, long-standing member of the Fianna Fáil party, although it was commonly believed among public and political commentators that McCreevy's politics were closer to the PDs than to his own party (Leahy, 2009).

Mary Harney, a PD minister from 1997 to 2011, and her political party held considerable influence while in government between 1997 and 2007 (Collins, 2005; Leahy, 2009). Started in 1985 after a small group of Fianna Fáil TDs left the party, the PDs are considered to have 'broken the mould of Irish politics', as the formation of the party and its success led Fianna Fáil to enter coalition government for the first time in its history in 1987 (Collins, 2005). The PDs are often credited with

shaping the low-tax, pro-business environment that contributed to Ireland's economic 'boom' during the 1990s and 2000s (Collins, 2005). Harney, a close ally of McCreevy, was leader of the PDs, Tánaiste and Minister for Enterprise and Employment when these tax breaks went through.

In order to understand Harney's influence on the government, her perceived closeness and shared mindset with the then Minister for Finance is important. An analysis of the Fianna Fáil/PD relationship in government and the power of what was called the 'McCreevy/Harney axis' states: 'It gradually became clear to [the then Taoiseach, Bertie] Ahern's staff – and the rest of his cabinet – that he [Ahern] had effectively allowed McCreevy and Harney to assume control of the most important parts of government policy making' (Leahy, 2009: 132). The strength of the Harney/McCreevy relationship also arises in the interview content and is detailed in chapters six to eight.

McCreevy was reported to keep the Taoiseach at a distance, while he was in continuous, close contact with Harney:

> *They were personally as well as politically close, and had been for years. McCreevy nearly joined the PDs at their foundation and despite his last minute decision to stay with Fianna Fáil, their friendship and shared political outlook grew, they holidayed together and socialised frequently, part of a group that included... they were a tight knit group and no one was closer than Harney and McCreevy* (Leahy, 2009: 133).

Also, given the history of coalition governments in Ireland not lasting their full five-year office term, both McCreevy and Harney believed they needed to front-load policy proposals so they had time to gain traction and have an impact (Leahy, 2009). McCreevy and Harney were considered the axis of the government's economic policy (Leahy, 2009).

As outlined above, in 2000/2001, there was considerable discontent with the poor quality of the public health system and the long waits for patients to get diagnosis and treatment in the public health system. There was also dissatisfaction with the quality of the health system despite a trebling of investment (Department of Health and Children, 2001a).

At the time, McCreevy regularly referred to health spending as the 'black hole' (Wren, 2003). As a response to the widespread discontent with the health system, the health strategy was developed in the run up to the 2002 general election (Department of Health and Children, 2001a).

During this time, McCreevy was lobbied by Dr James Sheehan, a co-owner of Blackrock Clinic in south Co Dublin (one of two private for-profit hospitals built in the 1980s) and by a doctor who intended to develop a healthcare park in Carlow (FoIs, 1, 4, 9). Sheehan enlisted the support of Frank Fahey and Eamon Ó Cuív, two Galway-based Fianna Fáil TDs, as he had plans to build a not-for-profit 'Blackrock Clinic' in Galway (FoI 4, Wren, 2003). As noted above, the Department of Health

and Minister for Health Micheál Martin objected to the move (Wren, 2003). The health strategy committed to increased state investment in public health services rather than investment in the provisions of private healthcare (Department of Health and Children, 2001a). Even the Department of Finance was concerned over the potential effect of unplanned, private finance on for-proft hosptials on the public health system (Wren, 2003, FoI 2).

5.2.3 Case Study 1: policy window

As the health-strategy consultation and development was fully underway during 2000, the then Minister for Finance, Charlie McCreevy, facilitated the inclusion of capital allowances for hospitals and nursing homes, first proposed in Budget 2001, which came into effect in March 2001 (Wren, 2003). McCreevy's solo run to drive through the tax breaks for health facilities in 2001 was strongly influenced by James Sheehan in 2000/1 and Michael Heavey in 2001 (Wren, 2003, FoIs). Heavey was a co-owner of a private hospital in Kilkenny called Aut Even and chairperson of the Independent Hospital Association of Ireland (IHAI), the representative body for private hospitals.

Sheehan, an orthopaedic consultant surgeon and high-profile advocate of private hospital care, lobbied McCreevy to give tax breaks to charitable, private hospitals during 2000 (Wren, 2003, FoIs). Sheehan was a supporter of 'catholic healthcare', which had declined in the 1980s with declining numbers of religious in place (Wren, 2003, FoIs). He wanted the tax reliefs to incentivise charitable foundations to provide healthcare, where profits would be reinvested in the facility and where the state could buy care for public patients on waiting lists for whom the public system could not provide (Wren, 2003, FoIs).

In a letter to McCreevy, in November 2000, Sheehan wrote:

> *My reason for writing is to make representation to you in the hope that some tax incentives could be provided for acute facilities* (FoI, Sheehan, 21 November 2000).

While the Finance Act is announced with the budget in December, it is not finalised until February/March of the following year, as it has to go through the Houses of the Oireachtas. In one communication between the Departments of Finance and Health during this time, there is a hand-written note from a senior finance official saying:

> *The Minister is under pressure from James Sheehan to concede tax incentives for his project* (FoI, Department of Finance, 5 February 2001).

Sheehan successfully lobbied McCreevy, and the 2001 Finance Act, published in March 2001, included stipulations that gave tax breaks to developers to build private hospitals (Department of Finance, 2001). The stipulations included that hospitals would have more than 100 beds and be of charitable status ie not for profit (Department of Finance, 2001). The changes introduced in 2001 were

not discussed in the Dáil (the lower house of parliament) but were briefly mentioned by the Minister for Finance when he addressed the Seanad on the Finance Bill:

> *Section 64 provides for capital allowances over a seven year period for the construction of private hospitals. A qualifying hospital must be operated by a body with charitable status for tax purposes. A number of other criteria must be fulfilled such as the necessity to provide a minimum of 100 in-patient beds. It will be a condition of the relief that 20 per cent of the bed capacity be available for publicly funded patients at a discount of 10 per cent. The extra beds capacity created under this measure will be matched by the Minister for Health and Children designating a corresponding reduction in private beds in public hospitals thus adding to capacity for public health patients in public hospital.* (Seanad Éireann, Finance Bill 2001, Second Stage, 27 March 2001)

Shortly after the Finance Act was passed through the Houses of the Oireachtas, Michael Heavey of the IHAI started lobbying McCreevy to extend the changes to hospitals that were non-charitable ie those that were for profit (FoI 12).

While only limited communication was obtained for this research through Freedom of Information on changes after March 2001, none of which is between the Department of Finance and the Department of Health, it is evident that McCreevy was lobbied and was open to extending the scheme the following year (FoIs 1-15). The Finance Act 2002 was amended to include the provision of tax free finance for the development of for-profit hospitals and qualification for the allowances reduced to 70 the minimum number of bed (Department of Finance, 2002; Wren, 2003).

> *The Finance Act 2002 provides for capital allowances for expenditure incurred on the construction or refurbishment of buildings used as private hospitals. The Bill will remove the condition that the hospital has to be operated by a body with charitable status for tax purposes and reduce the minimum requirement of 100 in-patient beds to 70. As announced in the Budget the Bill will provide for a broadly similar scheme for expenditure incurred on the construction or refurbishment of Sports Injury Clinics.* (Department of Finance, 2002)

Although significant, these two changes, which opened up hospital development to the for-profit market and decreased hospital size, received little political attention at the time and were made without registering on the public, political or media radars.

Implementation of the tax breaks

Within two months of introducing the 2002 tax breaks, there were eight groups looking to build private hospitals, many of them international private for-profit hospital firms (Wren, 2003). Only recently was their significant impact officially noted, as they resulted in large increases in the

numbers and proportion of bed stock for private for-profit hospitals and nursing homes (Burke, 2009; Department of Health and Children, 2010a; O'Reilly, 2011)

The Expert Group on Resource Allocation, which reported in 2010 to the then Minister for Health, Mary Harney, showed that the numbers of private hospitals beds increased by 34% between 2002 and 2010, rising from 2,626 to 3,525 (Department of Health and Children, 2010a).

Table 5.1 Numbers of hospital beds 2002-2010

Nos of hospital beds	Public beds in public hospitals	Private beds in public hospitals	Non-designated beds in public hospitals	Private beds in private hospitals
2002	9138	2444	916	2626
2003	9211	2471	1032	2625
2004	9622	2418	975	2600
2005	9884	2509	951	2650
2006	10186	2471	869	2695
2007	10279	2471	869	2676
Net +/- from 2002 to 2007	+1141	+27	-47	+50
2008	*9995*	*2468*	*1120*	3226
2009	*9746*	*2428*	*1136*	3219
2010	*9459*	*2413*	*1144*	3525
Net +/- from 2002 to 2010	*+321*	*-31*	*+228*	+899

(All figures in this table are from the Report of the Expert Group on Resource Allocation, apart from those in italics, which were obtained from the HSE in correspondence for this research, in April 2012.)

What these figures do not show is the over use of public beds for private patients. As stated earlier, in 2002, 25% of public hospital patients were private, not the designated 20% maximum.

Additional figures provided by the HSE for this research, assist with looking at the trend in the availability of hospital beds over time. They show that between 2002 and 2010 there was a net increase in public beds in public hospitals of 321. However, a closer examination shows that between 2007 and 2010 there was a net decrease of 820 public beds in public hospitals, ie all the growth in the numbers of public hospital beds took place between 2002 and 2007, after which there was a decline in public hospital beds reflecting cuts to the capital health budget. This reflects the significant decline in the health budget as a result of the economic crisis facing Ireland since 2007/8, which brought about the closure of many of these acute inpatient hospital beds.

OECD figures do not give bed numbers but their ratios show a persistent decrease since 2007 from 5.7 hospital beds per 1,000 in 2003 to 4.9 beds per 1,000 in 2008 (OECD, 2012). Further acute beds have been closed since 2008, reflecting cuts to hospital budgets, shorter average length of stay in hospital and increased day cases.

When bed numbers are looked at between 2002 and 2010, they show a significant increase in private beds in private hospitals, up 50 between 2002 and 2007, and up 849 beds between 2007 and 2010. This surge in private hospital beds since 2007 reflects the time it took for the capital allowances to take effect, due to the planning and building time involved in constructing new hospitals. But once new hospitals were opened, such as the Galway Clinic and the Beacon Hospital in 2008, significant increases in the numbers of private beds are evident.

The figures compiled for this research show a 3.5% increase in public hospital beds between 2002 and 2010, and a 34% increase in private beds in private hospitals during this time.

There was no estimate on the potential costs of the capital allowances for healthcare institutions and no official statistical data on the uptake of the tax breaks existed until 2004, when provisions were made in the Finance Act to enable the collection of such information (Revenue Commissioners, 2009).

Figures compiled for this research from 2004 to 2009 show that expenditures for building or refurbishing private nursing homes, convalescent homes, private hospitals, and sports clinics cost the state €154.4 million. Of this €154 million, €93.4 million was spent on private nursing homes and €52.6 million on private hospitals (extrapolated Revenue Commissioners Statistical Annual Reports 2004-2009).

Overall tax breaks are estimated to have cost the exchequer €1.9 billion in lost revenue (Department of Finance, 2011). In 2007, 5% of all property-based claims were related to nursing homes and 2% were for private hospitals (Department of Finance, 2011).

There has been very little commentary from a policy perspective on the impact of the tax breaks in healthcare, although in 2011 the Ombudsman made a speech outlining some of the issues from her perspective.

> *The recent big example of this in the health area has been the enormous development of for-profit private hospitals.... This enormous expansion of private sector involvement in hospitals... with an inevitable decline in public sector involvement, is self-evidently a critical issue in terms of the State's health policy – and not least because the private sector expansion was subsidised from the public purse. Whether one approves or disapproves of this shift, one might reasonably expect that it would have been a matter for debate in terms of the State's*

health policy. In fact, this development came about with almost no debate in terms of health policy and the measures were the brainchild of the Minister for Finance rather the Minister for Health. The Finance Acts of 2001 and 2002 included, amongst the plethora of other provisions, tax concessions which encouraged, and subsidised through taxes foregone, the development of private hospitals... (O'Reilly, 2011)

Policy entrepreneurs

Three policy entrepreneurs can be identified through the documentary analysis: the then Minister for Finance, Charlie McCreevy, as a political policy entrepreneur, who quietly facilitated the changes, having been successfully lobbied by private hospital developers; and the two hospital developers, James Sheehan and Michael Heavey, who personally influenced and lobbied McCreevy to give the tax breaks to hospitals in the 2001 and 2002 Finance Acts.

5.3 Case Study 2 – National Treatment Purchase Fund, 2002

The National Treatment Purchase Fund (NTPF) was set up in 2002 to buy publicly financed care for long-waiting public patients in public and private hospitals. The vast majority of procedures and care carried out under the NTPF was in privately run, for-profit hospitals, however some care was purchased privately from the public hospital where the patient was originally referred and or treated. This usually occurred when patients had particularly complex care needs and required treatment in the same hospital where their specialty was managed (NTPF, 2005).

5.3.1 Case study 2: problem stream

The Irish health system has a history of very long waiting times for public patients for elective treatments. The issue of long waits for the treatment of public patients in public hospitals was a persistent concern of the public, policy makers and politicians throughout the 1990s (Wren, 2003). Despite various initiatives to the tackle long waits, large numbers remained waiting for extended periods of time (Department of Health and Children, 2001a; Wren, 2003).

The long waits for public patients are caused by a combination of factors, including a shortage of public hospital beds (caused by lack of investment in public hospital beds), the legacy of the cutbacks from the 1980s, inefficient use of public hospitals, the provision of private care in public hospitals and incentives for dual practice consultants (Burke, 2009; Wren, 2003). This two-tier nature of public hospital care in Ireland allows private patients to gain faster access than public patients for elective treatment in public hospitals (Wren, 2003). The privileging of private patients over public patients further exacerbates the longer waiting times for public patients (Department of Health and Children, 2010a; Wren, 2003). No government had tried to abolish the two-tier system of hospital care since Noel Browne's attempt in the early 1950s (Barrington, 1987).

In 1993, the then Minister for Health, Brendan Howlin, launched the Waiting List Initiative (WLI). This was set up to deal with 'a persistent waiting list problem in acute public hospitals. This problem involved significant numbers of public patients waiting long periods for elective (non-emergency) hospital treatment' (Comptroller and Auditor General, 2004). The Department of Health set targets for the WLI in 1993 'that adults would not have to wait longer than twelve months and children would not have to wait longer than six months' (Comptroller and Auditor General, 2003). This was the first time targets were set and specific specialities with the longest waiting lists were targeted (Comptroller and Auditor General, 2003). These included cardiac surgery; ear, nose and throat; orthopaedics; general surgery; vascular surgery; and urology (Comptroller and Auditor General, 2003).

Although initially intended as a 'short-term initiative', the WLI ran for 10 years. The WLI provided funding to hospitals to reduce wait times. Hospitals had flexibility as to how to spend the money and reduce wait times, varying from paying staff to work overtime, to hiring extra medical staff and or administrators to oversee bed management and wait times (Comptroller and Auditor General, 2003).

In many hospitals, the WLI funding was used to fund temporary consultant posts on an ongoing basis, many of which over time became permanent posts. It also allowed hospitals to contract other hospitals to perform procedures, including, in some instances, private hospitals or paying for patients to travel abroad for treatment. The total cost of the WLI was €290 million between 1993 and 2003, and although it reduced waiting times in some specialities, others did not improve, while wait times in other areas grew (Comptroller and Auditor General, 2003).

There was no regular publication of waiting-list numbers or of the length of time patients were waiting in the early 1990s. For example, the 1999 Department of Health 'Health Statistics' report had 44 pages of statistics on hospital use but not one mention of the numbers of patients waiting, or the length of time they were waiting, to get into hospital for treatment (Department of Health, 1999). And it was only with the introduction of the WLI that the Department of Health began to compile national statistics on the numbers of patients waiting three months or more for treatment.

The office of Comptroller and Auditor General provides the only time-series analysis for this period. This shows that when the initiative started, in 1993, there were more than 40,000 patients waiting for treatment. These statistics went through a validation exercise which reduced the figures to about 25,000. From 1994 on there was an upward trend in numbers waiting. 'This trend continued into 1999 when the overall total number waiting peaked at around 37,000. The number reported dipped to 26,000 by the end of 2001 [when the strategy was published] and rose again to 29,000 by 31 December 2002' (Comptroller and Auditor General, 2003: 14).

The increases in numbers of patients waiting more than three months for hospital treatment in certain specialities also reflects the growing population since the early 1990s, alongside increased hospital

activity. This is evident in consistently higher numbers of emergency admissions, inpatients and day cases in all public hospitals (Department of Health and Children, 2010a).

In 1998, the then Minister for Health, Brian Cowen, set up a review group to examine the WLI and make recommendations to maximise its effectiveness. The report of the review group is no longer available but its recommendations are cited in the report by the Comptroller and Auditor General on the Waiting List Initiative in 2003. It makes a series of recommendations for immediate implementation including increasing physical and staffing resources in hospitals, better information systems, the validation of waiting lists, and the prioritisation and targeting of funding at those waiting longest (Comptroller and Auditor General, 2003: 50-51).

According to the Department of Health, on '30 September, 2000, waiting lists stood at 29,657. This represented a decrease of 7,198 since the beginning of the year' (Department of Health and Children, 2001b: 17). But this figure is selective as it is evident from above that more than two years later there were still 29,000 people waiting for treatment. The 2001 health strategy highlighted the need for 'the management and organisation of waiting lists to be reformed' as well as setting targets to reduce them (Department of Health and Children, 2001a: 104).

By 2002, nine years after the introduction of the WLI, there was a 39% reduction in the numbers waiting over the targets in the specific specialities, from 14,100 in 1998 to 8,700 people waiting longer than the initial targets set of 12 and six months for adults and children respectively, in December 2002 (Comptroller and Auditor General, 2003: 38). Some specialities achieved significant reductions in wait times and numbers eg ear, nose and throat; vascular; orthopaedic and cardiac surgery. In other specialities, such as urology and ophthalmology, the numbers waiting were the same in 2002 as they were in 1993, and in some areas such as general and plastic surgery, the numbers waiting increased (Comptroller and Auditor General, 2003).

Funding for the WLI increased from €25 million in 1999 to €44 million in 2000 and 2001 (Comptroller and Auditor General, 2003: 30). This reflected a general trend of increased spending on health since the mid-1990s, and particularly high increases in the health spend between 1999 and 2002, rising from €5 billion to €8 billion over three years (OECD, 2012).

At the end of 2002, 70% of those waiting longest were in east of the country. At that time, all hospitals in the east came under the remit of the Eastern Regional Health Authority, whose figures show that 'at the end of 2002, an average wait time of over 15 months' existed for the region (Comptroller and Auditor General, 2003). Crucially, an evaluation of the WLI found that it could not ascertain if the WLI increased elective activity, and even if it did, it could not tell if it resulted in care being provided for the longest waiters (Comptroller and Auditor General, 2003).

Waiting times for hospital treatment was one of the main issues raised in the consultations with the public and with stakeholders in the development of the 2001 health strategy.

> *Not surprisingly there were many calls for shorter waiting lists for elective procedures and for treatment of various kinds and reduced waiting times for outpatient appointments. People often linked these calls to comments about equity and fairness in access to services. Many people see waiting lists as a result of serious lack of staffing, resources and hospital beds. They want to see a big increase in nurses and medical staff, in particular, but also in the other essential staff needed to improve services (Department of Health and Children, 2001c*: 27).

Dealing with long-waiting public patients was one of the central challenges facing the architects of the health strategy.

5.3.2 Case Study 2: policy stream

In 2000, the government announced the development of a new national health strategy. Extensive consultations were held with the public, with patients and with workers in the health services, as well as with key stakeholders (Department of Health and Children, 2001c). As stated above, the issue of long waits for both outpatient and inpatient hospital treatment was a major issue of concern for both the public and stakeholders.

The Department of Health and Children published the new Irish health strategy (the first since 1994), 'Quality and Fairness – A Health System for you', in December 2001 (Department of Health and Children, 2001a). The health strategy contained 121 actions, with clear 'deliverables', target dates and responsibility assigned to whichever department or agency was responsible for their implementation.

Action 81, in 'Quality and Fairness', states

> *a comprehensive set of actions will be taken to reduce waiting times for public patients, including the establishment of a new ear-marked Treatment Purchase Fund* (Department of Health and Children, 2001a).

The strategy placed

> *a new focus on waiting times. The target is that by the end of 2004 all public patients will be scheduled to commence treatment within a maximum of three months of referral from an out-patient department. The intermediate targets to achieve this aim will be as follows:*

- *By the end of 2002, no adult will wait longer than twelve months and no child will wait longer than six months to commence treatment following referral from an out-patient department;*
- *By the end of 2003, no adult will wait longer than six months and no child will wait longer than three months to commence treatment following referral from an out-patient department;*
- *By the end of 2004, no public patients will wait longer than three months for treatment following referral from an out-patient department.*

The target improvements in waiting times will be achieved by:

- *A major expansion in acute bed capacity, as described above, together with reform of primary care, strengthening Accident and Emergency services and the provision of additional non acute places*
- *An ear marked Treatment Purchase Fund which will be used to purchase treatment from private hospitals in Ireland and from international providers. It may also make use of any capacity within public hospitals to arrange treatment of patients.*

A National Treatment Purchase Team appointed by the Minister for Health and Children will manage the new Treatment Purchase Fund, working closely with the health boards. The team will commence its work immediately, in parallel with other reforms below.... (Department of Health and Children, 2001a: 101)

'Quality and Fairness' also outlined how acute hospital capacity would be expanded with the provision of 3,000 extra beds designated for public patients by 2011, a planned addition of 25% capacity, 'representing the largest ever concentrated expansion of acute hospital capacity in Ireland' (Department of Health and Children, 2001a: 102). If delivered the increased capacity potentially could have impacted on giving priority treatment to long-waiting public patients and achieving the ambitious targets set out in the 2001 health strategy.

Eleven years after publication of the target that no public patient should wait more than three months for treatment, in December 2011, there were 26,337 adults and 2,513 children waiting more than three months for day-case and inpatient hospital treatment (HSE, 2012a).

The strategy also specified a new national hospitals office to oversee expansion of public hospital capacity and to co-ordinate functions to reduce waiting lists and waiting times (Department of Health and Children, 2001b). No such hospitals office was set up until the establishment of the HSE in 2005 and then it was abolished soon after as it was merged with Primary, Community and Continuing Care (Burke, 2009).

The two-tier nature of the hospital system and unequal access for public patients were highlighted as issues of concern in the consultations for the health strategy. However, in the final strategy documents there were no specific actions outlined which sought to undo them in the strategy (Department of Health and Children, 2001a, 2001c).

'Fair access' was identified as one of the four national goals in the strategy and assuring 'equitable access for all categories of patients in the health system' was specified as an objective. Central to achieving this as outlined in 'Quality and Fairness' was the achievement of the targets set above and the increased provision of public hospital beds.

> *This strategy outlines measures to ensure that all public patients can expect the high quality service within a reasonable period of time. This includes a ten year programme for the largest ever concentrated increase in public hospital acute capacity.*

The health strategy acknowledged the two-tier nature of the public hospital system and unequal access resulting in long waits.

> *The strategy must address the 'two tier' element of hospital treatment where public patients frequently do not have fair access to elective treatment. All patients should have such access within a reasonable period of time, whether they are public or private* (Department of Health and Children, 2001a: 48).

The persistence of high numbers of public patients waiting for hospital treatment and the continuation of the public-private mix is evidence that the 'two tier element of hospital treatment was not addressed' (Burke, 2009).

The 'treatment purchase fund' was named as a means to cutting long waits for public patients for hospital treatment and was the only element of this objective to be implemented (Department of Health and Children, 2001a).

Changes to the Finance Act in 2001 and 2002, which gave tax breaks to developers to build private hospitals, resulted in the increased availability of private beds for treatment of public patients under the NTPF. However, these private beds did not materialise until 2008 due to the time lag between the introduction of favourable conditions and the amount of time it takes to build and open a new hospital. Between 2002 and 2007, substantial, previously unused capacity in private hospitals was utilised by the NTPF. Table 5.1 earlier in the Finance Act section in this chapter shows the increased numbers of private hospital beds between 2007 and 2010.

5.3.3 Case Study 2: politics stream

Micheál Martin was appointed health minister in 2000 after a successful period in the Department of Education (Wren, 2003). The coalition in power since 1997 was in government at a time of significant economic growth. While there was some public dissatisfaction with the knock-on impact of economic growth, such as high house prices, long commutes to work and inadequate childcare, opinion polls showed general satisfaction with the government (Burke, 2009, Leahy, 2009).

However, dissatisfaction with the health service became an increasing area of public and political priority (Watson and Williams, 2001; Wren, 2003). As a key way to address this dissatisfaction, the government announced the development of the new health strategy (Burke, 2009). Significant time and resources went in to consultation with the public and with stakeholders in the health system as part of the strategy's development (Department of Health and Children, 2001c).

Significant extra resources were put into the health system in 2000 and 2001 – in the run up to the 2002 general election – yet dissatisfaction with the health system prevailed and the numbers waiting a long time for care remained high (Comptroller and Auditor General, 2003). A crucial meeting took place in May 2001 in Ballymacscanlon when the proposals and associated costs of implementing the health strategy were detailed.

Significant differences between the then Ministers for Health and Finance, Micheál Martin and Charlie McCreevy respectively, surfaced at that meeting, an early indication that the many promises in the health strategy would not be funded sufficiently and therefore would remain just promises on paper (Burke, 2009, Kelly, 2007).

The then Secretary General in the Department of Health, Michael Kelly, who was at this meeting, writing six years later, articulated the division between Martin and McCreevy:

> *The constructive mood of the meeting itself was somewhat marred by the very different perspectives on its outcome expressed respectively by the Minister for Health and Children and the Minister for Finance subsequently. The tension between these perspectives was to be a constant feature of the policy debate about health over the ensuing years and, I believe, a key influence in limiting progress that could be made in pushing forward with the development of the reform agenda which was adopted by Government in late 2001 but much of which remains to be implemented (Kelly, 2007: 30).*

The health strategy was published in December 2001 in the run up to the general election in 2002 (Department of Health and Children, 2001a). Health services were an area of concern highlighted in the election campaign and a key part of the Fianna Fáil/PDs election strategy was to ask voters to re-

elect them for another term to give them time to improve public health services through the implementation of the health strategy (Burke, 2009; Leahy, 2009).

5.3.4 Case study 2: policy window of opportunity

While the health strategy was in draft form, the government coalition partners, the PDs, launched the idea of a 'treatment guarantee fund' in September 2001. Writing on the PDs' new health initiative in the *Irish Times* on 26 September 2001, PD leader Mary Harney said:

> *Access to good healthcare services is a basic human right. Social justice demands that such access should be available to all on a fair and equitable basis, irrespective of social status or income level. Our present system is not providing that access.*
>
> *It is not acceptable that public patients should endure pain and hardship waiting long periods for badly needed treatment. It is not acceptable that some people spend literally years waiting for a hospital bed. And it is not acceptable that we should have a two-tier treatment system which, despite the best efforts of many dedicated professionals, often fails to deliver treatment to public patients when they need it.*
>
> *It is time to put a permanent end to indefinite public waiting lists. That is why the Progressive Democrats are now proposing a radical new initiative that will help to transform the Irish public health system. Under our proposals:*
>
> - *every patient currently on a public waiting list would be given a definite appointment date for treatment just as private patients are;*
> - *if implemented now, all waiting-list patients could be offered a definite appointment before Christmas; the current waiting list of over 26,000 public patients would, in practically all cases, be eliminated within six months, and the concept of the public waiting list would be ended permanently, never again to become a feature of the Irish public health system.*
>
> *These are bold and ambitious objectives but they are achievable* (Harney, 2001).

Referring to how the party's 'immediate proposal' would work, the PDs promised

> *to establish a new treatment guarantee fund as an additional line item in the central health budget... effectively what we are saying is that no longer will public patients have to bear the cost of the deficiencies in the health system* (Harney, 2001).

Little information is publicly available documenting the details of the PD's 'treatment guarantee fund' nor was it included in the draft health strategy in September 2001 (FoI 16).

According to information obtained under FoI, the PD proposal was met with scepticism by the then Minister for Health, Micheál Martin, the Department of Health and the Department of Finance (FoI 17). The Irish Medical Organisation (IMO) was also opposed to its introduction (Wren, 2003).

Martin pointed out, upon the announcement by the PDs of the 'treatment guarantee fund', that under the Waiting List Initiative, public patients' care was already being contracted out to the private sector and in some instances patients went abroad for treatment (Wren, 2003). This was true but only in a small minority of cases as the vast majority of WLI money was spent on treating patients in the same public hospital they originated from (Comptroller and Auditor General, 2003).

The Department of Health was concerned with the PD proposal as it felt it would exacerbate the public private divide, with consultants being paid a salary for public work and fee-for-service for private work (Wren, 2003). The Department of Finance queried how the treatment purchase fund would prevent consultants from manipulating the system to their own advantage, ie it could incentivise consultants to provide more private care in public hospitals (Wren, 2003). The Department of Health responded saying it would monitor consultants' activity and if there was any evidence, the team would review the position (Wren, 2003). A limit was imposed upon the percentage of public patients who could be treated privately in the same hospital in order to limit this perverse incentive. However, there were some cases where complex patients needed to be treated in the public hospital (Burke, 2000).

There was concern at the time that the NTPF would further incentivise consultants to maintain their waiting lists so that their public patients would become their private patients under the NTPF, meaning consultants would be rewarded or paid more for treating long-waiting public patients privately instead of publicly (Wren, 2003: 140). There was recognition that once the NTPF got up and running, it was usually beneficial to the public patients who got treated quicker in private hospitals. However, there were also concerns that the NTPF, 10 years after its establishment, did not address the underlying causes of the long waits, evident in the persistent numbers of those waiting more than three, six and nine months (Wren, 2003, Burke, 2012).

The IMO greeted the proposals with doubt as to whether the private capacity existed to provide such treatment under the proposed fund. According to Wren, however, it was

> *a gift to the owners of private hospitals, who were campaigning for tax reliefs. The Independent Hospitals Association of Ireland informed government that, were they to receive tax incentives to help them expand, they could treat a further 5,000 to 7,000 public patients a year... In the real politic of the coalition, a means had to be found to assuage the Progressive Democrats electoral anxieties, the health strategy incorporated a "new ear-marked Treatment Purchase Fund"* (Wren, 2003: 267).

Wren also points out that the proposed 'guarantee' by the PDs was toned down to a 'target' in the health strategy, 'Quality and Fairness'. FoIs show the 'treatment fund' was, like its predecessor, envisaged as a short-term initiative (FoI 17). However, the short term nature of the NTPF was dependent on increased capacity in the public sector so that it could provide timely care for public patients. As detailed in the previous section on the Finance Act changes, just one-third of the 3,000 promised additional public hospital beds (1,141) came on stream between 2002 and 2007, and after 2007 there was a sharp decline in numbers of public hospital beds. See table 5.1. By the target date of 2011, there were 899 more private beds in private hospitals than there were in 2001, ready for use by the NTPF.

The majority of the 121 actions published in the health strategy in December 2001 were not acted upon and remained unimplemented many years later (Burke, 2009). A key part of the non-implementation was the failure of government to allocate money to fund the specific commitments (Kelly, 2007). Many reports and reviews were commissioned after the strategy but few of the actions were implemented with the political will and economic support of the NTPF (Burke, 2009). In contrast to other measures which were postponed through non-action or commissioning reports on same, the NTPF was set up in March 2002, four months after the strategy was published, with extensive political support, although reluctant backing from the then Minister for Health, Micheál Martin.

Within months of its first pronouncement, Martin stated

> *the work of the National Treatment Purchase Fund will be patient-centred with the aim of taking public patients who have waited longest off waiting lists by providing them with the highest standard and quality of care... The NTPF will purchase procedures for pubic patients from private hospitals in Ireland and from international providers. It may also use any capacity within public hospitals to arrange treatment of patients* (Department of Health and Children, 2002).

It also stated that only when public or private care in Ireland is not available within a reasonable period of time, arrangements will be made under the NTPF to buy care abroad (Department of Health and Children, 2002). Both the PDs and Fianna Fáil campaigned for the 2002 election on the basis of eliminating waiting lists (Burke, 2009)

Despite initial opposition from the Minister of Health and officials from the Departments of Health, the NTPF was adopted and introduced with significant political and economic support. The level of political backing for the NTPF is evident in its financial allocation. The NTPF was allocated €5 million for its first year of operation – it was set up in April 2002 – but funding quickly rose to

€30 million in 2003, €44 million in 2004, €64 million in 2005 and up to €100 million in 2008 (Comptroller and Auditor General, 2004; NTPF, 2009).

Policy entrepreneurs

Mary Harney as leader of the PDs and Minister for Enterprise played a key role in the proposal and adoption of the National Treatment Purchase Fund as a policy response to long waits for public patients. Even though she had no responsibility for health in 2001 and 2002, it was her proposal that led to the establishment of the NTPF (Burke, 2009; Wren, 2003).

5.4 Case Study 3: Co-location

Co-location was announced by Minister for Health, Mary Harney in July 2005. The aim of the co-location policy was to build private hospitals on the grounds of public hospitals and thereby free up 1,000 beds for public patients in the public hospital.

5.4.1 Case Study 3: problem stream

The shortage of public hospital beds and long waits for public patients for hospital treatment were intractable problems in Ireland in the early 2000s, as detailed in Case Study 1 and Case Study 2. Much of the time between the publication of the health strategy in 2001 and the announcemnt of co-location in 2005 was taken up with reorganising the health service structures, specifically disbanding the health boards and setting up the HSE (Burke, 2009).

When the HSE came live on 1 January 2005, it had no chief executive and was unprepared for the enormity of the the task of merging more than a dozen organisations into one agency with more than 100,000 staff (Burke, 2009). Many health service managers and policy makers were preoccupied with the establishment of the HSE and other priorities, such as reducing waiting lists and delivering additional hospital beds, fell down the priority list.

Measures, as outlined in the previous two cases in this chapter, were outlined in the health strategy with the aim of improving the care for public patients. However the causes of the two-tier system were not addressed and the status quo of unequal access was maintained (Burke, 2009; Tussing and Wren, 2005; Wren, 2003). The two-tier system of hospitals contributed to long waits for public patients as many public beds were occupied by private patients and private patient care was subsidised by public money.

The 2001 health strategy specified 'improved access for public patients' in the same paragraph as 'increasing capacity through further investment' and 'working in closer partnership with the private hospital sector' as key elements of the framework to 'reform the acute hospital system' (Department of Health and Children, 2001a).

The health strategy committed to an additional 3,000 hospital beds, of which it was planned that 2,800 beds would be for inpatients (Department of Health and Children, 2001a). Despite the conflicting statements in the health strategy about how or where these additional beds would be delivered, it was envisaged that a limited number of the extra 3,000 beds to be added to the Irish system would be in the private sector. The majority would be added in the public sector (Department of Health and Children, 2005d).

While it had been government policy since 1999 that the full economic cost of private beds in public hospitals should be paid by insurance companies or private patients, by 2005 (even 2012) this was still not the case. Private patients' care in public hospitals was still subsidised by public money in 2005. While the costs of consultant-provided care and accommodation are charged to the patient or their insurer, other costs such as surgical theatre facilities, nursing and other allied health professional costs are absorbed by the public system. Also many private patients in public hospitals are not charged for their care, except for the consultants' costs, if they are in a public bed. Private patients get quicker care, they are more likely to get consultant-delivered care and their care is largely subsidised by public money (Department of Health and Children, 2005b; Tussing and Wren 2005; Wren, 2003).

5.4.2 Case Study 3: policy stream

The rationale for co-location was to build new private hospitals on the grounds of public hospitals, providing 1,000 additional private co-located beds. These new beds would free up 1,000 public beds, which up to then were occupied by private patients in the public hospital on the same grounds (Department of Health and Children, 2005d). As outlined in the problem stream, the rationale for co-location was manifold; a key driver was the shortage of public hospital beds.

There was no consultation or notice in advance of the announcement of the co-location plan. On 14 July 2005, the then Tánaiste and Minister for Health, Mary Harney, speaking at the launch of co-location, said

> *I wish to announce a strategic reform initiative for our health services. The Government has identified the need for new public beds in our hospitals. We are already investing substantial amounts in providing new beds. By now encouraging new private hospitals to take a substantial number of private and semi-private beds out of our public hospitals, we will create new beds for public patients in the fastest and most cost-effective way in the next five years...*
>
> *The policy is to allow up to 1,000 private beds to be moved from within the public hospital system over the next five years. This is an achievable and prudent target.*

This initiative today will improve access for public patients, while providing insured patients with purpose-built, new hospital facilities.

This policy sets out clearly a very important aspect of the configuration of our hospitals for the future. It is a key part of the context for a new consultants' contract.

This is a practical strategy aimed at achieving a fast response and a quick impact.

It will pull together in a concerted and focused way the different strands of Government policy in relation to the Health Strategy commitments, tax breaks under the Finance Acts, private insurance and economic charging. It will ensure greater capacity for public patients and, at the same time, a more vibrant and innovative role for the private sector.

It makes health policy sense and it makes economic sense. All patients will benefit. (Department of Health and Children, 2005e: 1-2)

The announcement was accompanied by a seven-page letter from the Secretary General of the Department of Health, Michael Scanlon, to the chairman of the HSE board, Liam Downey. This letter detailed the rationale for the plan and how the Department envisaged its development and implementation. The letter specified how the secretary general was issuing a policy direction to the HSE under section 10 of the Health Act 2004 (Department of Health and Children, 2005b). This was the first and only time such a directive was issued under Mary Harney's ministry between 2004 and 2011.

The letter stated that the new policy drew on action 79 of the Health Strategy:

'A significant proportion of additional capacity in the acute hospital system will be supplied in future by private providers. Government policy will aim to incentivise and attract private providers to develop private facilities, thereby freeing up capacity in public hospitals to treat public patients. The public sector will also procure a greater degree of services from the private sector.'

The letter continued:

The Finance Acts provide for capital allowances over a seven year period for the construction of private hospitals provided they meet certain criteria. This has already led to the construction and planning of a number of private hospital developments.

This policy direction is designed to pull together these different elements of Government policy in a coherent and practical way with the aim of:

- *increasing bed capacity for public patients in public hospitals;*

- *encouraging the participation of the private sector in generating extra capacity;*
- *maximising the potential use of public hospital sites;*
- *promoting competition among public and private acute service providers; and*
- *offering improved quality and choice to all patients.*

The co-location of private facilities on public hospital sites is already a feature of some public hospital campuses. If private patients could be 'migrated' from public hospitals to private facilities on the same site this could free up significant capacity for public patients. There are approximately 2,500 private beds in the public hospital system and the target would be to transfer no more than 1,000 such beds to private facilities over a period of five years. The Tánaiste is of the view that this offers a practical and relatively inexpensive method of providing significant additional capacity for public patients (Department of Health and Children, 2005b).

The documents, published on 14 July 2005, state that the plan for the co-located beds was that the full economic cost would be charged and would be paid by the insurer or the patient at no cost to the state, thus ending state subsidy of private patients in public hospitals. It also acknowledged that this had been government policy since the White Paper on Private Insurance in 1999, but was never achieved.

> *The charges for private beds in public hospitals are between 50 and 60 per cent of what can be calculated as the full economic cost* (Department of Health and Children, 2005d: 2).

The plan also envisaged as other policies had before (the Finance Acts and the NTPF) that the public sector could buy private care in the private sector for public patients who were waiting too long.

The seven-page letter to Liam Downey, chairperson of the HSE board, outlined an assessment framework and 10 criteria for participation in the project as well as core elements to meet those criteria (Department of Health and Children, 2005b: 5-6). The press release, which accompanied the letter and other background documents published on 14 July, detailed how the HSE board was briefed and discussed this policy initiative in its July board meeting and the directive that the 'HSE will begin work immediately so that as soon as possible invitations to tender for the new hospital development will be issued' (Department of Health and Children, 2005b: 2). It is clear from the letter that the policy initiative and assessment framework was drawn up without the involvement of the HSE (Department of Health and Children, 2005b).

It was unclear at the time of the announcement of co-location in July 2005 whether consultants with a Category 1 contract, which allowed them to practise privately on the public hospital site only, would be allowed to practise in the private co-located hospital. In 2005, 61% of all consultants had a Category 1 contract (Department of Health and Children, 2005c). A new contract was subsequently negotiated in 2007/8 which would allow for such dual practice (Burke, 2009).

The background papers published with the co-location announcement stated that the Department of Health and Children commissioned Prospectus, a private management consultancy firm, to provide

- *succinct and appropriate strategic and investment appraisal frameworks for the development of private facilities on public hospital sites; and*
- *formal criteria and conditions for such proposals that would both encourage the generation of private initiative and promote and protect the public interest.*

The consultancy assignment produced draft evaluation criteria to be applied by the HSE in assessing proposals and identified key policy issues which would need to be addressed in order to provide clarity for investors (Department of Health and Children, 2005d: 1-2).

This Guidance Directive specified what needed to be done to encourage the generation of private initiative and to promote and protect the public interest (Department of Health and Children, 2005a).

The Framework Assessment was produced alongside a 'memorandum on related policy issues' which details

> *the underlying policy thrust is to maximise the potential to increase provision of acute care through clear policy direction so as to allow all potential providers of care to assess on what basis they might bring forward initiatives in this area* (Prospectus, 2005: 1).

The memo states that 'there is real potential for greatly increased joint activity between the public and private sectors' (Prospectus, 2005: 1). It also acknowledged that the nature of the public-private partnership was yet to be established and that

> *the State, as the largest stakeholder in the acute health system will need to provide increased clarity and leadership to the market as to the terms of engagement with the private/independent sector partner* (Prospectus, 2005: 1).

The policy directive issued to the HSE chairman states that

> *a system based on public patients having access to private hospitals and private patients continuing to be treated in public hospitals would help to support high quality care for public patients. There would be an increase in public beds as private beds are moved to the private facility. The HSE would be required to ensure strict adherence to the resultant revised bed designation ratios and to ensure that consultants' private patients do not occupy public beds. These measures should help to ensure greater equity of access to public hospitals.*
> (Department of Health and Children, 2005b: 3).

The intended plan that private co-located hospitals, financed through tax breaks, would result in a redesignation of beds in public hospitals never materialised.

The policy was introduced with the intention of ensuring greater equity of access for public patients to public hospitals. The letter also states that the 'phased introduction of economic charging... would introduce greater transparency' (Department of Health and Children, 2005b: 3). It also acknowledges that the plan would require additional consultants although the costs or steps to achieving this were not specified (Department of Health and Children, 2005b: 3).

The memo prepared for the Department of Health on co-location by Prospectus provides some details of the benefits for the public system and the private hospitals in participating in the co-location plan. There is a clear emphasis on value for money, maximising potential use of current public hospital sites and protecting the interest of the public patient (Prospectus, 2005). The memo also outlines how co-location could result in a change to the tax reliefs and incentivise

> *a more planned and co-ordinated delivery of private facilities which more directly target the infrastructural deficits in the public health system and which support a more aligned whole system approach to healthcare delivery* (Prospectus, 2005: 3).

The memo highlights many of the obstacles in place for the plan to be implemented. These include clarity around the potential relationship between public and private hospitals on the same site, in terms of clinical governance, but also transparent financial transactions. It also emphasises the need for clarity around eligibility for services, what patients get charged for which services, and the consultants' common contract, which at the time of the memo was being reviewed and would have implications in terms of who could be treated where and by which types of hospital consultants, therefore potentially influencing the viability of co-location. The memo highlights how charging the full economic cost for private patients in privately co-located hospitals could result in increased private insurance premia. This, combined with increased public capacity, might result in fewer people with insurance and therefore fewer patients for private hospitals and a greater demand on the public health system (Prospectus, 2005).

From the documentary evidence of the policy announcement and background papers associated with the plan to co-locate private hospitals on the grounds of public hospitals, it is hard to gain a clear view of how and where the policy window emerged for co-location. Only one document obtained specified the 'possible drivers for co-location'. A presentation by Prospectus management consultants to students at Trinity College, Dublin in 2008 reveals these 'possible drivers for the Minister's policy initiative' as

- *Recognised capacity problems*
- *Resource shortfalls*
- *Fostering competition and measurement*
- *Increasing choice*

- *Ideology*
- *International trends*
- *Existing fiscal provisions* (Prospectus, 2008).

Four of the seven reasons given are related to the then minister's 'ideology'; belief in competition; 'increased choice', which was consistently used in the 1980s and 1990s as a rationale for increased marketisation and privatisation of healthcare (Lister, 2008). The 'existing fiscal provisions' refer to the Finance Acts that gave tax breaks to developers to build private hospitals.

These documents specify the aims of co-location and how the minister envisaged it would be implemented. However, they fail to deal with the main focus of this research, which is what influenced and drove this policy choice. The interviews help explain to a greater extent what happened.

5.4.3 Case Study: politics stream

The co-location project was controversial from the day of its announcement. It was viewed as an ideological project, driven by the then Minister for Health Mary Harney and her adviser Oliver O'Connor (Wren, 2003; Tussing and Wren, 2005; Burke, 2009; Drumm, 2011).

As previously stated, Harney and the PDs were viewed to have held considerable power in government between 1997 and 2007, with much more influence than their small party size represented (Collins, 2005, Leahy, 2009). The PDs doubled their seats in the 2002 general election from four to eight, and, although Fianna Fáil did well with 81 seats, they did not have a majority and went into coalition with the PDs, whose support was critical to the stability of the government (Leahy, 2009).

Harney was the Minister for Enterprise, Trade and Employment before she was appointed to the health ministry in September 2004. While in the Department of Enterprise, she made a seminal speech about 'Boston or Berlin', outlining the model in which she, the PDs and to a large extent the government she served in, believed in a model much closer to Boston than Berlin.

> *As Irish people our relationships with the United States and the European Union are complex. Geographically we are closer to Berlin than Boston. Spiritually we are probably a lot closer to Boston than Berlin...*
>
> *What really makes Ireland attractive to corporate America is the kind of economy which we have created here. When Americans come here they find a country that believes in the incentive power of low taxation. They find a country that believes in economic liberalisation. They find a country that believes in essential regulation but not over-regulation....*

Political and economic commentators sometimes pose a choice between what they see as the American way and the European way.

They view the American way as being built on the rugged individualism of the original frontiersmen, an economic model that is heavily based on enterprise and incentive, on individual effort and with limited government intervention.

They view the European way as being built on a strong concern for social harmony and social inclusion, with governments being prepared to intervene strongly through the tax and regulatory systems, to achieve their desired outcomes.

Both models are, of course, overly simplistic but there is an element of truth in them too. We in Ireland have tended to steer a course between the two, but I think it is fair to say, that we have sailed closer to the American shore, than the European one.

Look at what we have done over the last ten years. We have cut taxes on capital. We have cut taxes on corporate profits. We have cut taxes on personal incomes. The result has been an explosion in economic activity and Ireland is now the fastest-growing country in the developed world.

And did we have to pay some very high price for pursuing this policy option? Did we have to dismantle the welfare state? Did we have to abandon the concept of social inclusion? The answer is no: we didn't (Department of Enterprise, Trade and Employment, 2000).

In 2004, after a cabinet reshuffle, Harney, the then Tánaiste, was appointed Minister for Health. In first speech in the Dáil as Minister for Health she said:

I do not take my politics from any ideology; I am not an ideologue. My views come from my own personal experience... the one thing I want for the country I love is to have a health service that is accessible to every citizen, regardless of their wealth... We have the analysis and the blueprint... The challenge now is to implement the reform... I wish to confirm that it will be common sense reform, not driven by any ideology. It will be driven with only one motive in mind: the patients' interests (Harney, 2004).

This was to be a theme that Harney would speak a lot about throughout her ministry – of protecting the public interest, of taking on vested interests. Yet this approach did not always sit easily with her strong belief in competition and the market. Two of her main policy initiatives – co-location and the Nursing Home Support Scheme – sought to significantly increase private provision in hospitals and nursing homes, albeit, in her opinion, in the public interest (Burke, 2009). Some would argue,

including this author, that in fact these policies, and others such the consultants' contract, gave into rather than took on the vested interests (Burke, 2009).

As already stated, McCreevy and Harney were considered the axis of the government's economic policy, although McCreevy reluctantly went to a senior European post when Harney took up the health ministry in 2004 (Leahy, 2009). The co-location project was an application of their economic model to the health system, building on McCreevy's changes to the Finance Acts in 2001 and 2002 and Harney's commitment to competition and an increased 'market' for healthcare (Burke, 2009). McCreevy senior posting in Europe, some commentators say, was a response to concern in the Fianna Fail party that he was too close to the PDs and there was a need for Fianna Fail to reclaim its populist roots (Leahy, 2009). As stated in the announcement of co-location, Harney clearly believed that co-location acted in the interest of the public patient (Department of Health and Children, 2005d).

Although unexpected and never implemented, the co-location policy received more political and public attention than many other health policies. All opposition political parties (Fine Gael, Labour, the Green Party, Sinn Féin) opposed the co-location plan, continuously questioning Harney on the logistics and costings of the plan in the Dáil. All political parties, apart from Fianna Fáil and the PDs, campaigned against co-location in the run up to the 2007 general election. Even the Green Party, which subsequently went into government with Fianna Fáil after the demise of the PDs, in 2007, was opposed to the policy pre-2007, although they did a U-turn on that position once they went into government with Fianna Fáil in 2007 (Burke, 2009). Mary Harney, even though without a political party by 2007, remained Minister for Health until 2011.

There was also widespread opposition from medical representative organisations and unions – both the Irish Hospital Consultants Association and the Irish Medical Organisation spoke out against co-location when it was announced. The IMO in its pre-budget submission called for 'an increase to 15,000 in the numbers of Public Acute Hospital Beds' and said 'that private facilities [should] not be given undue favour with tax breaks – with funding diverted to the public hospital system' (Irish Medical Organisation, 2005). A year later, they advocated that 'the Minister [should] focus spending on the public hospital system rather than the private hospital system in order to solve the A&E crisis' (Irish Medical Organisation, 2006).

In 2006, the Irish Congress of Trade Unions commissioned a well-known journalist, Maev-Ann Wren, and a highly regarded academic, Dale Tussing, to carry out an assessment of the Irish health system and 'the case for reform'. In their book, published in 2006, they clearly articulate their opposition to the plan to co-locate private hospitals on the grounds of public hospitals and summarise their objections as follows, saying that co-location:

- *Will not free up private beds in public hospitals on anything like a one-for-one basis*

- *Cherry-picking will be facilitated*
- *The two-tier system of acute hospital care will be further institutionalised and locked into the system*
- *While the plan technically reduces the practice of private care in public hospitals, private care in fact moves only an enclosed corridor or the other side of a car park away, and the new configuration retains the most objectionable feature of the current arrangement*
- *If consultants from public hospitals are shareholders in the private hospital, they will have an added incentive (on top of private fees they may earn) to favour treating patients in the private hospital over devoting their time and energies to their public hospital and patients (Tussing and Wren, 2006*: 103-4*).*

The Doctors Alliance was formed, in 2006, 'to protect the public health system' led by ex-presidents of the IMO such as Christine O'Malley and Paula Gilvarry. The Doctors Alliance vehemently opposed the co-location and increased privatisation of medical care (Burke, 2009: 228).

Although the co-location proposals emanated from the Department of Health, the letter instructing the HSE was from the Department's Secretary General to the chairperson of the HSE board. There is an unusual line in that letter stating:

> *The Tánaiste is of the view that this offers a practical and relatively inexpensive method of providing significant additional capacity for public patients* (Department of Health and Children, 2005b).

This indicates a distancing of the position of the minister from the Department of Health's Secretary General (Department of Health and Children, 2005b).

As stated above, it was clear from the letter that the policy direction was imposed on the HSE and that the HSE were not involved in the policy's development. At the time of its announcement, there was no permanent chief executive. Brendan Drumm was appointed the first, full-time HSE chief executive in August 2005. The letter refers to the policy being approved at the July 2005 HSE board meeting, however HSE board minutes are available publicly only from September 2005.

In September's minutes, Drumm's first meeting, there is no mention of co-location. In the October minutes, co-location gets a mention: 'Re. private hospitals on public sites – the CEO and relevant Directors are to meet with representatives of the DoHC [Department of Health and Children]' (HSE, 2005c). The November minutes have just one reference to co-location:

> *It was agreed that a mechanism should be developed by the HSE in relation to the appropriate provision of hospital services on a public/private basis and the implications involved* (HSE, 2005b).

It was dealt with as a matter arising in the December minutes

> *Private hospital development on public campuses – Work in relation to determining the appropriate provision of hospital services on a public/private basis is continuing* (HSE, 2005a).

The only mention of co-location in the HSE Service Plan for 2006 was indirect:

- *Establish a forum to enable the involvement of the independent hospital sector in service development, emergency planning, information exchange and the identification of potential areas for service agreements*
- *Approve proposals under the 1,000 beds initiative which satisfy the assessment criteria established by the HSE* (HSE, 2006).

These points show there was no rush in implementing co-location. Speaking on 13 April 2007 about the type of services that would be provided by co-located hospitals, Drumm revealed his approach to co-location:

> *I don't think that anybody including the Minister would claim that all healthcare for paying patients can be provided within the private sector... The private health sector provides mainly elective procedures in a controlled manner without any accident and emergency access and that... the complexity of care that has to be provided in the public health services way outstrips what can or is provided in the private health sector... For those of us who end up with very severe complicated illnesses, the only service that will provide some of those supports is the public health service and you will end up coming to us [the public health system] for treatment* (Drumm, 2007).

In his book on his time as chief executive, Drumm reflects on the co-location project, admitting that it caused significant tension between him and the chairperson of the HSE board, the Minister for Health and her department officials. He objected to it on the grounds that he did not believe extra hospital beds were needed. In his book, Drumm states his main concern

> *was that consultants who worked in the public hospital were to be allowed to provide services in the co-located private hospitals... without any measurement of this activity* (Drumm, 2011: 113).

He outlines how the board of the HSE and the Department were supportive of this approach but points out:

> *In some respects, it is understandable that they might hold this view, as in other businesses outside of medical care, this approach might seem logical. However, in a clinical environment where the provider ie the consultant determines both the pace... the amount of service that is provided, the situation is very different... I could not continue to manage the public health service in a situation where this approach was implemented...* (Drumm, 2011: 114).

The controversy over co-location rumbled on for years with persistent delays in deadlines, tendering, signing of contracts and continued arguments on each side for and against the project. Seven years on from its inception and two years after the 1,000 beds were meant to be open, not one contract has been finalised. Oliver O'Connor left his role as adviser to the Minister for Health in October 2010 and Mary Harney stood down in January 2011: the two main protagonists of the policy were no longer in place. In March 2011, a new coalition government, made up of Fine Gael and Labour, was elected. Its programme for government stated the end to a policy which had never been implemented.

> *The existing policy of co-location of private hospitals on public hospital lands will cease. Tax incentives for private hospital developments will cease* (Government of Ireland, 2011: 35).

While these documents clearly outline the political divisiveness of co-location, they do not explain why it came about as a political project, or specifically who drove the project.

5.4.4 Policy window and policy entrepreneurs

The documents do not tell us the detail of the policy window or the genesis of the co-location policy. These are dealt with in chapter eight, where the interview content is analysed.

Chapter 6

Case Study 1: Finance Act interview data analysis

6.1 Introduction

This section draws on the interview data to explore what influenced the changes to the Finance Act which gave tax reliefs to developers to build private hospitals. As detailed in the documentary analysis on the Finance Act, the first changes in 2001 gave capital allowances to build not-for-profit hospitals, while the second change in 2002 extended these to profitable hospitals. The term 'private hospitals' is used to incorporate both not-for-profit and for-profit hospitals.

Each interview was coded as outlined in the methodology in chapter three. Coding allows the researcher to filter down the relevant content of the interviews to the specific policy area, in this instance the Finance Act. In the text here, interviewees are referred to as IV1, IV2 etc. The numbers associated with the interviewees were allocated randomly and are used so that I could keep track of the sources, if required.

Twenty out of the 21 interviewees responded to questions on the Finance Act. One did not as he felt he was not in any way involved and therefore could not respond. While 20 of the interviewees spoke about the changes, just five were closely involved in this specific policy-making process. Four of these were Department of Health officials; one was a private hospital owner and hospital consultant.

This section is written up drawing on the conceptual framework's three headline themes of 'policy characteristics', 'actor power' and 'political contexts'. Each of these headline themes has variables which are written up by drawing on the relevant code/s as detailed in Table 4.2. It is given here again for convenience.

Table 6.1 Conceptual framework used to analyse interview content

Category/headline theme	*Variables*	*Description of variable: factors affecting policy choice*
Policy characteristics	***Severity of the problem***	clear measures that show the extent and level of consensus about the problem
	Ideas for intervention	the proposed policy 'solution', the degree of agreement on solution, origins of 'solution' including policy transfer, opposition and alternative solutions to problem
Actor power	***Guiding institutions***	the degree of priority given to the issue, the role of government departments
	The role of policy entrepreneurs	the role and influence of policy entrepreneurs, particularly strong champions of the policy, in the policy-making process
	Private sector interests	the degree and influence of private-sector interests and lobbying
Political contexts	***Political ideology/ institutions***	the degree that contextual (historical, economic and political) and political institutions influence the policy choice
	Policy process/ window	The process through which the policy was made and the moment when the political, policy and problem streams comes together

6.2 Policy characteristics

6.2.1 Severity of the problem

There was universal agreement among interviewees that the shortage of public hospitals beds, which created long waits for public patients and a poor perception of the public health system, was a key driver behind the changes to the Finance Act.

> *There would have been, simply on the basis of supply and demand, a shortage of places. That was just caused by the failure to provide places in the public system over the years. And a*

rundown of the quality of what was available in certain institutions in the public system... on the acute side... we were not over supplied with capacity... (IV 1).

We had a problem with capacity in public hospitals at the time. We were still trying to get through what had happened [large numbers of hospital bed closures] in the late '80s, early '90s, so we had a problem with capacity (IV 11).

We were short of beds (IV 18).

Among the interviewees, there were many reasons given for and differing perceptions as to the causes of the shortage of public hospital beds in 2000, and these are presented below.

Shortage of public money to invest in public hospital beds

The main cause or explanation given was the shortage of public money or lack of willingness to invest public money in additional public hospital beds as outlined in chapter five. This is despite the fact that these policy changes took place during a time when investment in the public health budget was increasing.

Table 6.2 What interviewees said on failure to invest in public hospitals

What they said	Who
the capital budget, despite things [finances] being in reasonably good state at the time, the health budgets started to tighten up a little bit before the economy... And then there was a slow down after the 2002 election, that held for a few years, there was a realisation at the political level that... you had to pay for [hospital beds]	IV 1
the belief at the time was that we did not have enough beds... that we clearly were not going to be able to afford to provide them all through the public system	IV 5
the Department of Health always felt that there was insufficient investment in the acute hospital sector, capital was scarce on the public side, so why not bring private financing in?	IV16
no one had built a hospital, we needed capacity, we still need capacity	IV19
the debate was we needed extra capacity... we are not going to build it all ourselves publicly and therefore...	IV21

Increasing demand for healthcare

Some interviewees brought up the issue of the increasing cost of healthcare, with similar explanations as to why the cost was going up,

> *There was even, at that stage, a real fear about the rapid escalation in costs in healthcare for all the reasons we know – the rapid technology developments, an ageing population, the generation of higher expectations, as prosperity grows people expect more, that was all part of the background (IV 1).*

> *And as you move into the last decade (early 2000s), it's all demand-led, public sector going to the exchequer looking for more money, we need another €100-€200 million, year on year, just to cope with demand, changing demographics, it's huge demand, ageing population... (IV 21).*

Failure to reform the public sector

Interviewees from both private and public sectors highlighted the difficulty and failure of government to successfully reform the public sector and how there was a belief that the public sector could benefit from private-sector work practices and efficiencies.

Table 6.3 What interviewees said about reform of the public health sector

What they said	Who
there were clear opportunities to outsource services from the public healthcare system to develop more efficient solutions and by doing so to help to change some of the culture in the public health system, a lot of which was embedded in work practices that were Dickensian by late 20th/early 21st century standards... there was questioning of efficiency of exclusively public provision model, that was an international trend ... There was an efficiency rationale looking beyond the traditional ways of doing things	IV 1
[I was] genuinely shocked at how poorly managed the [hospitals] were and particularly the whole issue of quality of care, and how it was actually being run	IV16
No, it was just done on the basis that the public sector was not seen as providing high-quality, good, efficient, cost-effective service...	IV18
the public sector are bad at... building capacity, they take on average 20 years in building a hospital...	IV19
there was a feeling about that the private sector can give you something far better, far more efficient and effective, better than the public sector, that's an	IV21

argument that people have and that might have been a backdrop to it...	

While there was consensus among interviewees that a shortage of public hospital beds was a key driver for the changes to the Finance Acts, there were differing opinions to the causes of the shortage in beds.

A majority of interviewees believed that the perceived or actual inefficiency in the public sector and the perceived or actual efficiency of the private sector provided a rationale for public investment in private facilities. However, there was little consensus overall on this issue, with some believing the private sector to be more efficient (usually those in the private sector) and others believing that the public system needed reform but could be more efficient with good management and the required resources.

6.2.2 Ideas for intervention

There was unanimity among the interviewees that the changes to the Finance Act were an extension into the health sector of widely used property tax reliefs at the time.

Table 6.4 What the interviewees said about the application of tax reliefs to health

What they said	Who
In relation to the Finance Act changes, and the generation of a pro-investment environment around particular types of facilities... it was much more around economic activity, taxation policy... generating an investment climate... So you asked where the drive came from in relation to Finance Act: it was a real will to provide a very strong and positive investment plan for entrepreneurs, essentially, and on the other hand there was a market created through a rundown of the supply on the public side – I am not saying that was a deliberate policy stance but that's what happened, because the capital spend on health did not match the infrastructure requirements over many years...	IV 1
This unseen wealth up to then was beginning to... make itself known. I think a lot of the tax breaks... were given to expand the economy...	IV3
The primary influence was a belief that the private sector needed to be involved to a much greater extent than they were in the provision of beds... therefore it made eminent sense to involve the private sector to the greatest extent, one way was to assist a private market by offering tax reliefs...	IV 5
The tax breaks? No they were purely commercial...	IV 6

Things started to pick up allowances... they were there to develop infrastructure... they were carrots, they were simply there to generate spend... they are really incentives to generate activity and infrastructure perceived not to be available, so schools, hotels, and then eventually it went to hospital and healthcare entities	IV 9
If you look at it purely from an investment process, which is what the minister [McCreevy] at the time would have seen them as, it's an investment. It's going to generate additional employment in construction and post construction phase.	IV11
Tax breaks were seen as a good way of attracting private capital and the Department of Health always felt... if there was anything you could do to minimise the drag on public health capacity, then that would be a good thing. I think that was the primary rationale... there was a lot of nonsense going on... the tax breaks, it was people who were sitting on a net worth... there was an awful lot of money chasing tax breaks without ever looking at the underlying... prospect of the business, there was a lot of silly money chasing health as well	IV16
Most of all it's to aid the construction industry, get people to build hospitals, because otherwise it's doubtful if the private sector would build any of this... the private sector only does things if there is money in it... it was a money incentive to build up hospitals	IV18
... generating investment, it was encouraging investment in an otherwise unattractive investment position... therefore by promoting an attractive tax relief you are going to encourage investment	IV19
I would have become aware of the effects of the Act, the sudden proliferation of stories in all the newspapers of this and that group thinking about setting up a private hospital.... I suppose with hindsight that was beginning of the property bubble... there were people seeing these as property plays... in the same way as hotels and golf courses... in the same way that everything became tied up in property.	IV20

Policy transfer

When asked if the changes to the tax breaks were influenced by international trends towards private delivery of care, all but one interviewee said no. They felt the tax breaks were driven by Ireland's home grown model of economic development. Only one senior departmental official stated explicitly that the tax breaks could have been influenced by international developments in healthcare. He cited an international consultancy firm which did some work for the Irish Department of Health –

McKinseys – which advocated the state sector to encourage the private sector to invest in and build up private healthcare capacity, identifying this as an international trend at the time (IV 1).

Freeing up private beds

As explained in the documentary analysis chapter five, the Finance Act specified that when private hospitals were built, the state should redesignate private beds in public facilities. The intention of the 'redesignation' of public beds was to increase the numbers of public beds available to public patients. This was to ensure that the public patient benefited from the tax breaks ie the changes to the Finance Act were to incentivise and subsidise the building of private hospitals, and therefore take some private patients out of public hospital and improve the access of public patients. One senior official involved in health policy at the time said that he never believed a redesignation of beds would occur:

> *If you, as a result of private capacity coming on – and in fairness to McCreevy and co, this would have been part of their thinking too – there is a bonus in this to the public patient as well. Because you displace some of the private work from the public system into these new private hospitals. And there was also a requirement that so much of capacity be available for public patients in private [hospitals]... some concession in any event so that some of the private capacity could be bought by public system (IV 1)*

This redesignation never happened.

A belief in the private sector

A majority of interviewees brought up the issue of the advantage of the increased use of the private sector in healthcare provision. Some justified it on the basis that they would benefit the public patient.

> *They would have seen it as a good enough alternative to public provision. I think the philosophy was led from the top and it was led at a particular level... (IV 7)*

> *If these facilities can be put in place – are going to be state of the art, very well-appointed, they represent good infrastructure – there may be opportunities to work the system in different ways so that we can get a better service for everybody (IV 1).*

This point was also contested by those who felt that the private sector was good at providing certain services but avoided more complex care and focused on easier, more profitable treatment.

Opposition to tax breaks

Interviewees who were opposed to the tax breaks were from the public sector while those who supported them were usually from the private sector. Two particular areas of concern were cited.

One concern was that the capital allowances would attract people/developers into healthcare who have no healthcare experience:

I always held the view that there was no point in developers building hotels because they want to build hotels, that's the wrong reason to be in the hotel business and it's the wrong reason to be in the health business and the wrong reason to be in any business. We have the results of it today (IV 3).

Unfortunately it's the same mistake that existed in the financial services sector, in that the people who had access to capital were largely people who had their expertise concentrated in property, so you had a flood of money into... hospitals, people who really did not know the business who really did not know anything about it... (IV 16).

The main concern was about quality and safety in the tax-incentivised private hospitals.

It does not make any sense that you would create very favourable conditions to promote private capacity without ensuring quality, and not direct where that should be, or in what diseases, or where that should link (IV 4).

But essentially we were pushing the quality line in particular… we argued strenuously against it... on the grounds of quality. We were trying to promote a more coherent provision of acute hospital services, which most certainly did not include the provision of a plethora of small private hospitals (IV 5).

Large aspects of the private sector are appalling too. And it's not just regulation and standards, you got to change the culture, you got to manage it properly, you got to a have less of an individual-based culture, which is where and how our clinical leaders are taught and trained (IV 16).

Some private sector personnel interviewed brought up the issue of quality to a contrary viewpoint. They outlined how private hospitals pursued quality standards before the public sector was talking about quality.

The irony was that the private sector [was] trying to introduce standards ever before the public hospitals were doing so. That was one of the huge interesting issues, that on the one hand people in the public sector would criticise the private sector for not having and conforming to standards. And yet many – not all, but many – of the private hospitals had JCI and other group approval, whereas there was none of public side (IV 17).

The issue of poor quality health services, both public and private, was brought up in many interviews.

There was some consensus among interviewees on the 'severity of the problem' and the 'ideas for intervention' variables, especially in their unanimous belief that the key driver for the tax reliefs was an application of the broader political economy model of tax reliefs to the health sector.

There the consensus ends for 'policy characteristics', with the interviewees' responses demonstrating very differing worldviews of the causes of problems in the public hospital system and the required solutions. Some felt strongly that the failures of the public system and shortage of public hospital beds could be addressed by a vibrant private system, while others were firmly of the view that such a response failed to address the underlying causes of the problems in the first place, that the public sector needed to be reformed and invested in.

6.3 Actor power

6.3.1 Guiding institutions

As detailed later in the chapter in section 6.4.2 on the policy-making process, little political and policy priority was given to these policy changes except by the Minister of Finance. The interviewees were unanimous in their belief that the changes to the Finance Acts, which brought about tax reliefs for private hospitals, emanated from the Department of Finance, under direct instruction from the then Minister for Finance, Charlie McCreevy.

As shown in the documents section, there was a divergence in approach and attitude to the Finance Act changes between the then Ministers for Health and Finance. The Department of Health and its minister stridently opposed the changes. Documents obtained for this research also show concern on the part of the Department of Finance officials and clearly state they were being pushed through by McCreevy.

Given that the changes to the Finance Act went ahead despite warnings from the Department of Health and the Department of Finance, particular attention is given in this section, to the role of the government departments. No official from the Department of Finance agreed to be interviewed for this process as none of them felt they had a sufficient insight in to this policy process, and the key person is dead, so the interview content is skewed by the perspective of the Department of Health officials.

Role of Department of Health

Officials who had worked in the Department of Health spoke openly in the interviews about the resistance in the Department of Health to the tax breaks and private-sector involvement and how the Department of Health had little, if any, say in the changes made to the Finance Act.

Table 6.5 What interviewees said about the Department of Health and tax reliefs

What was said	Who
I think there would have been an anxiety about plonking what would seem to [the	IV1

Dept of Health] an investment, opportunity-driven set of infrastructure. It's like hotels, housing, anything development driven. An investor who is looking at the location of a hospital is not necessarily going to be driven by rational planning in relation to a whole hospital system... in so far as there was health thinking in this... the changes to the Finance Acts eg health clinics, there was simply no health involvement at all. These were one-off instances which were about investment adventures being undertaken by people, which was supported directly by specifics in the Finance Act...	
I am not aware of anyone on record [in the Department of Health] saying this was a good idea	IV5
The department logic did not go that far... it was institutionalised, it went very deep... for example... we were struck when the Department of Finance began to make separate calls based on tax incentives about the construction of hospitals... there was severe agitation... and stress in the finance unit [of the Department of Health] and in the hospital services side of the Department of Health	IV10
Tax breaks ... did not impress us [the Department of Health]	IV11
Let's say, that would never have been discussed in the health department. There was no thinking [he laughs]. There was no thinking on ... the whole thing of tax breaks for private hospitals.	IV18
Primarily that [changes to the Finance Act] came from within Finance, I don't think there was a strong interaction between Health and Finance.	IV21

Over half of those interviewed for this research stated that the Department of Health was hostile to the private sector having a role in healthcare development and provision. While a majority of these were working in or involved in private-sector developments, some of these were people working in the public sector.

> *They [the Department of Health] didn't want to know about the private sector, as far as the Department of Health was concerned, public healthcare was their brief and no one else was taken into consideration (IV 15).*
>
> *Traditionally, the private hospital sector would have been regarded as a threat to the public hospital sector and would have... been suspicious... of the private hospital ... I suppose I'd be talking more about people at a policy level within the department or within the HSE, there was that resistance to involving the private sector in discussions about policy issues (IV 17).*

Failure of Department of Health to have oversight of private sector developments

The hostility expressed by private-sector personnel was put to departmental and ex-departmental officials. Most officials interviewed concurred that they avoided dealing with the private health sector as they did not feel it was part of their remit and a majority felt, with hindsight, that this was a mistake.

In this context, the role or the absence of a role for the Department of Health in planning the private health sector and having an oversight role was highlighted in many interviews, especially from officials who had worked in the Department of Health.

Four interviewees pointed out how a framework to oversee private healthcare developments was in the 1999 White Paper on Private Health Insurance but also how the department had failed to follow through on this policy commitment . These four interviewees were working in the Department of Health at the time of the changes to the Finance Act. This point is illustrated by one of the most senior officials interviewed for this research. This interviewee's name was cited by many other interviewees as having a central role in the Department's opposition to the changes to the Finance Act.

> *I would not have seen a problem necessarily with increasing private hospital capacity, provided there was joint planning done... bring the public and private side together in terms of capital investment... instead of having decisions taken on the public side which were entirely only looking at the public hospitals.. You had replication of public hospital facilities in private hospitals and vice versa... It's more than that. There wasn't a total view taken of the health system. And if you did that, then you could have a very rational development of private hospital capacity, provided everybody knew what everybody else was planning. And decisions were taken as to what the planning priorities should be. And that was one of the problems with the... tax breaks: there wasn't any involvement by anybody in the planning of those facilities (IV 11).*

This interviewee stated that while the plan for greater public and private co-operation and oversight of private care was in the health strategy, 'Quality and Fairness – A Health System for You', the department had never delivered it and how he felt a responsibility for that.

> *The health strategy, it made reference to greater co-operation with the private sector... but to put flesh on that, you would need a team to do all that... I would say in retrospect that we were just as responsible as anybody else in the department for not putting a coherent framework in place... I would blame myself more than anybody on that... because I was responsible for capital investment and perhaps I should have given more thought to it at the time. Remember, it was not a new idea either: remember we had in the 1999 White Paper on health insurance that spoke about a planning forum... I wish we had done something about*

it... getting people together, both sides, and you try to arrive at a coherent plan... I think that would have been a huge advantage to everybody, in health and finance, and also to the political system... (IV 11).

Two other ex-departmental officials concurred with this belief, that it was a mistake of the department not to have oversight and plan private provision as well as public health services:

The only thing written down was we have a mixed health system, that's about it.... a policy maker's mindset which was yes we have a mixed system, but we as policy makers don't engage with the mixed bit, with the other half of that system, our responsibilities, our planning responsibilities... don't comprehend the private bit, so we are actually overseeing a mixed system but we are only concentrating on the publicly owned and publicly delivered bit and there are endless examples of that (IV 10).

I remember saying we can't go on forever disregarding... the private sector... I went to a number of meetings about hospitals in Europe, when you'd talk to your counterparts in... They'd say in the public sector we have 12,000 and in the private sector we have 6,000. I'd say, well, we have 12,000 public beds and we are not too sure how many private. And they'd say, 'They are all hospitals and you are the Department of Health.' Traditionally the department was well distanced from the private sector... it was not seen as the remit [of the Department of Health] (IV 18).

When questioned about this, a senior political person, who worked closely with the department, questioned the capacity of the Department of Health to give effect to major reform, pointing out that there were

basic capacity issues within the Department of Health, they were real... strengths and weaknesses, very patchy people... some divisions just not, some brilliant people... the guys on the private sector side... they worked very hard, that was very complex stuff, they had too much on their plate, very complex stuff: risk equalisation, the interaction with Europe, Commission people over and back all of the time, very complex stuff... the big row with the medical indemnity union... Those guys had to cope with all that... I don't think the capacity existed in the department [to oversee the private sector] (IV 21).

This senior political person also explained the amount of developments that were going on in the public system and how this may explain the department's failure to have oversight of the private developments.

You see at the time, government was doing both... there was public expenditure rises across the board... what you have almost because of the unprecedented economic climate you are in,

you have both public-sector expansion at an unprecedented levels... across all the big spending departments, and you have private sector expansion and no one's arguing that both can be accommodated, hence the rows did not have to happen (IV 21).

These quotes from departmental officials show that the Department of Health at that time felt solely responsible for the public health system with a level of disdain for private hospitals. It indicates a level a purposeful blindness by them and their department in relation to the private sector. It also highlights the contradiction that on one hand the Department of Health is promoting the public-private mix of healthcare, while on the other it only felt it had a remit and responsibility for the public health system.

Role of medical profession

A senior political person involved in the policy process at the time also thought that consultants played a role in the acceptance of the changes to the Finance Act

You have consultants saying, 'I want to get a piece of the action and we can do both the public and the private thing,' and I think that's a factor that allows the economic model (IV21).

While the role of hospital consultants in general did not come up in other interviews in relation to the Finance Act, the specific role of one private hospital owner who was also a hospital consultant, who lobbied and influenced McCreevy and subsequently wrote the relevant sections of the Finance Act, was mentioned or referred to a majority of interviews. This is dealt with in the next section on 'the role of policy entrepreneurs'.

Role of Department of Finance

All of the public officials interviewed said that the changes to the Finance Act were part of a policy driven by the Minister for Finance that was strongly opposed by health officials. There were differing opinions from health officials as to whether the Department of Finance officials supported the measures or not, with a majority agreeing that the finance officials expressed serious concerns about the proposed changes.

Table 6.6 What interviewees said about tax breaks and the Departments of Finance and Health

What they said	Who
It was the Minister's [McCreevy's] own very personal philosophy that this was the way to go... he would have had the support of people in Department of Finance, in the Public Expenditure (PE) division. Every large budget has a lead, so the powers that be in the Department of Finance would have seen	IV1

the merit of going this way. They would have seen it as a good enough alternative to public provision. I think the philosophy was led from the top and it was led at a particular level	
I think it's fair to say most if not all of his [McCreevy's] officials were opposed to it but... he [McCreevy] made a virtue of saying, 'I am doing what I believe.' I think that was very much a feature of the man. So [McCreevy] went ahead and did it... We had a complete conflict between the stated policy in the health strategy, the agreed approach by government and the decision by an individual, be it a very strong minister, who decided to go in a different direction	IV5
now there may have been differing emphasis between ourselves [in the Department of Health] and Finance	IV11
Finance was doing all that – they were doing it on whole range of areas like hotels and all that...	IV18

My interpretation of this, combined with the documents, is that officials in the Department of Finance were equally worried about the impact of the changes but from an economic rather than a health-policy point of view. And when health officials refer here to 'Finance', they mean the department, but it was very much driven by the minister and the department was just doing what it had to ie what the minister wanted.

One of those quoted here went on to explain how the development of the Finance Act worked to the exclusion of other government departments, even if it related to them.

> *That's one of the problems with a department of state: the Finance people do the Finance Act. You are of course very much part of the governing body and you know what direction it is going in, but... is the policy on health and tax breaks and for-profit hospitals? Is it part of the health policy or part of finance policy? The whole thing of tax breaks for private hospitals... that would never have been discussed in the health department (IV 18).*

When it was put to a senior political person involved in the policy-making process of the health strategy that documents showed the Department of Health stridently resisted the introduction of the changes to the Finance Act yet they went ahead, his response was as follows:

> *How many ditches do you f***ing die on? Cancer was a big one, heart was a big one, the health strategy, primary care plus other issues, and they [the minister and Department of*

*Finance] are saying tax reliefs are in. We are not delighted with it but we live with it, for f***'s sake, you can't win them all (IV 21).*

This point was reiterated by other interviewees, that when the tax breaks for health were introduced, the health strategy was being developed and department officials had many other distractions and this was not even near to the top of their priority list.

6.3.2 The role of policy entrepreneurs

Three policy entrepreneurs clearly emerge from the interviews. The first is the then Minister for Finance Charlie McCreevy who championed the changes to the Finance Act which gave tax breaks to developers for healthcare in 2001 and 2002. The other two entrepreneurs are from the private sector who lobbied for the changes, firstly in 2001 for the not-for-profit sector, and secondly in 2002, for this to be extended to the for-profit sector. These private hospital developers directly lobbied McCreevy, who then drove through the changes.

Political policy entrepreneurs – Charlie McCreevy, Minister for Finance

There was a strong consensus that the changes to the Finance Act were politically driven by the then Minister for Finance, Charlie McCreevy. In this context, McCreevy is identified as the political policy entrepreneur as he was the key driver of the policy change within political and government circles.

Each interviewee was asked 'what motivated the changes to the Finance Act?' and 'who drove them?' There was a consistency in their responses.

Table 6.7 What the interviewees said about policy entrepreneurs and the Finance Acts

What they said?	Who
On...[the Finance act and] hospitals, it was the Minister's [McCreevy's] own very personal philosophy that this was the way to go	IV1
You have to look back and assume that the Harney/McCreevy axis had a lot of influence at that time... and you can imagine at the cabinet table that the two of them would have been well able to advance an agenda and force something through... I think they were socially very close and ideologically very close, both very dominant players at the cabinet table...	IV4
We then had a minister for finance who was a very, very strong minister and who decided very much personally even against the advice of his officials who decided it would be a good idea to use tax relief as a means of funding the provision of additional private beds, even his own officials.... without overstating the power of the minister, but a strong minister with a strong view of	IV5

how things are to be done – he was highly regarded; he had no difficulties carrying his colleagues with him	
It goes back to that, to McCreevy	IV9
Who drove it politically? I think the Minister for Finance would have driven it you know	IV11
I think he'd [McCreevy] justify it as an economic driver and just another area for development	IV14
The rumour that was out of there, that...Charlie McCreevy, very pro-enterprise guy, pro-business, and that he readily drove in the [changes]	IV17
It was very much driven by McCreevy, as I see it	IV18
The Finance Act was primarily Finance driven	IV21

A senior political person involved in policy making at the time felt that the Competition Authority and, in turn, Mary Harney who was the then Minister for Enterprise, Trade and Employment, had influence on McCreevy and the Finance Acts, which would open up the market to healthcare. He described the Competition Authority as

> *American purists in terms of competition... you get this stand coming in to public policy that says public-sector provision is all monopolies and cartels... you need to free this up, a private-sector, efficiency-type model... but health is not quite like that (IV 21).*

This was the only interviewee to mention the potential impact of the Competition Authority on the Finance Act and health policy. However the Competition Authority was under the control of the Department of Enterprise and Employment where Mary Harney was minister while the changes to the Finance Act relevant to health were introduced.

Private sector policy entrepreneurs

Over half of the interviewees mentioned the involvement of a high-profile private-sector hospital doctor/developer who they believed had a very strong influence on McCreevy as minister and on his decisions to give tax allowances for healthcare developments. This private sector person was interviewed for the thesis and he describes in detail going in to the Department of Finance and assisting officials in writing the section of the Finance Act in 2001. The description of his involvement is outlined in the 'policy window', later in this section.

He describes how his involvement was personal and demonstrates the personalised and largely covert nature of this policy making process.

It was a very personal act. It was a very personal act... Charlie McCreevy and myself were the only two involved in it (IV 15).

Many interviewees from different perspectives confirmed that this private-sector person lobbied McCreevy although it was not known until I did the interview that he wrote the relevant sections of the Act.

Yes, xx would have been lobbying an awful lot. I'd have got brochures but I'd have said, 'I don't care, it's nothing to do with me – if you want to go ahead and build it, do' (IV 6).

This private-sector person lobbied for the introduction of tax breaks for people building hospitals on a not-for-profit basis in 2001 – he was at the time trying to develop a not-for-profit private hospital. When asked if he was involved in lobbying in advance of the 2002 changes that gave tax breaks to profitable ventures also, he said he was not aware of those changes:

No, I was completely unaware – it made no difference to me at that stage (IV15).

When it was pointed out that he went on to benefit from the tax breaks for for-profit hospitals, he acknowledged that he did but that

the main advantage to me of the breaks, it was the only acknowledgement that the state was not opposing what I was doing, because everything else the state would have been against (IV 15).

He subsequently acknowledged in the interview that he benefited from €14 million worth of capital allowances on that specific project.

A small number of interviewees specified that another private hospital owner who was also the chief executive of the Independent Hospitals Association of Ireland (IHAI), was known to have lobbied for the extension of the tax breaks to profitable hospitals.

My recollection was the lobbyist on this occasion was xx, this is answering your question on extending the relief to for-profit and reducing the required hospital size, it was xx chief executive who objected on the basis that they were not charities. Health redirected [his objection] to Finance (IV 20).

The interviews confirm what the documentary evidence shows: that the initial changes to the Finance Act which gave tax breaks to not-for-profit healthcare, was proposed by a private hospital owner/hospital consultant who lobbied the Minister for Finance. The Minister for Finance drove it through ignoring concerns and opposition from his department and from the Minister for Health and his department.

The interviews reveal less information about what influenced the 2002 changes that opened up the capital allowances to for-profit hospitals but support the documents which show that the Department of Finance was lobbied by a different private sector person, who was chief executive of their representative body at the time, the IHAI. The IHAI lobbied that the Finance Act apply the allowances to profitable hospitals and other profitable healthcare institutions.

Although the private hospital developer who lobbied for the first change to the Finance Act benefited financially from the second change when his development changed from a not-for-profit to a for-profit hospital, the interviews seem to point to this being coincidental.

Three clear policy entrepreneurs emerge from the changes to the Finance Act case study: the then Minister for Finance, Charlie McCreevy, and two private hospital owners/chief executives. Mary Harney, who was leader of the PDs, Tánaiste and Minister for Jobs, Enterprise and Employment at this time, was considered very close to McCreevy and a strong supporter of the economic model, including tax reliefs, being pursued by McCreevy.

6.3.3 Private sector interests

The degree of influence of private sector interests is evident in the previous section on 'policy entrepreneurs' as clearly the changes to the Finance Acts were a direct result of effective lobbying by private hospital interests who had the willing ear of a pro-market/-enterprise Minister for Finance. More than half of the interviewees specified these two particular private hospital personnel, while other private sector interests were mentioned by all interviewees who spoke about the changes to the Finance Act (20/20 interviewees).

Everybody was asked the extent of lobbying that was going on by the private sector to influence the changes to the Finance Act. The issue of lobbying by private-sector interests was raised by a majority of the 21 interviewees.

A person who represented the IHAI after 2002 acknowledged that there was lobbying, although not in a concerted or systematic way:

> *My sense was that a lot of developers, investors, people interested in tax breaks were pushing for it and it could have been that the likes of xx, xx was pushing for it, it could have been, it could have been, because he wanted to expand the network of hospitals that he had... you could be pretty sure he lobbied for that... But it was not concerted.... (IV 17)*

This is contradicted by the documentary evidence, which clearly shows the IHAI lobbied, although this is possibly explained by the fact it occurred before this person became involved with IHAI.

Three of the five Department of Health officials interviewed denied that they were specifically lobbied but acknowledged that others could have been lobbied:

> *No, I was never lobbied (IV 11).*

> *I certainly was never lobbied [for the Finance Act changes]... I don't remember the ministers at the time either Cowen or Martin [being lobbied]... I certainly didn't attend any meetings with them where lobbyists came in looking for that. They may have been met separately, I don't know. Maybe [the Department of] Finance was involved and those discussions took place in Merrion Street. I was never involved in those, I think those decisions would have been taken at a political level ... and lobbyists are met in all sorts of places you know... (IV 5)*

> *I think if that was going on, it was going on privately at dinner or whatever etc... It did not involve any civil servants (IV 18).*

Another ex-departmental official said that the private sector lobbying departments was a matter of course, including the Department of Health:

> *The developers, there would have been people like xx, developers and operators who would have included the Department of Health in their circuit (IV 10).*

Four interviewees mentioned that they thought McCreevy drove the second change to the Finance Act after he was influenced or lobbied by a constituent. The 2002 changes opened up the tax reliefs to for-profit groups, reduced the numbers of the beds required for hospitals, and opened it up to sports clinics.

> *There is definitely a clinic in x, that influenced McCreevy... and another, a sports clinic, am not sure if they were the same, but the sports one just appeared out of nowhere, it was a real peculiarity... it seemed to relate to one very specific establishment (IV 1).*

> *Charlie McCreevy made that decision; he introduced it in the Finance Act. Nobody knew about it until it actually appeared in print and that he was lobbied by the guy who was building the clinic down in x... I don't know if the clinic was ever actually built, but it was a developer in Charlie's constituency who lobbied him directly to try and get the rules expanded to cover his particular clinic (IV 14).*

A few of the interviewees involved in private hospitals, as executives, owners or developers, made the point that it was easier not to take the tax breaks. They detailed how the breaks involved so many loops to go through they were hardly worth it:

The tax breaks did not seem to us to be the best commercial away to do it – it should stack up in any event (IV 7).

However, two of those interviewed who availed to the tax breaks, when asked how much they gained from the tax breaks, responded as follows:

Obviously we availed of the breaks; it did not make a huge difference. People have a skewed idea of how great the breaks are, we spent about €100 million on that development and it aided us to the extent of €14 million from the breaks, so it's 14%. People are inclined to think these hospitals are built with taxpayers' money: they are not; it was 14% of what we actually spent (IV 15).

It's great to have €43 million tax-free, saves you whatever it is, €2 million a year (IV 18).

One of these private sector people, who was closely involved in lobbying and the introduction of changes to the Finance Act, resisted the use of the term 'private':

I don't like the term private: to me it's 'independent' – independent of the state and the taxpayer... The term private is a misnomer because there is nothing mysteriously private about it compared to the other system. And the second aspect is that... anything I have been involved with is 'complementary'. I am complementing what is lacking for modern patient care in a civilised, western country... Those two aspects are important to me: 'independent' and 'complementary'... I don't leave anyone talk about competition – it's a banned word, because it's not competition, it's complementing what people are not getting at the moment and trying to give better care (IV 15).

While this viewpoint was made by only one interviewee, it is important as it is also used in the name given to the representative body of private hospitals – the Independent Hospitals Association of Ireland – and is a distinct attempt to distance himself and his business from profit and to neutralise his position.

Conclusion

These three variables in 'actor power' – 'guiding institutions', 'the role of policy entrepreneurs' and 'private sector interests' – are critical to understanding what influenced the changes to the Finance Act, which opened up tax reliefs to not-for-profit and then for-profit hospital developers.

In particular, these variables demonstrate the vital role of the policy entrepreneurs, a Minister for Finance with a strong belief in the application of the market to all aspects of social policy and two private-hospital personnel who lobbied and successfully influenced him to make the changes.

It also reveals weak or distracted government officials and a Minister for Health who unsuccessfully opposed the changes. Most critically, it shows how just a few people can quietly have a major impact and introduce economic policy (which impacts upon health) that is contrary to the health policy being pursued by the same government.

6.4 Political contexts

6.4.1 Political ideology/institutions

The documentary evidence detailed in the 'policy entrepreneur' and 'policy process/window' sections of chapter five each details the critical and powerful role that then Minister for Finance Charlie McCreevy played in ensuring that capital allowances were applied to not-for-profit and then profitable hospitals.

The documentary section also revealed how the prevailing political economy, the influence of the PDs on government, the closeness of McCreevy to the PDs' ideological position and the unilateral approach McCreevy took to the budgetary process were all important factors in facilitating McCreevy to drive through the capital allowances for private hospitals. These points were reiterated in the interviews:

> *The point of all this, that cuts through all public and private provision philosophy, is that it was a much more politically saleable way of putting expensive public services in place (IV 1).*

The other important contextual factor is that the changes to the Finance Act in 2001 and 2002 took place just before and after the publication of the health strategy. The Finance Act changes were out of synch with the commitments in the health strategy to significantly increase the numbers of public hospital beds. The tax breaks to incentivise building private hospitals, especially 70-bed hospitals as legislated for in the 2002 Finance Act, were also contrary to the government policy that followed the health strategy in 2003, the Hanly report, which recommended rationalising publicly funded and run hospitals, and encouraging bigger acute public hospitals with higher volumes of activity (Department of Health and Children, 2003c).

Earlier in this chapter, the 'ideas for intervention' section outlines the extent that interviewees felt that the primary rationale for the tax breaks was that they were seen by McCreevy as a natural application of capital allowances, which were being used as a central driver to the booming economy of the time, to the health sector. Alongside this was a firm belief in the market. The tax reliefs reflected the general political economy at the time as evidenced in the quotes below.

Table 6.8 What interviewees said about the rationale for the tax breaks

What they said	Who
The generation of a pro-investment environment	IV 1
Tax breaks were given to expand the economy	IV 3
To assist a private market by offering tax relief	IV 5
Incentives to generate activity and infrastructure perceived not to be [publicly] available	IV 9
It's an investment. It's going to generate employment	IV11
Tax breaks were a good way of attracting private capital	IV16
A money incentive to [private sector] to build private hospitals	IV18
By promoting an attractive tax relief, you are going to encourage investment	IV19

One senior health official, in the Department of Health at the time of the tax reliefs, specified how this particular ideology was pursued by McCreevy

> *In that particular era, the Minister of Finance was the most influential person; he was a very independent thinker about these things. He also made no secret of the fact that he was a great believer in market solutions to all sorts of things. He did not believe in over-regulating the market. He was very pro-business in all of his thinking and policy actions, and we have seen the culmination in a lot of those in more recent times (IV 1).*

The use of tax reliefs as an economic driver and its application to the health sector was the central rationale for the changes to the Finance Act. However the underlying public-private mix within the health system was also cited as an important contextual factor that influenced their application to healthcare.

The public and private mix of healthcare, even in public hospitals, as outlined in chapters two and five, was brought up by a small number of interviewees as an important policy context in which the changes to the Finance Act took place.

One senior political person closely involved in the policy making process at the time outlined how Ireland had always had

> *a mixed system since the last century... we have had private and public from the beginning and this allowed measures like the Finance Act to come in largely unopposed... At a senior*

level, the argument being: look at it you have the mixed care. The Finance Act did not create a new idea that basically you are going to have private hospitals – that debate did not take place (IV 21).

This point was also made in the earlier section on the Department of Health: how the contradictory position of having a public-private mix of hospital care, even within the public hospital system, combined with the department's lack of oversight and responsibility for the private healthcare sector, created space for private healthcare to thrive and develop, as detailed in 'guiding institutions'.

As stated earlier, McCreevy drove through the changes to the Finance Act against the advice of his departmental officials and that of the Minister for Health and his department. These findings are relevant as they show how the 'institutions' of the government departments, which recommended against the application of tax reliefs to the health area, had little impact on a strong Minister for Finance and a prevailing political economy where tax reliefs were widely applied as an accepted method of 'reform'.

Most of the departmental officials from Health interviewed spoke about the divergence of opinion between what McCreevy thought should happen and the opposition to the proposed changes to the Finance Act from finance and health officials, as well as the then Minister for Health, Micheál Martin. A few interviewees spoke about the tension between McCreevy and Martin and their different perspectives on Health, the budget required for the health system and the potential political conflict over this.

I think within the department there was a gap in understanding between McCreevy and the department [of Health]. McCreevy, when he saw the department coming, would say, 'Oh no – more millions, more money.' He said it publicly: 'I have given twice as much money to the health department: are we twice as sick? It's a black hole.' There was no understanding at all between McCreevy's version of finance and Micheál Martin's version of the health service (IV 18).

Another departmental official confirmed the Department of Health's and Martin's opposition to the changes to the Finance Act but was unsure to what extent Martin opposed them:

Although how strongly he [Martin] personally objected to it is another question, but certainly we were not objecting as officials without clearing it with our minister – stating the obvious – we were not just giving the departmental view, we were giving the minister's [Martin's] view (IV 5).

The political and contextual factors highlight the conflict between the two ministers and the conflicting nature of applying the tax breaks to build private hospitals with government health policy.

The tax breaks were however typical of economic policy and with the broader political economy of the time and reflect the ideological position of the then Minister for Finance and the PDs, to whom he was closely politically and socially aligned. This political context and the power of one minister ensured that the minister's belief in the tax breaks over-rode any opposition to them from the Minister for Health and the Departments of Health and Finance.

6.4.2 Policy process/window

The two changes to the Finance Act were made as the health strategy was being developed and shortly after its publication. Although none of the interview questions were specific to the health strategy, many respondents brought up the issue of the health strategy when explaining the introduction of the tax breaks.

'Quality and Fairness – A Health System for You' was the largest health-policy development in the state and involved a wide-ranging consultation process. The interviewees usually brought up the health strategy to clarify the context in which the strategy was made and the conflicting nature of the changes to the Finance Act with the intentions in the health strategy.

Table 6.9 What interviewees said about the tax breaks and the health strategy

What they said	Who
Those things [changes to the Finance Acts] happened behind closed doors – there may be very last-minute consultations as to whether it was a good or bad idea. That would have been cloaked in smoke and mirrors as the Minister for Finance does not want the detail of what's going to be in the Finance Act talked about on the street. You hear about it in the run up to it, you'd hear the skeleton of what's going through and you could begin to think about it... But that would not have been unusual, that changes were just visited on the system overnight.	IV1
And there were millions of hours spent consulting and looking at the evidence and then one or two things happen that can change it all... It is an abject lesson in policy making. At one level you have a very involved policy-making process with a huge amount of consultation, culminating in a health strategy, which had very specific views and a very specific approach to one kind of action. And then that is up-ended by a Minister for Finance who can persuade his colleagues that the opposite or a conflicting approach is the way to go... I think it's an exceptional example of a conflict between the two.	IV5
I think the backdrop to health policy and this would not have featured in '01. The development of the health strategy itself had a profound effect on the... background to the formulation of the health strategy. And it was clear even with the formulation of the health strategy that unwritten within that, not on the elderly side but more so on the primary-care side, there	IV21

would have to be a degree of private sector.	

Interviewees who worked in the Department of Health during the time that the changes were made to the Finance Acts pointed out that there was so much else going on: the changes to the Finance Act may not have been their main focus and the extent of the impact of their changes were not realised.

> *They were not the most controversial aspects of the Finance Act, and maybe they did not get too much air time, as they were just one-liners (IV 1).*
>
> *We had a big reconstruction when we took ERHA [Eastern Regional Health Authority] in 2000 that took a long time to get ready and put in place... So you have all these things coming in. These things take a long time to prepare. At the same time, a lot of people began to get interested in both extending their private hospital and also getting new hospitals up and running. So there was a rush of developments going through on the private side and we were grappling with big issues coming through on the ERHA side and then the HSE (IV 11).*
>
> *You see at the time, in 2001, we did not see a lot of that coming. We had a lot on. We had huge battles with Finance. This was just one element: it was not a major element, not one of the big flashing lights. We had other ones which were big flashing lights, like the cardiovascular strategy published... There was a million things going on. Then you have a scandal... SARS, emergency stuff... they probably did not see it coming [the private sector development]... there was not a sense when I was there that it was going to go that way... If you are fighting other battles and they say we want to go ahead with this and it gives us extra capacity in some quarters, you say ok (IV 21).*

When asked how much notice the health departmental officials had of the changes to the Finance Act, there were different answers from officials involved (six departmental officials were interviewed for this research, all of whom were in the department when the changes to the Finance Act went through in 2001) that at a maximum they had several weeks notice, and often it was just days.

> *Weeks. I won't say days, but certainly days. Now in fairness in a Finance Bill that would not be enormously unusual – a lot of things get done in the weeks coming up to that legislation, in the weeks coming up to the budget... But what was clear: we were more asked about the logistics of how this would work, how you might define a hospital and those sort of questions, rather than do you think this is a good idea – rather than what we thought of it. But we took it on ourselves to say 'hold on a minute, we really don't think this is a very good idea'... (IV 5).*
>
> *We had an opportunity to comment on it before it became, before it went to government... My*

comments to Finance would have been before it became a government decision, so we were certainly consulted on it... I expressed my strong disapproval of it, so did my Finance colleague and I always thought, I'd always suspected, I'd get a severe rocketing for that, but I never actually did, so I had a problem with that policy (IV 11).

Another departmental official, not so close to the budgetary process, says he first became aware of the proposed changes 'on budget day, same as everyone else' and went on to explain the separate roles of the Departments of Finance and Health

That's one of the problems with a department of state: the Finance people do the Finance Act. You are of course very much part of the governing body and you know what direction it is going in, but this... is the policy on health and tax breaks and for-profit hospitals – is it part of the health policy or part of finance policy? The whole thing of tax breaks for private hospitals... that would never have been discussed in the health department (IV 18).

Most of those involved in health policy in 2000-2002 interviewed for this research spoke about a meeting between senior health officials and government that took place in May 2001. Documentary analysis on this is detailed in chapter five. At this meeting in Ballymacscanlon, senior health officials and the then Minister for Health, Micheál Martin, outlined a draft of the health strategy, alongside its cost implications, to the cabinet. These were publicly rejected by McCreevy, who said that there would not be the public money required to finance the proposals in the health strategy. This is important as it provides the political and economic context in which McCreevy choose to include the tax breaks.

The real upshot of Ballymacscanlon was the degree to which Finance could not accept or even contemplate a health budget of £12 billion that we were projecting ahead – [we were] saying 'look, this is going to hit £12 billion at some stage'. Now I might be getting my figures wrong but their response was 'Jesus no way'... if you look at '97 on, it's just going up, up, up – health expenditure – and that's not just an Irish phenomenon; it was an international phenomenon... If you keep at that level of expenditure and as demand continued to rise, people were asking, 'Are there different ways of doing it? Better ways of doing it? More effective ways?' (IV 21).

As outlined in chapter five, a person from the private sector lobbied McCreevy for the initial changes to the Finance Act to give tax breaks to not-for-profit developers to build hospitals. In an interview with him, he described how he assisted in writing the relevant sections of the Finance Act (see below). It catches the moment that the problem, policy and political streams come together to influence the policy choice/outcome. Here he tells how he lobbied for the changes.

I introduced the Finance Act. I approached Charlie McCreevy... I tried to start x as a charity because at this stage of my life... I was not interested in a business... I said, it'd be nice to have a charitable institution in x and the hospital would run on not-for-profit basis and I set it up on that basis – x Clinic is a registered charity... During that time, I said it would be easier if it's a charity and if I can get some tax breaks for people... They could put money into the property. The property would be owned by a group of tax-based investors. The charity would then lease the property and run it on a not-for-profit basis, and leave the ownership of the property with tax-based investors who found it worth their while to invest in it... At this stage they were pouring money into car parks, hotels particularly, into an awful lot of section 23 properties, and I said why has healthcare to be the poor relative, why was it never considered? Also there were no other incentives to develop healthcare – like there was for the multinationals coming in... There was not one euro of grant aid at any level for employment [in private hospitals]. And I said why has the healthcare sector to be the poor relative? Why can't we do something to stimulate some investment in healthcare 'cause the state aren't doing it? So I approached Charlie McCreevy on that basis while I had started building... and I said, 'Look is there any chance you could extend it to the health situation?' He said, he'd look at it, he'd put me in touch with his officials in the department. And I sat down with them and we wrote the Finance Bill (IV15).

I sought clarification on whether this was for the change in 2001 (not-for-profit) or 2002 (for-profit). He clarified it was in 2001. While I knew this person had lobbied for the changes, I was unaware until then that he had written sections of the Finance Act for the Department of Finance, so I sought clarification on that.

Q. And you literally sat down with departmental officials and wrote sections of the Finance Act?

A. They asked me for my views and we drafted it together.

Q. And was McCreevy wholly supportive?

A. He was wholly supportive, yes.

Q. And the officials in the Department?

A. The officials in the department I'd say were not as supportive. He [McCreevy] saw the wisdom of it, he [McCreevy] realised, I did not know Charlie McCreevy... I went with a submission, he met me and he was very helpful. He saw the wisdom in it; he saw that healthcare was badly in need of investment and it made an awful lot more sense than building hotels. The department officials were very helpful too...

Q. Did you have many meetings?

A. Only one or two meetings... It was detailed though because... there were 15 or 16 stipulations that a hospital should meet... a number of things like A&E departments, seven out of the following 12 headings at least. Basically what I wanted to avoid was people coming along to rip off the system, and I was very committed to it on a charitable basis.

Q. So the Finance Act: it was a Charlie McCreevy/XX initiative?

A. Yes.

Q. And the proposals that you put to [the Department of] Finance and were included in the Finance Acts – were they based purely on the Irish model of tax breaks for car parks, hotels and Section 23s applying them to healthcare, or did you look at international, similar models?

A. I just put down what I felt would help us in Ireland for not-for-profit hospitals to raise some money. It was based on the formula that I said to you, if you had a group of tax-based investors, like in the hotels, owning the property that the charity could then rent it. It means that you got your infrastructure – it was a bit like a PPP, you'd one group owning it.

I asked if he remembers any reaction at the time to the proposed changes in the Finance Act that he drafted.

A. There was no debate around it – it was in the Finance Act but politicians don't seem to bother reading drafts of the Finance Bill... It glided through, yeah, there were no questions...

Q. But you were aware it was going through?

A. I was aware. I don't know who else was aware it was going through. I was aware of it going through... and there was no question in the Dáil whatsoever about it, because no one raised it, because I think no one read it. That'd be my reading of it... (IV 15).

This position is backed up by two other interviewees:

Often many things go into Finance Acts and nobody realises until after the event (IV 20).

There'd be no prolonged debates at cabinet. Finance keeps a fairly close, tight position in terms of tax changes... Prior to the budget, you don't get much... you get a Finance memorandum and you have discussions. In fairness, every department gets sight of a draft bill; health did not oppose it hugely (IV 21).

Just over half of those interviewed named the person who wrote the sections with Department of

Finance officials as being the key lobbyist who sought the application of tax reliefs to private hospitals. All officials who worked in the Department of Health at the time named this person. This is backed up by documentary evidence.

None of those interviewed could explain specifically who or what influenced the specific policy window for the 2002 changes, although four speculated on the role of another private hospital owner who is thought to have lobbied for the 2002 changes. This is verified by the documentary analysis outlined in chapter five.

The changes made to the Finance Act occurred without what is usually thought of as a normal policy-making processes – of gathering evidence, weighing up the options, consulting with stakeholders and making a decision. All interviewees concur that these changes were purely political decisions, influenced by private hospital developers lobbying the then Minister for Finance, Charlie McCreevy, who in turn pushed them through, over the heads of government officials and then Minister for Health.

6.5 Conclusion

The person who played the most significant role in introducing the changes to the Finance Act was the then Minister for Finance, Charlie McCreevy. He drove through the amendments to the Finance Act, which gave tax breaks to build private hospitals, which were largely contrary to the health strategy being simultaneously developed. McCreevy proceeded with the changes against the advice of officials in the Departments of Health and Finance and the then Minister for Health, Micheál Martin. It is possible to deduce from this that a weak Department of Health and Minister for Health enabled a strong Minister for Finance to push through the tax reliefs.

The extension of tax reliefs to the health sector fitted with the political economy of the time in Ireland, where tax reliefs were used extensively as an economic driver, to aid the construction industry and fuel a building boom. This policy was strongly in line with the ideology and policies promoted by the ministers' coalition colleagues in the PDs, with whom they were in government at the time and whose leader was Tánaiste of the government. It was an economic model that was unsustainable and whose effects caused chaos in Ireland's economic and social life post-2008.

The public-private mix of healthcare in Ireland influenced the environment where tax breaks for private developments were not resisted. This, alongside the rundown of public facilities and the failure to invest sufficiently in them, created a space for the development of private, profitable facilities.

This chapter also shows the many contradictory components of this policy-making process – that one minister in government acted against the advice and policy of another minister of the same party in

government. On one hand health policy was recommending a rationalising of larger hospitals, organising in regions, while finance policy was incentivising the building of smaller hospitals anywhere, outside of any hospital planning process. Another obvious contradiction is the policy-making process for 'Quality and Fairness', a health strategy that had an extensive, wide-ranging, inclusive policy-making process, in direct contrast to the Finance Act, which was drawn up behind closed doors, drafted by an owner of a private hospital, and steered through by a minister who ignored officials and government health policy.

The interviews clearly reveal that a small number of people involved in private hospitals lobbied the Minister for Finance for the changes to be introduced – one of whom was invited into the Department of Finance to write the relevant sections – demonstrating a policy/political system easily influenced by a few people and the personalised nature of this policy-making process. There is little indication of the use of evidence in this policy-making process. The fact that there was no public or political debate on the changes, which went on to have a huge impact on bed provision in public and private hospitals in the decade that followed, demonstrates the covert, closed character of policy making in these instances.

Chapter 7

Case study two – NTPF interview data analysis

7.1 Introduction

This section draws on the interview data to explore what influenced the introduction of the National Treatment Purchase Fund (NTPF) in 2002. All 21 interviewees answered questions on the NTPF.

Each interview was coded as outlined in the methodology in chapter three. Coding allows the researcher to filter out the relevant sections of the interviews to the specific policy area, in this instance the NTPF, and then into each coded area.

This section is written up drawing on the conceptual framework's three headline themes of policy characteristics, actor power and political contexts. Each of these headline themes has variables which are written up by drawing on the relevant code/s which were detailed in tables 4.2 and 6.1.

7.2 Policy characteristics

7.2.1 Severity of the problem

There was agreement in 2000 and 2001 when the development of the health strategy was in progress that one of the big policy challenges facing the Irish health system was the long wait for a public patient in need of treatment in public hospitals. As outlined in chapters five and six, there were differences in opinion as to the causes of the long waits. These differences are also reflected in the interview analysis outlined below. While long waits for public patients was a political and public issue, there were also differences among those interviewed as to the severity of the problem.

Extent of the problem

A significant issue that came up in the interviews was the inability to assess how many patients were waiting, for how long and for what specialities and treatments.

> *In the run up to the 2002 election, politicians were hit with this on the doorsteps. It was one of the central issues in the development of the health strategy... Pre-2005, the Department of Health compiled the waiting lists; there were big problems with them – figures did not include x and y; also they don't reflect specific problem areas (IV 3)*

> *I spent my time [in the run up to the health strategy] asking people what is the actual waiting list – they could not tell you (IV 6)*

> *Waiting lists would have been around 35,000, which of course could have been anything to be honest with you: the waiting list figures itself and the way it was managed at the time and*

manipulated out there by the hospitals was outrageous.... And that was the problem with that system (IV 11).

Interviewees brought up the fact that no one knew exactly how many people were waiting for what kind of treatment, with different numbers being given by different interviewees ranging from 26,000 to 46,000. However, there was complete agreement that reducing, and where possible eliminating, long waits was the primary area of concern for health policy and the health strategy in 2001.

Table 7.1 What interviewees said about the difficulties of defining the extent of long waits for public patients

Obviously, waiting times for outpatient appointments and for elective procedures were very long. If you look at PQs [parliamentary questions], through the whole of the 1990s, it was an ongoing and a seemingly intractable problem. One of the major focal points of the health strategy was how do we solve this?	IV1
Waiting times for surgical procedures and operations. People had to wait a long time for operations... having already waited a long time to get an appointment with the specialist in the first place. People were waiting two to five years for treatment and there were big numbers waiting this long.	IV3
At the time there was an elective waiting list... People were regularly waiting two to four years – eight years was not uncommon. It was a constant, constant feature of political and media attention...	IV18

Causes of long waits

There were differences in opinion among interviewees on the causes of the long waits, as identified in chapters five and six. This difference in analysis of the causes of long-waiting public patients is important as it impacted on the potential solutions identified and adopted in the health strategy and the emergence of the NTPF.

A lot of interviewees identified how the public health system was organised as the key contributor to causing long waiting lists and times. These included perverse incentives for doctors and hospitals and the under-provision of beds in the public health system

Table 7.2 What interviewees said about the causes of the long waits for public patients

What they said	Who
There was no accountability; waiting list budgets were routinely going to supplement existing budgets. The higher your waiting list, the more money you got each year, a couple of times a year – a whole system of perverse incentives. If you used up all your money by October, you got more money between October and December... The bottom line is... there was no way in God's earth that the public system had the capability – they may have had the funding, but they did not have the capability – to deliver that.	IV2
I think certainly going down the road, if you were to utilise facilities... for example MRIs, why the hell do we have a waiting list as simple as MRIs, when we have machines sitting empty at weekends and this sort of stuff? Doctors protecting beds and all sorts of carrying on... It did not lead to a good system. I believe the public system should be able to work effectively to deliver what people need. You can do it through different funding mechanisms, but they have to be performance managed, which the system wasn't. If it is the case that money is thrown in a hole for years, then people continue to wait four, five years routinely for treatment for basic procedures.	IV3
The analysis [for addressing long waits in the health strategy] was very clear, which was that there was a substantial capacity issue in the system, that there was a substantial strategic-leadership deficit in the acute hospital system, and there was a substantial equity issue.	IV6
A lot of consultants'... reputation was measured by the length of their waiting list: the longer your waiting list, the more people who want to see you, the better you were... Fixing the public system capacity problem is not a resource issue; it's not a financial resource issue, or a human-resource issue: it's a systems issue and above all a cultural issue... Look at the waiting-list data for a particular type of patient in any type of hospital: it was always around the same – a year or 18 months... It's a cultural issue that needs to be managed and changed...	IV9
A lot of medics at the time believed that lists were a good thing to have because that's the way you got allocated resources, that's the way you won. The whole allocation of capital, of revenue funding, was haphazard... And there was a sense	IV16

that the bigger the disaster you were sitting on, the more likely you were to actually get your problem solved, so therefore it was in the interests of hospitals and doctors to have big waiting lists...	
Money was being thrown at them, as far back as the mid-'90s... But it was either not used for the purpose meant or not used efficiently for the purpose meant. Either way, waiting lists were getting longer, rather than shorter; it wasn't working... The tradition in the Department of Health and the public health sector has been: you get your budget, but you know the budget is not really related to the mix of things we do; we do the best we can, we run a up budget deficit, we know we are going to be bailed out. That's dysfunctional...	IV17
This is where the whole thing becomes perverse, hospitals, hospital managers, trying to live within their budget of €200 million, if you get them to utilise their beds much more efficiently or effectively, it will add to their budget... and with block grants there is very little you can do	IV18

The above quotes demonstrate the range of reasons given for long waits, but central to them all was the interviewees' belief that the way the health system, and specifically hospitals and doctors, was paid incentivised waiting lists. They make the point that there was no relationship between money allocated to a hospital and activity, that facilities were under-utilised out of hours, that it might be in doctors' interests to have a long public waiting list because they could earn more from their shorter private waiting lists. Some interviewees also make the point that it was not about resources but that the culture in the system rewarded inefficient work practices. Some interviewees, all from either the Department of Health or working in the HSE, identified the public-private mix as a contributing factor to the long waits for public patients.

Table 7.3 What interviewees said about how the public-private mix impacted on the shortage of public-hospital beds

What they said	**Who**
If you looked at a [public] hospital as a business, the private income they were getting from privately insured patients was helping to pay their bills. There was more private practice going on than there should have been: there was no doubt that there was more than the 20% quota. It was being exceeded regularly... Consultants directly benefited each time a private patient came in.	IV1

The running of public facilities to a private agenda was a cancer on the system. Now, how do you deal with that? That was the big challenge, and one of the core ways was to remove the incentive for the most important decision makers to run the system to the benefit of the private patient...	IV6
There was a... policy-makers mindset. It was: 'Yes we have a mixed system, but we as policy makers don't engage with the mixed bit, with the other half of that system. Our planning responsibilities don't comprehend the private bit, so we are actually overseeing a mixed system, but we are only concentrating on the publicly owned, publicly delivered bit.' There are endless examples of that.	IV10
My own view is, if you stand back from it, we have had private and public from the beginning – we had a mixed system since the beginning of the last century, that's how it [the NTPF] evolved	IV21

The above quotes show a mixed view of the causes of shortage in public hospitals beds, but contributing to the problem was an unfair, inefficient system with the wrong financial incentives in place in public hospitals, which privileged private patients over public patients and encouraged longer wait times for public patients.

7.2.1 Ideas for intervention

Origins of the NTPF

Each interviewee was asked 'what was the origin of the NTPF?' Many, especially those who had been in the Department of Health, referred to the Waiting List Initiative (WLI) in the 1990s to address long wait times. A majority felt that the NTPF emerged due to the failure of the WLI to reduce the numbers waiting.

Table 7.4 What the interviewees said about the influence of the Waiting List Initiative on the National Treatment Purchase Fund

What they said	**Who**
There was already in place a Waiting List Initiative, which was run largely in the public hospitals. There was some minor private hospital involvement in the WLI that was making inroads at the time. It was achieving results, but there was still game-playing going on by the hospitals.	IV1
In the 1990s, there were various Waiting List Initiatives for waits in high volume	IV3

surgical specialties, for lumps and bumps, especially the longest waiters in orthopaedics, urology, neurology, ophthalmology, ENT. The WLI poured money into hospitals but it was diluted, due to other competing demands. The money put in was swallowed up into a black hole. A 2003/4 Comptroller and Auditor General report found WLI of very little benefit: the problem was not solved and the long waiters remained...	
We had a bad experience... with the so called Waiting List Initiative. Frankly I thought any variation of the Waiting List Initiative which restricted itself, by and large, to public hospitals... I thought it was doomed to failure, given the way we funded public hospitals and given the way they were managed.	IV5
I was directly involved in spending that money... We ended up, various POs [principal officers], having bundles of money to do this... just like the NTPF. It was a very crude instrument. I remember trying... to prove the people that the WLI was paying for were people who were long waiters. But there was a genesis of the idea of using a fund...	IV10
The Waiting List Initiative in my view was a disaster, always had been a disaster, always was – it was pure political. It was nonsense from the word go. And it was only in place because the politicians felt they had to respond to it. It was throwing money down a black hole, because people were using it... I know damn well that the hospitals... used it as a technique to look after their overrun. That's not what it was about...	IV11
I was there when we got the £20 million for waiting lists ... There was a Waiting List Initiative, the first year with 46,000 waiting, and this came down hugely but here's the secret about the waiting list: 46,000 – some were dead, some were on two or three lists, so when you start to offer the procedure, your numbers come down. The following year it was only £10 million, and then the following it went down to £5, and then it went back up, but it went from 46,000 to 26,000 over a period of two years.	IV18
The famous Waiting List Initiative: we'd give them £40 million a year, it was just, you could never benchmark anything out of that, whatever you gave them. It's generally agreed that went in to the black hole: it just got absorbed; it did not measure performance or outcomes or benchmarking...	IV21

While the above quotes demonstrate mostly negative opinion of the Waiting List Initiative fund, there was some agreement, that it paved the way for the NTPF. Instead of putting additional money into public hospitals, which did not result in a reduction in the numbers of public patients waiting long times, a separate independent fund was established.

Policy transfer

Each interviewee was also asked 'was the NTPF an example of policy transfer, from aboard or other Irish initiatives?' A majority believed it was a transfer either from other countries or a similar small-scale initiative introduced in the 1990s.

Table 7.5 What interviewees said about the NTPF as an example of policy transfer

What they said	Who
They looked at the Norwegian example as far as I remember.	IV1
They had looked internationally... the NHS, Northern Ireland, particularly Scandinavia, Norway, Sweden, Germany, England...	IV2
The Norwegian model was looked at. But it was not based on a Norwegian model. Nothing as similar to Norway – other NHS waiting list initiatives were looked at...	IV3
It builds very much or draws strongly on a purchaser provider split where you have a commissioner or an entity buying services for its patients, so it would have been influenced by that, the UK...	IV5
There were funds in Britain and Scandinavia that were doing that kind of thing.	IV10
There was a development in the UK as well, whereby the UK and the NHS had actually bought in largely from South Africa and Australia... the Independent Treatment Centres basically farmed out, unlike the Irish scheme, huge volumes, enormous compared to the Irish system. And I would say that that probably had an influence on the thinking as well.	IV16

Five out of six of the above quotes come from people involved in devising or implementing the NTPF and show that some international examples, especially the UK and Norway, were looked at while the concept of the NTPF was being developed.

Four interviewees, all involved in private hospitals, talked about the NTPF being influenced by specific Irish initiatives in place.

Table 7.6 What interviewees said about how previous Irish initiatives influenced the NTFP

What they said	Who
We were one of the first hospitals approached. The government was already contracting us to do cardiac surgery in advance of the NTPF. The cardiac waiting list was, at the time, long; highly news worthy. We had an arrangement with the Department of Health to do their work, and that in my mind provided a model for how that [NTPF] might work and they used that model in a very rudimentary sense.	IV12
The cardiac surgery initiative came out of, 'is there more that we can do?' We knew it was very high-profile at the time: it was the biggest problem and obviously the most life-threatening one in terms of waiting lists, so that initiative came out of that.	IV15
The first one... predated the NTPF. X did a deal with the Department of Health to take 50 patients off the cardiac surgery waiting list back in the late 1990s. There was an average waiting time of over two years for cardiac surgery. I persuaded the department to pilot the scheme. It was very successful and X joined in shortly afterwards, and that was a forerunner to the NTPF... Cardiac surgery waiting lists were demolished in a relatively short period of time... That was seen as a big success and that paved the way for... the NTPF	IV16
He went to Micheál Martin at the time and said I can deal with this list by bringing them to John Hopkins, 10 at a time, and I can do it until the list is gone. Micheál Martin agreed and funded it. And he brought 10 kids out at a time... so he did that once a month for 18 months and got rid of the waiting list [for child heart surgery]	IV19

These quotes show that two private hospitals and one specific doctor were contracted by the Department of Health to carry out adult cardiac surgery in Irish private hospitals and child cardiac surgery in the USA and these were very successful initiatives with tangible outcomes ie saving lives. The success of these small schemes seems to have influenced the idea of the NTPF.

The degree of agreement on the solution

People were interviewed for this research between eight and 10 years after the establishment of the NTPF. By the time of the interviews, most people supported the NTPF. Some of those who did not support it initially changed their mind due to its perceived success. Two people still opposed the concept of the NTPF.

The strong support for the NTPF among most interviewees was evident in the following responses. When asked 'what was the rationale?' or 'what were the origins of the policy?' many gave responses as to why, in their opinion, it succeeded, albeit retrospectively.

Table 7.7 What interviewees identified as the success factors of the NTPF

What was said	Who
[The NTPF] was destined to succeed: it had huge political commitment behind it, it had a very generous budget when compared with everything else, it was being selected out and fuelled up... Lots of people have been delivered lots of quality of life as result of it. I think that's tremendous and I have changed my mind. I think it probably was the right idea and we probably wouldn't have been so successful trying to work the public system in the old way. And it probably delivered a different dynamic in terms of competition between public and private providers: the public no longer had a monopoly on public work; it spread that principle of state as standard setter, regulator and payer; and showed that model could actually work.	IV1
The NTPF is a limited scheme with a small budget that is very successful. If it is totally successful it will do itself out of a job.	IV3
It was Harney saying that there is danger that if she did not do that [ring-fence NTPF budget] that the money would not get spent in the way she intended, and that the only way to do it was to have it directly out of the health vote, and she did sponsor it. I think the budget went from €30-€40 million in year one to €60-€70 million in year three, growing faster even in those heady days... It looks to all the world like a very conscious decision to access private capacity and protect that access to private capacity rather than simply asking the HSE to use €100 million of its own budget to achieve the same means... when I say protect, I think it's a very conscious decision, that they we are going to absolutely red circle this funding and put a red circle around it so that this money does not get lost in the wash.	IV4
It did its job properly, in taking large numbers of people off the waiting lists at end of each year... It ring-fenced itself from the pressures that the system itself will face. It was able to get stuff done 'cause it did not have to worry about budgets or anything else taking it or its money being used at the end of the year to balance its books of the health service itself... The NTPF was getting significant budget increases while the HSE was being cut. It was always top-sliced and ring-fenced – protected. In one sense it was a bit of a holy grail: it had to be protected – it made everyone look good	IV9

at the end of the day; it made the minister look good... Here you have all these numbers coming down...	
Now I know the arguments about simply diverting public money away that should be put into the hospitals, but that would be perfectly alright and a very tenable argument if the public hospitals were efficient, if we felt that whatever €100 million or €90 million now, whatever it is, were able to give you €90 million of real value for money, then I would accept that....	IV11
It's efficient and it's slick and it's quick: you are not dealing with chronic illness, you are not dealing with multiple sclerosis; you have someone who has a hernia operation, it can get sorted out really quickly in the private sector, so let's just sort it out... All that as a political initiative, it's pretty clean and good.	IV12
If you took the whole of the funding, say €75 million, today and threw it into one hospital, the x hospital for example, that wouldn't improve their efficiency to bring more patients in and operate on them electively. The NTPF did...	IV13
The Department of Health was aware that they could actually get good value in terms of marginal output. The big argument around the NTPF or not was a marginal increase to the entire healthcare budget or the entire acute hospital budget because the original allocation amounts to the NTPF could have been about €40-50 million... That would not have given you any marginal output from the acute hospitals so the whole principle was if you were to allocate that across the acute hospital system, can you find a marginal output improvement that you get for that increased input?	IV16
It makes sense to have a pot of money there and have it focused on dealing with the problem... The test of how important things are for the organisation... what's the first thing you think of doing?	IV17

Supporters and even opponents of the NTPF identified what they perceived as its critical success factors. These were: a ring-fenced budget that increased dramatically when all other budgets were leveling out or being cut; the high level of political support for it; and the fact that a specific agency was set up to deal with just one thing: long-waiting public patients. It was also noted that there were much more obvious benefits from allocating a relatively small amount to the specific treatment-purchase fund compared to adding this money to the entire health or hospital budget, given how inefficient the public hospitals were.

Although many of the interviewees said they supported the NTFP, albeit retrospectively, they were able to articulate the strident opposition to it when it was first introduced.

Table 7.8 What interviewees identified as the rationale for opposing the NTPF

What was said	Who
I said to myself, I am sure the Department [of Health] will go out of their way to ensure that it won't happen... I was quite taken aback that the Department was so set in its ways – it was that forceful that it was not going to be entertained	*IV1*
There was huge resistance to this [NTPF] in the Department [of Health]... The Department was completely opposed to it. If you are trying to understand the genesis of it, the Department was opposed to it... the entire department. Well, a lot of people in the Department were opposed to it...	*IV2*
I'd say the view from the Department of Health would be that the public system should be able to look after itself... I think the system did not like it [the NTPF]. It certainly would not have been the number-one choice on how to deal with waiting lists in the Department of Health. I think the health boards objected to it too, on the basis that it was going to be outside their control. There were some politicians who had leanings on the other side of Mary Harney who did not like it either because it was money going away from publicly provided service. Some of the managers would not like it, their patients going outside of their control. Some of the consultants would not have liked it and to this day they are still around, as you well know... Particularly category-one consultants who do not practise outside of public hospitals. Also, some grievances from the general public who do not want to see money being spent away from their local hospital.	*IV3*
Well, it was imposed on us: it did not land on us in the happiest of circumstances. So if you are to talk initially about the Department [of Health] and our view, there was scepticism certainly about how was it different to the waiting list initiative, are we simply now setting up an agency to do this?	*IV5*
I have yet to see any reason why I should change my view as I enunciated it at the time. If it was a success, it should be out of business. And that's not a criticism of the people who were there doing what they can: it's a criticism of the health system as such... Our view was the health services were being under-funded to deliver what was expected or what was required. Our view was that the funding designated for the	*IV8*

[National] Treatment Purchase Fund should have been put into the public system to allow those medically in need of urgent treatment to be treated as the priority they are.	
There would have been people in the public system who would have opposed it generally... The medical profession were always opposed to it: very few of them will support it; they feel there is a dilution of clinical responsibility, which is nonsense in my view. And in the Department [of Health], yes, there would have been people in the department not happy with it. But I was always happy with it...	*IV11*
The docs had mixed views about it. Some of them were very enthusiastic, some were very resistant, but over time the doctors' resistance diminished ... When I was talking with the doctors, I said this is too big for the hospital to ignore... It's not going to go away any time soon so you might as well get used to it, and that's what happened: they got used to it... There were arguments that that money should go in to the public hospitals and that sort of thing, but they got worn down really, and the NTPF was buying large amounts of surgery...	*IV12*
The surgical opposition to it was: you are putting public money into private hospitals instead of public ones. And the other big one was: you are double-paying surgeons that could be doing this in the public sector; you are paying them to do it in the private sector... I think you'll find very few surgeons now not thinking it matters to the person it benefits, and that's the patient, so the NTPF is now accepted by most surgeons...	*IV13*
The biggest resistance I got was from [medics]...	*IV16*
I think the initial resistance [of the Department of Health] was made known to people who were politically behind it.	*IV18*
Yet if you look... at the quarterly national household survey at the length of time people are waiting and the percentage of people who are waiting ... in absolute terms, it really hasn't improved matters. You still have a minister saying his target is waiting over a year... this is the QNHS [Quarterly National Household Survey]. This is survey data, this is reputable data and it's a good big survey – 3% of adults were on an outpatient waiting list, 1% inpatient, 1% on day-patient lists, 12% of those on outpatient, up from 7% in 2001.	*IV20*

The opposition to the NTPF emanating from the documentary analysis is clearly reiterated here, interestingly by many who supported the NTPF.

A primary argument against the NTPF is that the public money allocated to the fund should be invested in the public hospital system and should address the cause of the long waits in the first place. This is the argument used in reverse to justify having a specific fund and identified by interviewees as a success factor: that a specific ring-fenced fund could provide much more benefit than spreading a relatively small amount of money – when compared with the overall hospital budget – across the entire system.

It seems from the interviewees that most opposition came from the Department of Health and hospital doctors, although quite quickly they seemed to overcome their opposition, in that the NTPF was successfully implemented initially by the Department and needed doctors' co-operation to work.

A very small minority of interviewees stridently opposed it and believed it was not a success. Many cited the success as bringing down the numbers waiting. The numbers do not necessarily reflect this, as outlined in chapter five and as articulated by one interviewee (IV 20). This clearly shows a difference between perception and the reality of what happened.

7.3 Actor Power

7.3.1 Guiding institutions

There are very strong findings from the interviews, that the extent of political priority for the NTPF was central to its introduction. The political support is detailed in the final section of this chapter. Another strong theme emerging from the interviews was the role the Department of Health played in its opposition to the NTPF, in particular, its initial resistance to it even though it was given the task of implementing the policy, once the political/policy decision was made.

The opposers to the NTPF were dealt with in previous sections, many of which articulate the resistance of the Department of Health to the scheme. This is given some further attention here.

Role of the Department of Health

Apart from the hostility of the Department of Health to the NTPF, two other important points were brought up by interviewees from both inside and outside the department. One is the attitude of the department officials that waiting lists were inevitable no matter what you do.

> *In terms of the NTPF, it's hard to get rid of the lists* (IV 3).

> *It was certainly accepted that waiting lists are in every developed health service in the world, especially those that are tax-funded. They are simply a feature of them, but you have to deal with them as best as you could, without ever pretending you could abolish them entirely...*

Well, to the extent that you can count them, because we have the same problems with outpatient waiting lists today as we had with inpatient waiting lists pre-NTPF (IV 5).

The other point made was the lack of capacity of the Department of Health to deal with intractable issues:

There is a lack of leadership and a lack of management expertise. There's fundamentally a lack of leadership in the Department of Health, for years and years and years. By leadership I mean people who take initiatives, who challenge the status quo, who ask the question 'why aren't we doing this' and 'why are we doing that?'(IV 17).

I don't think the capacity existed in the Department... (IV21).

Many of those who spoke about the opposition of the department to the NTPF were asked why the Department of Health opposed the NTPF:

Table 7.9 What interviewees said about why the Department of Health opposed the NTPF

I would have seen it as eventually paying twice for the same service, on the basis that we weren't prepared to take the hard decision, which was to force the public hospitals to operate in a particular way, which was fair to everybody, and one that was not dictated by fast-track, insurance cover.	*IV1*
One, it was acknowledgement of failure. Secondly, maybe ideological... and the third one was control... At the time we were talking about €34 million... what is it now? It's up to €80-90 million, that's a lot of money...	*IV2*
The big criticism you could make of it is: have you addressed the other underlying problems or have you shifted the problem? And in a sense we have... but we have not addressed the outpatients or the gap between GP referral and OPD [Outpatient department] appointment and OPD referral to time of surgery and that is a huge issue...	*IV5*
The default feeling would have been: hang on, you have just thrown money at the private sector as a means of cherry-picking and all that. The second would have been: hang on, this is illogical – why not just give the money to the public hospitals?	*IV11*
I know that the Department at the top expressed its grave reservations about that: it did not think it was a very good idea... There was some verbal arguments made	*IV18*

against it... it was not the best use of public funds.	

The above quotes show the mindset of the Department, as perceived by the interviewees, in its resistance to private healthcare and the NTPF. It is interesting to note that despite the opposition from the Department of Health, it was charged with setting up the NTPF. Part of the Departmental resistance to the NTPF was the setting up of a separate entity to carry out its function that had a standalone budget and was outside of the control of the Department. In hindsight, all these factors were considered critical success factors for the NTPF. Also it is notable that a majority of the officials who resisted it in the first place, were willing to admit their hostility to it and felt with hindsight it was a success. Whether this was the case or the interviewees are rewriting history is impossible to tell, but there is probably an element of both in their views.

7.3.2 The role of policy entrepreneurs

Each interviewee was asked who drove the policy process that led to the introduction of the NTPF. The responses give a clear verdict on who was the policy entrepreneur of the NTPF.

Table 7.10 What interviewees said about NTPF policy champions/entrepreneurs

What they said	**Who**
And the main champion of that at the time was the adviser to the then Tánaiste [Oliver O'Connor was Mary Harney's adviser at the time]	IV1
Oliver O'Connor.	IV2
Oliver O'Connor was very, very centrally involved in conceiving the NTPF. I think he says it was his idea. It clearly emanated from Harney's office before she was in Health.	IV4
It would be much in keeping with Oliver [O'Connor]... Oliver was certainly the main champion of it... He was a strong, strong architect, no doubt about that	IV5
[Oliver] O'Connor was the chief ideologue.	IV6
It came from Oliver O'Connor. Let's face it: it was purely his brainchild. He's the one who set it up; he's the one who had ownership of it; he's the one who took credit for it. He's the one who convinced the minister at the time to set that up... It got traction during the health-strategy negotiations and was put on the table by Oliver as a way to reduce waiting lists, and they it got into the health strategy, and then it got set up very	IV9

quickly.	
I'd land all of that [the idea of the NTPF] on Oliver [O'Connor]'s brain for good and for bad... As far as I know that sprang from Oliver's head. Certainly I recall that	IV10
I think Oliver was... It took Oliver about 10 minutes to convince me when I had a telephone conversation with him... I rang him and said, 'Oliver, what's all this?' and he began to convince me.	IV11
From my perspective, it came from Harney and Oliver [O'Connor] – he was very much the person who argued the case for it.	IV14
Q. And do you think Oliver was the architect? *A. Oh I would imagine so, I would imagine so yes*	IV18

When the above comments are combined with those in the political contexts section, there was unanimity among the interviewees that Oliver O'Connor, as adviser to Mary Harney, the then Minister for Enterprise, Trade and Employment, devised the policy and was its primary policy champion. He was wholly supported by Harney, who, as Tánaiste and leader of the PDs, held considerable political weight and influence at the time. It is not possible to tell from the documents or the interviews whose idea it was: Harney's or O'Connor's. However, the findings make it clear that together they were a formidable force and had a significant impact on the making of government policy, including aspects of health policy even before they entered the Department of Health in 2004.

7.3.3 Private sector interests

Each interviewee was asked did they think there was lobbying in the run up to the adoption of this policy and the extent of the influence of the private sector on policy developments. There were just three responses.

Table 7.11 What interviewees said about the extent of lobbying for NTPF

What they said	**Who**
I would imagine that there may have been some element of it. I mean, it was known that there was capacity in private hospitals, 'cause there was no private hospitals 100% out-the-door, unlike the public hospitals.	*IV3*
I have no doubt. I would expect that they were [lobbying]. They weren't coming straight to us: a lot of this type of lobbying, unsurprisingly, would go through the	*IV5*

political system. I am sure there would have been lobbying [long silence]... I would expect, but I do not know for certain, that any of the private hospitals who were looking for business – remember a number of them had started up around that time and were hunting around understandably for business. So I am sure the Independent Hospitals Association [of Ireland] would have been advocating this and the independent private hospitals, but I don't have direct facts about this so won't say anymore...	
I didn't lobby for this, but when it was announced, I said, yeah, it makes sense...	*IV17*

Nobody from the private hospital sector said they lobbied for a treatment-purchase fund. This makes sense in terms of the policy process, as it emanated from the larger health strategy process and came as a political proposal into the policy process.

However, one interviewee who represented the private hospitals in the early 2000s spoke about a meeting he had had with the Secretary General in the Department of Health suggesting private hospitals could assist with resolving the problems in Accident & Emergency departments.

> *I contacted Michael Kelly [then Secretary General in the Department of Health] and I said, 'I think the private hospitals could help... There can be spare capacity in the private hospitals at weekends or even during the week, and you have elective surgery you might want to cancel. But you have patients in the public hospitals that could be moved to a private hospital for back-up care, where you would not need surgical or other interventions. And rather than blocking a bed for elective procedures in a public hospital, you could unblock some of them by transferring the patients down to the x or y or z private hospital... It won't solve A&E but it could help.' And he said, 'Oh what a good idea,' and nothing happened – not through his fault; it was assigned to someone else. He thought it was a good idea, but he didn't want to give money to do it... So that was the nature of the way we began to engage with the public sector: not in a crafty way but in a logical way. They had a problem, could we help with them, and if we helped with them, it would be a financial benefit clearly to the hospital, but you'd be making a contribution to a national crisis and you'd be establishing some credibility. 'We know you have problems – if we can help, we will,' you know? (IV 17).*

One private hospital person whose hospital had been involved in the successful cardiac surgery initiative said:

> *The private hospital sector and I would have been very vocal as would x and x [other chief executives of private hospitals]. We were largely ignored, largely ignored. We did not have*

the ear of the minister; we were not influencing policy. If we were influencing policy it was through things that we did that were deemed to be successes, that could be politically positive... (IV 16).

These responses indicate that there was not purposeful lobbying in advance of the NTPF for such a specific fund to be developed but there had been meetings between the most senior official in the Department of Health and a representative of private hospitals letting him know about their 'spare capacity'. Also, many interviewees spoke about how the establishment of the NTPF worked in the interest of the private hospitals and created a market for consultants and private hospitals.

Table 7.12 What interviewees said about how the NTPF created a market for private hospitals

What they said	Who
On the results, it's been very effective, it made a market certainly for the private hospitals, it made a market for the consultants.	*IV1*
The thing that the NTPF did was that it did start using capacity in the private sector that was not being harnessed up to that point. There were private hospitals out there who could do some of these procedures, and subsequently did those procedures.	*IV5*
The xxx and xxx gets the majority of the [NTPF work] as well – there was a joke going around that xxx [chief executive of a private hospital]'s car has NTPF 1K as its number plate.	*IV9*
I would have said the work in the private sector is what – €90 million now? You got to look at how much money is paid out to the private hospitals by the insurers – that's the key to it. Is this significant? Yes, I think it is significant. Is it enough to make a difference in investment? Is it enough to keep a private hospital ticking over? Yes it is...	*IV11*
There was no resistance from the hospitals. Private hospital managers looked at this as an opportunity... It is a major source of healthcare funding in the country.	*IV12*
It was xxx, the xxx, supposedly its financial viability... was dependent on was the [National] Treatment Purchase Fund and it still is... to make the private hospitals that Charlie McCreevy had built commercially viable, we built this private capacity deliberately. I also believe that Mary Harney held down	*IV14*

public capacity as soon as she came in, and the treatment purchase fund was a way to subsidise the private sector	
According as a problem arose, there was a private-sector solution devised for it, so a problem with waiting lists – a private sector solution was the NTPF.	*IV18*
It exacerbated a whole lot of perverse incentives. It definitely created a favourable flow of income to private hospitals: whether by accident or design, that's what it achieved. It completely changed the profit environment for the X hospital... What changed that in my view is the National Treatment Purchase Fund... The reason why that group was able to sell on and make a lot of money was because of the NTPF... so in terms of the state creating an environment on which big profit could be made on the back of State funds that's what the NTPF did.	*IV20*

Half the interviewees believed that the existence of the NTPF contributed to the financial viability of private hospitals and also hospital consultants who benefited from private fees for treating public patients under the NTPF, most of these interviewees were not in the private sector.

7.4 Political Contexts

7.4.1 Ideology/political institutions

The NTPF emerged from the health strategy policy process. The issues related to this are outlined in the policy process/window in section 7.4.2, while the broader contextual factors were outlined in chapter two. The broader economic and historical factors did not come up in the interview, apart from reference to the Waiting List Initiative as detailed earlier. The strongest contextual factors that came from interviews were the political factors, which very strongly influenced the policy choice.

Political support for NTPF

Each interviewee was asked what drove the introduction of the NTPF. There was a consensus among all interviewees that the high level of political support for the NTPF was a key factor in its success.

Table 7.13 What interviewees said about the politics of the establishment of the NTPF

What they said	**Who**

Some policy gets made as a reaction to a crisis eg nursing home repayments, Leas Cross. Some gets made in a planned rational way. And sometimes in an unplanned, pragmatic way that the political process just happens to be supporting. The political process was fully behind the NTPF, which is why it happened and got a budget disproportionate to all other aspects of health.	*IV1*
If you asked me to prescribe what was the most fundamental of what I am saying about the department [of health], ultimately they are driven by political imperative, and politics and political imperatives are so fundamentally stitched into all of this here, that you can't ignore it: these are political decisions in the Irish measure.	*IV7*
I think it was political: it was really to do something about waiting lists. I think it's been really successful policy for government. I think it was political.	*IV16*
I think it was a political move. It was not discussed at medium levels of the civil service. It was thought it was a good idea... Politically the decision was made: we are going to have this. The money was there for it and it was forced on us and it was our job to implement... Most of the decisions were political when you look back over them... Despite the fact that it happened during Micheál Martin's time, it was quite obvious that it wasn't his pet project.	*IV18*

FF/PD government – coalition politics

There was unanimity among interviewees that the PDs had a critical role to play in the introduction of the NTPF. In particular, the importance of the support of the PDs for the NTPF was highlighted by all interviewees, specifically the ideology of the PDs, which would be supportive of private-sector involvement. More detail of this is given in the policy window/process section as well as below.

Table 7.14 What interviewees said about the role of PDs in the NTPF policy-making process

What they said	**Who**
At that time you had the influence of the PDs. The NTPF was always credited to the PDs. The PDs were credited with the NTPF concept – it was a FF/PD government at the time, it was a Fianna Fáil health minister, but that's how it came to be.	IV3
But it clearly had a sponsor in Harney, in getting itself established as a statutory agency and its own board, not reporting to the HSE, funded directly by Health and	IV4

a growing budget, year on year.	
I have no doubt it was through the then Tánaiste. It was quite quickly set up in the sense that strategy was launched November '01, and as far as I recall it was set up mid-2002 or very shortly afterwards... with the power of political will, things can happen very swiftly	IV5
What happened was the PDs on their daytrip into health policy, as I used to call it, with their chief ideologue, who had undue influence, who has created the mess we are in now...	IV6
The NTPF? It was political... From my perspective it had PDs written all over it. It was right up their alley: to solve a... what was quite a significant political problem at the time.	IV8
They were thinking in terms of a small party in a large government. They had an explicit policy of very selective interventions based on strategic choices which leveraged their influence a lot. Some of them were planned from long range, some of them were opportunistic... If you ask me why would Oliver [O'Connor] be intervening and Mary [Harney] be intervening from Enterprise and Employment, that is why they would have. I can still recall half bits of conversations that they would have looked at: what is it about the health system that people are most pissed off with? What is most dysfunctional? Waiting lists are scandalous – how can we fix that in a way that is most is commensurate with our view of government and people?	IV10
And it would have been something that would have been pushed by the PDs, who were not in Health at the time, but had an influence on it because, I think Oliver [O'Connor] was, I think Oliver was on a group in the health strategy... It was PD issue, a PD viewpoint.	IV11
It always seemed to me that even though it was a coalition, the government of that time, that the PDs liked it to be realised that the NTPF was their baby... So it was a PD initiative that the Fianna Fáil government had to introduce.	IV13
The Department of Health was aware that they could get actually get good value in terms of marginal output but who actually triggered that policy? Obviously Mary Harney.	IV16

It was very much a PD initiative, as I understand it.	IV17
Things get done because governments decide they should get done, now what goes into that is the mix of different ideologies, different people, it was a very strange kind of government... I believe that the ideological push for this [the NTPF] came from the PD end of Fianna Fáil and the PDs, and if you put everything in a line and say, Look, there's the Fianna Fáil party and there's the PDs, the people in the Fianna Fáil party who were PDs, such as Charlie McCreevy, then Mary Harney, Des O'Malley, Michael McDowell – real PDs – that was the segment of government driving the changes.	IV18

There was total consensus among interviewees that the NTPF was a PD-derived and -delivered policy. When this is combined with the quotes from the policy entrepreneur section, the findings are stark in the level of political and specifically PD support for the policy. This is a particularly interesting finding given that the PDs did not have responsibility for the health ministry at that time. The only explanation as to why they took on this issue comes from interviewee number 10 who suggested the PDs as government partners would have considered what are the most problematic areas in health, identified waiting lists and come up with a solution in line with their political ideology.

7.4.2 Policy process/stream

All political people and government health officials, from the Department of Health, the health boards and the HSE brought up the emergence of the idea of the NTPF in the context of the health strategy and the closer they were to senior positions and power, the more the origins of the NTPF was explained in that policy and political process.

Many interviewees referred to how the 2001 health strategy, 'Quality and Fairness', was a big opportunity to shape health policy in the decade that followed it, how there was an element of optimism in the run up to its publication.

> *We needed something better than the 1994 policy*[1]*, we needed to put a vision out there to the political world, to the people. So we became very enthusiastic – this is our one shot at this,*

[1] In 1994, the previous health strategy 'Shaping a Healthier Future' was published by the Department of Health

let's try and get it right... we have one chance to show the people the kind of health service we want and need, so let's concentrate on that... (IV 18).

You know we can do for health what Donagh O'Malley[2] did for education. They [Department of Health officials] really felt that at the time, in 2001, it was a terrible missed opportunity (IV 20).

A senior health official working in the Department of Health at the time of the health strategy development explained how the strategy would have needed to address long waits:

For that strategy to have meaning for people on the streets, one of the things it was going to have to deliver was a better solution to waiting times... You can position any policy change on two axes, there is the policy analysis axis and the other axis is the political. You can position any policy change in any of the quadrants – and some are much more laden with political analysis and some with policy analysis. The NTPF, for example, was based on policy analysis, and while there were political considerations brought into the decision making, there was an analysis behind that (IV 1).

Despite the recognition in the health strategy development process that in order to do reduce long waiting public patients that the two-tier public hospital system would need to be dismantled, these issues were avoided or sidelined in health strategy discussions (Department of Health, 2001c).

A number of interviewees closely involved in the strategy development spoke about how there was never an opportunity, despite the extensive process involved in the strategy's development, to address the public-private mix or to undo the two-tier hospital system.

These interviewees commented on how a universal system, whether tax or insurance based, was ruled out from the beginning of the strategy-development process, and how this in turn directly or indirectly enabled the emergence of policy ideas such as the NTPF.

From my recollection, there was absolutely no discussion of the public-private mix. The public-private mix was never discussed (IV 8).

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[2] Donagh O'Malley was a Fianna Fáil Minister for Education who introduced free secondary school education in Ireland in 1964, a policy that is credited with huge gains made in educational achievement across the population

I don't think the people who were busy trying to strategise were ready to try and deal with that big a question [the public-private mix]... When you look at what the big calls were: the biggest calls were around primary care – are we going to entirely reshape our system around primary care? They put the restructuring question on hold. I think they weren't ready to take it on within the shape of the strategy – should we look at financing our system in a different way? Should we explain/elaborate the public-private mix? I just don't think they were ready for it... (IV 10).

One interviewee who participated in the 'finance chapter' reiterated this point:

I had a role in the Finance Sub Committee of the health strategy and there were two interesting aspects: the remit of the committee was to agree how health was to be funded as part of the strategy and at an early stage in the one of the early meetings, one of the members raised the issue of a health-insurance scheme as opposed to a taxation scheme, and x [a senior departmental official who chaired this sub-committee] was absolutely adamant that there would not be a universal-insurance scheme for the very simple reason that the department would not be in control... Universal health insurance was closed down from the beginning of the strategy negotiations: they did not want to know – they were absolutely adamant about that (IV 8).

Another senior official felt that there was no way a universal system was viable for cost reasons:

We cannot have a universal system in current budget, costs will have to come down, we need a capped system for unlimited demand (IV 3).

The chair of that health strategy finance group was interviewed for this research. He stated that there was openness to a new system of financing or a universal system, but the group decided against it.

I was on the one that was looking at the whole financing piece and what changes should we make in it – should we change the old one, should we change from the current system of financing it? And the group came down and said no we shouldn't for the moment anyway (IV 11).

This point was strongly denied by five other interviewees, who explicitly stated this particular person prohibited the discussion of a different system of financing or a universal system.

No that was the chapter on the finance and that never really got an airing, that decision was already made... (IV 7).

One senior official who claims he advocated a universal health insurance system, explained the political and institutional opposition to it.

I think the government of the time moved off the cliff and looked in and saw this enormous drop and enormous task of getting a country like Ireland into universal health insurance contributions and pulled back (IV 18).

Some interviewees identified a particular moment of conflict in the health strategy development as the policy window for the NTPF – when the problem, policy and political streams came together to open the policy window.

This policy window was identified when senior political figures rejected a proposal for a common waiting list for public and private patients in public hospitals and from that rejection came the PD proposal of the NTPF. In 2001 when this discussion was taking place, private patients had faster access to public hospital care (as detailed in chapter two). The introduction of a common waiting list would have been one way ensuring equal access for public and private patients. I put this description of this critical juncture being the rejection of a common waiting list to interviewees who would have been close to it, many of whom concurred with the series of events albeit with slightly different versions of it.

These interviewees describe how there were many layers overseeing the health strategy including a high level political group made up of cabinet members including the Taoiseach Bertie Ahern, Tánaiste Mary Harney, finance minister Charlie McCreevy and some of their advisors.

One senior health official describes how there were just a small number of people making decisions on the health strategy:

There was a small number of heads and hands dealing with these things. There was just a small number of people, they had a really complex process, and while there was a moment at the start when that [common waiting list] might have been up for grabs. I think the feeling probably was, we have nine months to sort this strategy and wrongly they said, 'we'll hang on, we are not really going back to a blank sheet of paper here, we are focusing on other things' (IV 10).

Another very senior official describes the moment when it became apparent that a common waiting list was not acceptable politically:

I remember it being argued very forcefully by some of the political actors, that the idea of a common waiting list in a public hospital was a great idea. But, in terms of the political realities around this, it was absolutely a' no brainer', you could not do it. And I think the term I can remember being used, at a political ambush meeting, which was heavily populated by advisors to the Minister for Finance at the time and the advisor to the then Tánaiste at the time [O'Connor] was that that this common waiting list represented some sort of 'state of

nirvana', how naive could we be to suggest that we would piss off the one single group of people who actually showed some satisfaction with how the health system worked, as it then was. So that approach was going nowhere and it was out of the ashes of that particular discussion that the alternative idea of the NTPF was put up on table. And the main champion of that at the time was the advisor to the then Tánaiste [Oliver O'Connor], and of course that fitted very neatly with the principle of the PDs (IV 1).

This description of events and a political rejection to the common waiting list was put to other interviewees. The next person interviewed who could have known of such a meeting agreed that such an interaction took place, that the politicians were not happy with the proposal of a common waiting list, although he felt there it might not be as direct as previously stated:

in the end, particularly for the PDs, this idea [a common waiting list] did not travel, they were not happy with it and they pushed these other ideas instead. And in fact, almost the alternative to a common waiting list was the NTPF. And it was not the only alternative, it was not that they suggested, 'well we don't agree with common waiting list, so let's produce the NTPF', but it certainly influenced their thinking and the NTPF emerged from that (IV 5).

This series of events was verified by a senior political person involved at the time:

*Its genesis [the common waiting list] goes back to the health strategy. I remember coming in, in 2000... We wanted to do one major initiative in the strategy, and when I say we, I mean the health side, and I was pushing it strongly and it was one we just did not have the political power to pull it through. It was basically that we would to do the waiting lists on clinical, only medical prioritisation [a common waiting list] and a lot of earlier drafts we had that in – that basically irrespective of whether you were a public or private patient you got to be dealt with on the basis of clinical need. Now there was a lot of opposition from Harney and McCreevy on this... Harney insisted on being on the overall political health steering committee, which did not do a whole lot but oversee. We were left to write the strategy, but on this one their view was that this would just create further log jams in the private sector and undermine capacity, that it would not help the situation. I don't know if Bertie [Ahern] was there: Gerry Hickey normally represented Bertie at it... And you have Oliver [O'Connor] I think was Harney's man, and Mary Harney was at this one, with McCreevy and myself. And their view was this would make the waiting lists longer – that was their view... We had a couple of meetings on this... but that was their view. They thought it would f*ck up, make the pressures more, that basically it would not work, it'd create longer waiting lists. That the private-sector person... if you are the person paying your insurance, paying your tax, and you are going to be longer on the waiting list, having gone through all of that. That was their*

argument... that was the core part. We lost that argument. I think the Taoiseach sided with McCreevy and Harney... (IV 21).

Another senior political person involved in this health-strategy development process stated that it was the consultants who were the breaking point to the common waiting list being acceptable at a political level:

You have a common waiting list, it was proposed, it was in an earlier draft, it came to the first meeting of the cabinet, it was not singled out, I believed that I had the Bert [Bertie Ahern] squared on this and I actually believed that I had McCreevy squared on this, to the extent that we didn't really talk about it, to the extent that I did not think we had much of a problem. But the PDs turned up and they went mental about it and started quoting the amount of people with private health insurance, what impact it would have on them. And they had absolutely no answer to the point, and this was the biggest disagreement of the strategy – it wasn't the funding: they had absolutely no answers to the question: why should the state subsidise queue jumping?... There was a very passionate debate – very. But what he [McCreevy] did say: 'This is crazy, this is crazy.' Clearly he and Harney must have talked before as he [McCreevy] changed his position on it. It involved a substantial argy-bargy, primarily me and X on one side. It did not substantially involve officials... It was a policy discussion by political people. The politics, as far as we are concerned, were central to it... But this was linked very closely to the dramatic increase in available resources made available by the new contract... Ultimately... they were arguing that the consultants would bring the system to a halt, they would game the system and destroy it in order to maintain their highly subsidised private work. They did not actually have an argument. It was: we cannot afford two to three years of consultants screwing over everybody, that you can't afford the morality of what will happen. In terms of the system, you cannot afford that loss of confidence in ability to bring about change and that this is a fight that is not worth having... The three elements proposed – zero subsidy of private medicine, new consultants' contract public only and extra capacity...

When I asked who blocked those elements in the health strategy, he responded as follows:

It was the Bert [Bertie Ahern] who called the shots. There was a meeting in the Sycamore Room [the cabinet meeting room in Leinster House]... the Taoiseach sits in a particular place, his secretary sits on his left and x sits opposite and the senior minister sits beside him, so basically it was a side-to-side barney between the Bert and McCreevy, which was very unusual and awkward because in coalition governments you try not to sit on opposite sides of the tables [if you are members of the same party]. But he [Bertie Ahern] had been quiet for much of the discussion – in fact he'd been missing for much of it, in Northern Ireland, always

getting pulled out for such stuff. He said at the end of it: 'If we pick a fight with the consultants, they'll destroy us,' and that was the end of it... That was the end of the discussion – basically fear of the consultants. And he quoted something about Michael Noonan: Michael Noonan tried and they destroyed him. And basically he got persuaded ... that it was not a big enough or an important fight to take to and that was the end of it... It was probably September/October 2001. The NTPF is the thing which caused fury... (IV 6).

When this series of events was put to departmental officials, they said they could not know what discussion happened at cabinet level. It seems unusual that they would not have heard about the tensions on such a vital issue that other senior officials seemed so familiar with, and they were hesitant and reluctant to discuss the matter. One of these officials then went on to say that although he was not privy to any cabinet discussion, he had heard that the consultants' contract was a point of contention:

What I heard was a big issue was the consultants' contract – I certainly heard that. I also heard that... access – remember there was a lot of access for the 50% or whatever the figure was at the time who had private health insurance, people who had access to private hospitals... I am not sure how much of a problem that was. The consultants' contract was definitely one... (IV 11).

Another senior official close to these negotiations reiterated the department's support for a common waiting list, which was overruled politically:

We strongly argued within a number of those [health strategy]groups for a common waiting list and, interestingly, it did not find favour at the political level, as much as anything else, for what they saw as logistical reasons. They asked how can you have a common waiting list and, if you do, how do you distinguish between public and private patients? What's the point in taking out private [insurance] at all... To be honest we felt that was somewhat simplistic and that a common waiting list, if properly organised, could still work. It'd be difficult but could still work and we would be very, very surprised indeed if that led to a sudden collapse of membership of the VHI (IV 5).

One interviewee said that at the end of this meeting, Oliver O'Connor, Mary Harney's adviser, agreed to come back to the group overseeing the health strategy development with a proposal (IV 1). However this was not verified by any other interviewee.

Two interviewees referred to PDs holding a press conference to announce the NTPF without knowledge of the Minister for Health, Micheál Martin:

We were quite literally putting the finishing touches to the health strategy. In fact... we were

in Carr Communications doing the communications element of the health strategy, when we got a call to say the PDs, who were in government, were having a press conference that afternoon to announce quote their policy that they wanted, that became the National Treatment Purchase Fund. So it was relatively late in the day. The process was unusual to say the least... Micheál Martin let it be known at the time how irritated he was that his own colleagues in government were holding a press conference to announce a policy in relation to health when they could have quite easily, in the normal way, have had an input to its announcement within the health strategy, so that in itself was unusual. So it was put into the health strategy as an initiative. The PDs understandably then took the direct credit for it and said it was, quote, their idea. It was, and it was very quickly pursued thereafter in 2002... (IV 5).

*The NTPF was proposed one Friday afternoon in a press release by xxx. He was making shapes about winning one of the only seats they had a chance of and so they were busy bigging him up. So in the name of xxx, they 'issued' the press release. It was a rule-based proposal: if you don't get your treatment within a certain time, we'll buy it. Basically the strategy was in draft and going to cabinet so this was very f**ing late for this. The proposal was ridiculous, uncosted, not thought through, any of the basic questions, perverse incentives etc... I don't know what happened in the end but I know there was an extremely disagreeable lengthy negotiation in the Department of Health* (IV6).

The next day, on 26 September 2001, the *Irish Times* published an opinion piece by Mary Harney which proposed the idea of a 'Treatment Guarantee Fund' for patients ie that all public patients would be treated within three months of referral.

In order to achieve this guarantee the PDs proposed sending public patients for treatment in private hospitals. Many interviewees attribute this article as the first public and political airing of what would become a Treatment Purchase Fund.

Mary Harney or Oliver O'Connor wrote an op-ed [opinion piece] in the Irish Times *in September, two to three months before the strategy was published, and apparently that threw the cat among the pigeons and Micheál Martin was furious about that article* (IV 10).

When the 'Treatment Purchase Fund' was first proposed it included reference to guaranteed treatment within a certain amount of time. Although the NTPF was in the health strategy, it did not give a guarantee as originally envisaged by the PDs (Department of Health, 2001a).

There was a pronouncement to give everyone treatment within three months – we were never that naïve to think we could do that (IV 3).

> *They were looking for a treatment guarantee but apparently the officials toned it down... Officials hate any guarantee for anything* (IV 10).

The 'treatment purchase fund' was named in the health strategy as a mechanism to cut long waits for public patients for hospital treatment. When I asked officials why the PDs got their way with the treatment purchase fund, the following response is illustrative of responses:

> *It is the nature of coalition government – that happens in anything, at some point. The party that is not in charge of the policy turns around and says we want our slice – that happens in every coalition to date. And it will happen in all future coalitions. It's a question of having a big government strategy foisted on you without any of your ideas, given that they had already taken away what we saw as very important [the common waiting list], that was a bit rich* (IV 18).

I asked various health officials if the common waiting list would appear in earlier health strategy drafts. The response was consistently no. One response was:

> *We could not be seen to be producing a document that was so entirely at odds with what was subsequently decided by government. Unfortunately in FoI days, there is always a nuancing of documents that are prepared for this purpose. It would have created a political difficulty if it was showing strongly that a group was advocating one particular approach that was entirely set aside and replaced by another...* (IV 5).

The policy process/window section shows clearly how the NTPF emerged as an alternative to the introduction of a common waiting list, during the health strategy policy development process. It was a PD proposal which gained political traction and was successfully implemented by a department that was angered by its announcement and proposed 'solution' to long-waiting public patients.

7.5 Conclusion

This policy process/window section draws heavily on a few key interviews. These people witnessed first-hand these events and therefore it is told in their voices. Also, all components that are told, sometimes at length, have been verified by at least one other interviewee.

The NTPF policy process tells an important story in Irish health policy. All interviewees are in agreement that the NTPF emerged during a much larger health strategy development process. The documentary analysis also found this. However, what the interviews add to the documents is that the NTPF emerged as an alternative when a much bigger health policy proposal – a common waiting list, 'a nirvana' – was rejected.

The interviews expose the fact the Department of Health officials and the Minister for Health avoided dealing with key financing issues in the health strategy ie whether to change to a universal-insurance model. They also reveal that they sought to address the unequal access to hospital care in Ireland through the introduction of a common waiting list for all patients, public and private. But these were both rejected. The key reasons given by interviewees for not introducing a common waiting list was the government did not want to confront hospital consultants or to upset the privileged half of the population with insurance who had speedier access into public hospitals.

Some of those leading this process thought they had got support for a common waiting list. However, when it was discussed at one (or a few) high-level political meetings in September 2001, it was rejected on the basis that it would upset the status quo for half the population who had health insurance – who happened to be the half of the population with privileged access to public hospital care. In other words, if implemented, the insured half of the population would wait the same amount of time for diagnosis and treatment in public hospital as public patients. If achieved, this would have contributed to addressing the fundamental inequality in the Irish health system.

From this rejection, the alternative idea of the NTPF emerged, 'out of the ashes'. The NTPF idea seems to have been worked up solely by the PDs, specifically by Oliver O'Connor, adviser to Mary Harney, the then Minister for Enterprise, Trade and Employment. While department officials were not lobbied specifically for such a fund, there was at least one meeting between the most senior official in the Department of Health and a representative of private hospitals. There it was proposed that private hospitals could assist the public system in providing care that the public system was unable to do as it was operating over capacity, if paid accordingly.

The NTPF, which became such a mechanism, was announced publicly without the prior knowledge of the Minister for Health, Micheál Martin, or the Department of Health, even though it was weeks in advance of the launch of the government's new health strategy, in which the PDs were a partner.

The Department of Health and its minister were not happy with the idea of the NTPF but lived with it as a compromise. According to four interviewees, these types of compromises are typical of coalition governments, where the smaller party wants to have a say in a large policy, in which they did not have much input. This policy process clearly demonstrates the power the PDs had in government, a strong ally in the Minister for Finance and the perceived powerlessness of the Department of Health and its minister, Micheál Martin.

The NTPF was set up to buy private care for long-waiting public patients, rather than 'fix' the cause of the long waits in the first place. Critics of it say it was typical of a PD proposal, finding a private-sector solution to a public-sector problem, rather than fixing the public sector in the first place. Two other interesting findings emerge from the interviews. Firstly, the difference between the perception

of the interviewees that it was a success and the reality that, 10 years later, over 26,000 people remain waiting over three months, the target set in the 2001 health strategy. Secondly, that while there was not direct lobbying for such a fund, the private hospital sector was lobbying to carry out more public work. The establishment of the NTPF resulted in hundreds of millions being spent in private hospitals, which, according to some interviewees, made them viable and profitable.

The emergence and implementation of the NTPF is indicative of the power of a small party in coalition politics, where a particular ideology prevails and where the party has strong ministers to persevere, even when the policy was contrary to the advice of government officials and the wishes of the Minister for Health.

Chapter 8

Case Study 3 – Co-location interview data analysis

8.1 Introduction:

As outlined in chapter four, a conceptual framework was developed drawing on a range of public-policy and health-policy literature. The interviews are analysed here drawing on the conceptual framework following headline themes and variables. Seventeen out of the 21 interviewees answered questions in relation to co-location. The findings are outlined using the themes and variables of the conceptual framework as detailed in tables 4.2 and 6.1.

8.2 Policy characteristics

8.2.1 Severity of the problem

As outlined in the documentary analysis, the rationale behind co-location was the requirement for additional hospital beds to meet growing demand and make up for severe reductions in bed numbers in the 1980s and 1990s. Everybody interviewed for this research agreed that in 2000/1 extra public hospital beds were needed.

> *The health strategy had promised 3,000 [hospital beds]... So the problem we were faced with is how are we going to produce these additional hospital beds?* (IV 5).
>
> *Obviously a huge one was extra beds and capacity was required* (IV 10).
>
> *We need extra beds* (IV 16).

By 2005, when co-location was announced, there were some, albeit a minority, who felt that more beds were not necessarily needed: what was needed was the better use of existing beds. Ten interviewees are quoted in this section. The quotes are illustrative of the tone of comments in relation to the issues outlined – the lack of investment in public hospital beds, the perceived inefficiency of the public hospital system and how co-location was a mechanism to address unplanned and uncontrolled development of private hospitals as stimulated by the changes to the Finance Act in 2001 and 2002.

Lack of investment in public hospitals

There were varying opinions from the interviewees as to the precise causes of the shortage in public hospital beds. The most-quoted cause of the shortage of public hospital beds from interviewees was the failure of government to invest in the public health system.

Table 8.1 What interviewees said about lack of investment in public hospital beds

What they said	Who
It very quickly became clear, even in the middle of the boom that the public capital programme was not going to produce sufficient money for nearly the number of beds [3,000] that... was believed to be needed, so we began searching around for alternatives... The arguments for were the ones I just summarised: 'Forget using public money for this – we do not have it'... But that was certainly the starting point: absence or shortage of money.	IV 5
The capital programme got sidelined. There were good intentions – to make a 50/50 investment in acutes and non-acutes... Getting the system to respond was very difficult... You follow the money... roughly from midpoint of the last decade. We had very few additional beds... in the public hospitals.	IV11
Co-location did ultimately go back to the same thing. We need extra beds. We are not going to get them the money to build them...	1V16
They [consultants] felt there was not going to be any money from central government to build anything of note, which is true.	IV19

Among interviewees, there was general recognition that despite increases to the health budget after the publication of the health strategy, the shortage of public hospital beds was caused by the failure to invest in sufficient additional public hospital beds. This was given as the headline reason for co-location – to free up 1,000 public hospital beds by building private co-located hospitals. This point was made by a majority of interviewees, although it came across more strongly from those working within the Department of Health or in the public health system.

There was also a widespread belief that the public patients fared badly in the public hospital system. In the words of one senior official from the Department of Health:

> *There was always a feeling in the public system, and I am talking about the public system generally, that we had a dreadful, an appalling, system; that the public patient in the public hospital would always lose out, and especially with the increase in numbers with health insurance (IV 11).*

Inefficient public hospitals

There was also a strong belief among interviewees that there was a perception that public hospitals were inefficient and that private hospitals were efficient. The logic of this perception was that it was more realistic to support private hospital development (in the form of co-location) than to attempt to reform the public hospital system.

Table 8.2 What interviewees said about the inefficiency of public hospitals

The relative efficiency of hospitals, if you look at the HIPE [Hospital In-Patient Enquiry] data, look at the length of stays, the DRGs [Diagnostic Related Groups], there are some extraordinary difference...	IV5
It's how you manage those beds, it's nothing at all to do [with] bed blockers. Any where you go in the world will have complex discharges... It's just the way it is managed... If for 10 years this amount of beds are blocked by complex discharges, you need to restructure your hospital. It's how you manage and structure your hospital: that's the problem, but they don't change that.	IV9
I think she [Harney] saw the problem as pouring €10-, €12-, €13-, €14 billon into the HSE. That the public sector was a complete and utter disaster, it cannot be fixed. And the only solution was to create as much capacity as possible in the private sector.	IV14
Overtime rates are the stuff that makes the health services very inefficient – perverse incentives. You could earn up to 20 times your hourly rate treating after six o'clock, so guess what: productivity was enormous after six o'clock and not great before it. That was all-pervasive.	IV16

Specifically, the long lengths of stay in public hospitals, the costly overtime rates, the failure to find appropriate accommodation for 'delayed discharges' (bed blockers) all contributed to the belief among interviewees that the public system was inefficient. In this context it was also pointed out that Mary Harney believed that the large amounts of money being invested in the public system was a waste and that solutions lay in the private sector.

> *According as a problem arose, there was a private-sector solution devised for it... As there was a problem with inpatient beds, which they accepted, the private sector will do it through co-location. You name it, there was a private-sector solution first (IV 18).*

As outlined in chapters five and six, the tax breaks given in 2001 and 2002 meant private hospitals could be built anywhere they got planning permission. Quite a few interviewees believed co-location was a way of putting a framework around the tax breaks, so that private hospitals were built in line with health policy and need. Co-location was seen to address this problem of unbridled private hospital development and also allowed for close co-operation with public hospitals.

Table 8.3 What interviewees said about co-location utilising the tax breaks

My own take on it was... that it was a hamfisted attempt to do what should have been done in the first instance [with the tax breaks]... You seek to correct the governance, the clinical governance and the corporate governance gaps that were created by going off in the first round and not putting any conditions on where the hospitals get built...	IV4
Those changes were not viewed as important, as they came to be viewed, until Harney became stronger on it and the whole co-location debate. I don't remember them being particularly controversial until co-location.	IV 6
Now that we have these tax reliefs, can we use it some other way and see what could be done. It's the old dilemma: there's someone with a need, someone with money; you put them both together and you can solve both problems. At the time, the public-private partnerships, in a range of government services, were being floated as the way to go, such as schools and so forth.	IV8
Someone has got to come up with an idea of co-location, to be honest I think. I would really much prefer to see it developed in that kind of framework, than in a piecemeal kind of way...	IV10

There was a general agreement among interviewees that the failure to invest in and deliver on public hospital beds, promised in the 2001 health strategy and the perceived inefficiency in the public hospital system were the central motivations for devising the co-location policy. Also co-location was seen as a way of remedying the unwieldy nature of tax breaks introduced in 2001 and 2002, which incentivised the development of private hospitals without any link to national health policy to ensure they were matched to population need and/or specialities.

8.2.2 Ideas for intervention

The proposed policy solution

As detailed in the documentary analysis section, co-location was billed as a solution to the shortage of public hospitals beds by freeing up 1,000 public beds in public hospitals, by 'migrating' the private patients to the private co-located hospitals. While a majority of interviewees said they disagreed with the proposal, there was complete consensus from all interviewees that, in their opinion, its intention was to do this. It is impossible to differentiate between what is being told with the wisdom of hindsight and what is not.

Table 8.4 What interviewees said about co-location freeing up beds in public hospitals

What was said	**Who**
If you can have co-located private hospitals on the site of the public hospital, why not do it in a way that shifts your private activity from the public to the private and that frees up your beds in the public hospital to treat more public patients?	IV5
Co-location would free up about 30% of public beds, that would allow hospital to restructure their bed stock... to move to a place that VHI was paying full economic value within the public hospitals.	IV 9
... so why can't we decant the private patients. And the volume of private patients as you know in public hospitals is huge, particularly in acute hospitals – so why can't we decant them over?	IV16

As detailed in the previous section, the shortage of public money and a failure to invest in public hospitals was a key driver of co-location. Harnessing the tax breaks in a more coherent and planned way was also a driver for co-location. The failure of successive governments to reform the public sector and a belief that the private sector was more efficient and cost effective were also given as rationales for the policy (as detailed in the previous section).

One interviewee who worked in the public health system outlined how it was a cheaper way to obtain 1,000 additional public hospital beds, although this point was contested by other interviewees (these points are made in the section below on 'opposition to the policy').

> *So the [co-located] beds are built, they are fully equipped, fully staffed, all you are replacing is the actual lost income for that [public] hospital and it can treat 20% more so for... There*

was €80 million of lost revenue, so you were getting 1,000 beds for €80 million, which in one sense is a phenomenal saving (IV 9).

Public private mix of hospital care

A majority of interviewees felt that the two-tier nature of public hospital care in Ireland and the public-private mix facilitated the development of co-location. Some felt, it would enhance the system by allowing greater co-operation between public and private providers, while others believed it further institutionalised an unequal system of hospital care.

Table 8.5 What interviewees said about co-location and the public-private mix

What we were looking for was closer co-operation between public and private systems... You will share costs, you will have much closer operational, co-operative relationship than we would have had with a purely PPP-style private hospital	IV5
It had to with the notion that public is public, and private is private. And if you had them both on one site, you'd get the best of all worlds. It's a PPP type of philosophy... but the notion is you should not have a confusion of roles, or you should not have people with conflicting incentivised payment systems.	IV 7
The concept was good: the project agreement in allowing the [co-located] site to work as one was very, very good.	IV9
Part of the rationale was that there was this parallel system running uncontrolled in the private sector... If you were responsible for the whole system, you were responsible for the whole system, so bring them closer together... Limerick and Beaumont had... put together a business case [for an onsite private hospital] with a policy rationale behind it, to put to the Department of Health. I am pretty certain part of the genesis for Oliver's thinking would have come out of looking at this business case, in inverted comas, which had the policy fix on it. So it wasn't just to make profit, but it fits in with the health agenda	IV10
We had people leaving the public hospitals, consultants rather, who would come in at say seven o'clock, do their rounds in the public hospitals and off they'd scoot to Blackrock Clinic, the Mater private, the Hermitage or wherever, and off they'd go, and they would not come back, if at all, till about five o'clock in the evening to do another round. So what value were we getting out of that? They were looking after their private patients both on and off site. I could not see the public patients getting a huge amount of value out of our consultants... How are we going to address the problem of more and more consultants spending more and more time off-site, and nothing being done... about it?	IV11

As detailed in the earlier section on severity of the problem, the failure to reform the public hospital system and its perceived inefficiency were commonly held views among interviewees. Associated with this view was a belief in the private sector, that given the absence of a public-sector solution, government should look to the private sector to build and run the private co-located hospitals.

This point was articulated by many interviewees and encapsulated by one owner of a private hospital:

> *They saw an ability for the private side to come in and build capacity that they could not see on the public side. Their views were that if we could come in and build a hospital quickly, they were going have more capacity...* (IV 19).

Another significant point coming from interviewees was that the co-located project as first proposed was of considerable benefit to the private developers, as it guaranteed patients and a full hospital, because private patients would be 'migrated' from the public hospitals. Plus it guaranteed staff as consultants would be facilitated to work in both the public and private co-located hospitals on the same site. As interviewees 15 and 19 stated, both of whom had interests in private hospitals, it took the risk out of it for private developers by ensuring both patients and staff – 'a win-win' situation… 'taking out two of the biggest risks'.

Table 8.6 What the interviewees said about co-location as a private-sector solution

The only thing going for it from a private hospital point of view was the fact that they were guaranteed the patients and they'd access to what would be the best consultants... so you have demand and you have consultants.	IV9
Part of the rationale was, the private sector should/would be prepared to take some of the risk of providing them [hospitals] and could provide them faster.	IV10
With co-location, the consultants were there and the patients were there, so it made my job infinitely easier. And I thought ... that it was a win-win for everybody, for public patients, for private patients, for the public hospital, for us. I see no down sides to it.	IV15
Because if I can be guaranteed to be opened up and be full on day one and have a full team of consultants on day one, I have taken out the two biggest risks....	IV19

While there was broad understanding about the intention of co-location, a majority of interviewees interviewed for this research opposed it as a proposed policy solution. This is detailed in the following section.

Opposition to co-location

A small minority of interviewees supported the co-location policy. Of these, two were closely involved with its provenance, two with implementing it and one who bid for one of the co-located hospitals. And while some were initially welcoming of it, they became opposed to it as it was implemented in a slow, incoherent way. While the implementation of the policy is not the focus of this research, it is an important part of the policy process. The issue of its implementation, or non-implementation, as it turned out, is dealt with in the policy process/window section 8.4.

What follows is an outline of the main opposition to the policy and an alternative which emerged from it. The opposition to it reflects the public and political discourse at the time, which is detailed in the 'politics stream' in the documentary analysis in chapter five.

Reinforcing the two-tier health system

The most-voiced concern about the proposed co-location policy was that it would reinforce rather than remedy (as outlined above) the two-tier nature of public hospital care. As detailed in chapter two, the Irish health system was organised so that both public and private patients have access to public hospitals, and private patients gain speedier access and their care is greatly subsidised by public money. While co-location aimed to 'free up' the beds occupied by private patients by 'decanting' them to the co-located private hospitals, opponents of co-location felt this was unlikely.

Table 8.7 What interviewees said about opposition to the co-location policy

What they said	Who
Our board took a decision on co-location... that it was wrong to have patients, two lots of patients, private patients turning left and getting a great service in the co-located hospital and public patients who couldn't afford it, having to turn right and wait in a queue. It crystallised that conflict...	IV12
That was a daft idea from the start... It was another master stroke, we needed a 1,000 beds or more and they came up with this brilliant idea of privatising the building of those hospitals and then only transferring the private beds.	IV14
I am on the public record as opposing it. I don't see why there should be separate doors for people, public and private.	IV15
I could not say, look if you do that, this will be the workhouse and that will be the private hospital. But that's the worry and concern that people had [in the Department of Health]...	IV18

I became very convinced that this represented an extraordinary exacerbation of the two-tiered system. Why would you do it? It became this 'decanting' argument, it's a terrible word to use about people... But it was an argument that completely ignored the reality of the nature of hospital care and the nature of private hospitals and that really what you were doing was creating a fast-track elective facility for private patients that was really even faster than what you were getting already.	IV20

Opponents to the policy outlined how the public hospital would lose out due to a loss of the revenue it was getting from private patients as the patients would be 'decanted' in to the private hospitals on site. While proponents of the policy said that the public hospitals would be reimbursed, those opposing it did not believe this would happen. Some interviewees also said they did not believe that the most critically ill patients, who are usually the most expensive patients to care for, would be in the private hospitals, as private hospitals would not provide the complexity of care necessary. These concerns outlined by the interviewees reflect much of the public and political discourse at the time as detailed in chapter five.

Table 8.8 What interviewees said about how public hospitals could lose out under co-location

The problem with the co-location model was that it created the 1,000 beds but where is the funding to keep those beds open for public patients when you move them out? It was going to take the revenue stream attached to those patients, what the insurers pay to those public hospitals was going to go, so you were going to create a double hit...	IV14
My argument was the complex private patients would be treated in the public hospital... and thereby you'd have created your private capacity but you are still treating your private patients, particularly your more complex ones, in a public hospital. How's all that going to work? [Co-location] moves private patients and activity from public to private hospitals – that assumes that the private hospitals is sufficiently constituted and organised and a much smaller entity generally to provide the full gamut of private specialities that are currently in the large public hospitals. How is that going to work in terms of volume... and safety?	IV5
You were still going to have that competition going with the acutely ill medical patients competing for elective beds with the public patients, and the privately insured acutely ill medical patients probably should not be in this private facility –	IV20

they probably should be in the major hospital	
Arguments against were many of which I would have been a strong arguer, eg, huge concern about constructing it in a way that did not simply allow private hospitals into a space where just they did not take the public money and ran... How could we be sure that they would operate the way we would want them to do in partnership with the public system and huge concerns that this would actually be genuinely implementable.	IV5

Alternatives to co-location

Alternatives to co-location were suggested by just two interviewees. At the time of its announcement the opposition was widespread and the case for public investment in public hospitals was still being widely made. This is evident in the fact that all political parties campaigned for the 2007 general election with the promise of additional public hospital bed capacity. By 2010-12 when the interviews took place, Ireland was in the midst of a severe economic crisis, when such alternatives seemed unlikely due to unprecedented cutbacks in public expenditure. This probably explains why alternatives were not being suggested in the interviews.

One alternative came from a representative from the IMO. The IMO opposed the co-location policy at the time of its announcement. He spoke about their counter-proposal that new hospitals would be built on the grounds of private hospitals, but for elective cases only:

> *We lobbied aggressively. We produced a position paper on it, which we launched at an AGM, specifically to deal with the fact that it was going to copper fasten two-tier medicine. And we came up with a counter-proposal, we said this is a good idea to build up separate capacity to provide elective care which is predominantly what happens in private hospitals. The only issue is it's providing it to the wrong people. We should separate a stream for elective care and provide it equally to public and private patients and try and rescue the space from the bigger, emergency driven hospitals to cater with emergencies and deliver the more highly complex stuff... This would create capacity and access to it should be based on need, not ability to pay. The HSE should pay for public patients, the insurers for private patients, that was the plan and we produced a paper on that* (IV 14).

Another interviewee outlined the incoherence of co-location, from their perspective, and how it could be remedied under a universal-insurance system:

> *When it was apparent that the public hospitals needed public capacity, if you wanted to use PPP fine, to build a block of elective care which you would ring fence from the rest of the*

public hospital... I remember saying to people, look if the worst comes to the worst and it happens, ok there will be additional capacity. And in a universal system, there'll be additional capacity for everybody, so it's not the end of the world. This is an irrational policy that can be dealt with rationally; its consequences can be dealt with rationally (IV 20).

What this and other the policy opposition content show is that while a majority of interviewees said they opposed the co-location project, few 'alternatives' were developed after its announcement. And alternatives aired at the time – making the case for increased public investment was no longer made by the interviewees reflecting the radically altered economic environment by the time of the interviews. It could also be explained by the extent of political support for co-location at the time of its publication (as detailed in the 'political contexts' section) and the preoccupation by and distraction of departmental officials with the establishment of the HSE that was happening simultaneous to co-location.

Policy transfer

Each interviewee was asked was whether co-location was an example of policy transfer. Most responded by saying did not know, or no, or by answering with a different response.

Three responded with yes and while one said 'no', he acknowledged that he was aware of similar, but different, models in Australia.

Table 8.9 What interviewees said about co-location as an example of policy transfer

There are some in Australia, when we looked and did not see many examples. When they did, they happen from default in a campus like the Mater rather than sponsored by government	IV4
There was a similar initiative in the UK. Bioplan... they were going around the UK building private hospitals on the grounds of public hospitals, very virtuous, sharing the public hospital services... They went bust in the end	IV12
I know we looked at PPPs and the experience from other countries and again there was a sceptical view as to how successful the PPP model was...	IV5
We looked at loads of countries, desk based, mostly, loads of places, South Africa, Australia, New Zealand, Britain. So we looked at those kind of models: how do you procure things differently, what are the risks, and all the rest of it.	IV10

There were differing views from Department of Health officials as to whether they looked at

international models as the basis for choosing co-location as a policy. Two out of the four officials still in the Department in 2005 said they did not know if the Department looked at international models, despite being in very senior positions there at the time. One departmental official said the department did not look at international models while another said they did (IV 5).

One interviewee explained (as detailed in the policy window section) that as the management consultants hired by the department to work up a 'strategic and investment appraisal framework' and 'draft evaluation criteria' on co-location (Prospectus, 2005), they did look at international models but only after 'the political decision was made'. This could explain why the other departmental officials were unaware of the department looking at other countries and also would indicate it was a post-hoc, policy transfer, ie international models were used to justify and inform a political decision that was already made.

Four interviewees responded that the co-location plan was influenced by the public and private hospitals on the campuses of St Vincent's and the Mater, three of these were private sector personnel, one was from the public sector.

Table 8.10 What interviewees said about on co-location as 'homegrown' policy transfer

It was largely as a concept being modelled on what the Mater private/public, co-located cooperation... she [Harney] would have looked at it and seen it as impressive... if she was scratching her head and thinking how do we get private sector involvement? And she knew of what was happening in the Mater or in Vincent's	IV4
We also looked at the Irish constructs: we looked at the Mater Public/Mater Private. There were a couple of proposals on the table, for example, there were plans for the development of a private hospital on the site of Limerick regional. So there were again things which raised policy issues.	IV10
I suppose the Mater would have been seen as been a real success, it had massively over taken Blackrock in terms of numbers of patients and successes of business and even quality wise ... and it had the advantages of co-location. I think the Mater campus demonstrated it	IV16
Vincent's and the Mater are doing it now, and James's and Tallaght tried to do it. That'll be resurrected I am sure	IV11

The interviews demonstrate that, while there some international models in place, the co-location plan was more influenced by existing co-located Irish private hospitals on the grounds of major public teaching hospitals. And that it was only after the 'political decision' was made and the department put out to tender for technical advice on the plan, were international models considered.

8.3 Actor power

8.3.1 Guiding institutions

The section on 'policy entrepreneurs' and 'political contexts' detail the extremely strong level of political priority given to co-location by Mary Harney and her political adviser Oliver O'Connor.

Role of the Department of Health

Three of the four government officials interviewed for this research who were in the Department of Health in 2005 distanced themselves from the decision on co-location. Two out of three of Department of Health officials, who were in the department at that time, said that it was a choice that came about quickly, without much or any knowledge of senior officials in the department. Given that they were each on the senior management team – the Management Advisory Committee (MAC) – in the Department, I queried how they could have been unaware of it. When I put this to each of them and asked 'How close were you to it?' I got the following responses:

> *In relation to co-location, I had the least involvement. In my view, that was derived from a decision I was not involved in* (IV 1).

> *I haven't been directly involved in it but I will answer as fairly as I can for it ... Now I am not as certain on this as I am on the other businesses* (IV 11).

> *My usual answer: not very close to it. [The decision was] a political one..* (IV 18).

Given their senior positions within the department, it's would be unusual they were as distant, as they claimed to be, from the policy's development. One senior departmental person interviewed for this research had left the department before it was agreed as a policy. Given that the policy was announced in summer and he left in late spring, again this seems unusual. Whether they were aware of it and/or involved or not, their responses confirm that there was not support from these senior officials within the Department of Health for this policy. The other departmental official said he was involved in discussions about co-location in advance of its announcement, although in an informal way.

> *We did not have a formal group, but certainly I recall being involved in discussions of this kind* (IV 5).

This opposition is also reinforced by the fact that some of the most strident hostility to the policy came from those interviewees who were departmental officials. Further evidence is available in the section dealing with the non-implementation of co-location outlined in 'policy process/window' section.

Another issue which came up was the lack of oversight of private healthcare development by the Department of Health. Six interviewees brought up this point – the fact that the department did not have such a remit created a space for private developments, interestingly all six of them came from the public sector. While this point came up by interviewees usually in the context of the Finance Acts and the NTPF, they reiterated it in relation to co-location.

> *It [oversight and planning of private healthcare] was never developed to the point it was meant to be developed... it's one column in the 1998 white paper.... if the principle had been accepted... it would have captured ... co-location. It would have meant the department and the public system accepting that... they would not be in full control of what they wanted on their capital programme...* (IV 10).

This point was reinforced by a senior official from the department and a senior political person.

> *The health strategy... made reference to greater co-operation with the private sector... but we did not do it... If you step back a little bit and look purely at it from a policy level... everything... points to one thing: lack of planning and coherence and a framework. They all come back to that and again* (IV 11).

> *The health officials alluded to not keeping an eye on the private sector* (IV 21).

No other government department was involved with co-location and the HSE's involvement is dealt with in the policy process section.

8.3.2 The role of policy entrepreneurs

The documents do not reveal who drove the co-location development, although the letter issued to the HSE by the Secretary General specifies that Mary Harney felt co-location 'offers a practical and relatively inexpensive method of providing significant additional capacity for public patients' (see political ideology/institutions section below).

Each interviewee was asked 'who led its development?' and 'was there a policy champion?' The vast majority of interviewees believed Harney and her adviser were the key initiators and drivers of co-location. Four interviewees did not talk about co-location as they did not feel they were close enough to it. Of the other 17, most named Mary Harney and/or her adviser Oliver O'Connor as central to developing and championing co-location.

Table 8.11 What interviewees said about policy champions for co-location

What was said	Who
On Co-location... it may have been one of the issues myself and Harney would not have seen eye to eye on.	IV 1
Mary Harney very much, very much her, and Oliver [O'Connor] was very wedded to it...	IV 4
I think Oliver O'Connor was closely involved in it...	IV 5
It had Harney/McCreevy written all over it.	IV 8
I think Harney and O'Connor... It is a great example... it's something where a powerful minister, with a powerful position, in a relatively precarious government, uses that power.	IV 9
As far as I know it was Mary Harney's... it was a PD proposal	IV 11
Co-location is ... part of the grand masterplan... Driven by Harney... and O'Connor	IV 14
I assume it was Mary Harney...	IV 15
She [Mary Harney] was meeting doctors all of the time and of course many of the doctors would have seen it as an opportunity for more private capacity.... I have not met Mary Harney all that often. I'd have seen her... or I'd bump into her but I never had a conversation with her about co-location. Oliver, I would have certainly had one or two, but it was beyond the genesis at that stage	IV 16
I think it was a PD initiative rather than it came from the civil servants.	IV 17
I think Mary Harney might have heard it from consultants and said it to Oliver – lets work up this idea. And they commissioned xxx to do a paper on it.	IV 19

When asked if Oliver O'Connor was the architect, the response from one senior health official was

> *Oh I would imagine so, I would imagine so yes* (IV 18).

When I asked another senior health official (who was trying to distance himself from co-location) 'if co-location was a political choice?' he replied:

> *It was a rational response; it probably came from, those sort of conversations she [Harney] had had...* (IV 11).

A senior political person not involved in health in 2005 when co-location was announced agreed that it was driven by Mary Harney and Oliver O'Connor. 'Absolutely I'd agree' (IV 21).

Another interviewee who participated in the bids for co-location spoke about how many people claimed responsibility for it:

> *Everyone claims to be the origins behind it... There is a consultant in Waterford whose names escapes me, who said he proposed such a thing to the minister. St James's hospital said they came up with the idea. And then it was supposed to be Oliver O'Connor's idea as well... There were a couple of consultants who were very, very keen on it* (IV 19).

In relation to co-location, it is clear that the policy was politically driven and led by the minister and her political adviser who were the policy's entrepreneurs.

8.3.3 Private sector interests

Due to the high level of political involvement in the co-location policy, there was a perception among interviewees that politicians were lobbied for the decision to be made. Each interviewee was asked this question.

The minister said at the time that this idea had been brought to her attention by hospital consultants. However, medical representative bodies, including the Irish Hospital Consultants' Association (IHCA), spoke out against it at the time and said in the interviews they had not lobbied for it. Harney said at the launch of the policy that individual consultants had spoken to (or lobbied) her, while some interviewees felt they would also have been talking to her adviser, Oliver O'Connor.

> *I have heard consultants say that myself, nothing to do with Mary Harney. Long before Mary Harney came into the department, I've heard many consultants saying it to me...* (IV 11).

A chief executive of a private hospital concurred:

> *But sure, she was meeting doctors all of the time... Many of the doctors would have seen it as an opportunity, there'd have been that side of it, but also it was an opportunity for more private capacity potentially, if you had more private capacity on campus* (IV 16).

Organised lobbying by the consultants' representative body was denied:

> *Q. Were you aware of specific lobbying at the time?*
>
> *A. Not specifically for the co-location project...* (IV 8).

Department officials denied they were being lobbied, but some felt that consultants were lobbying politicians:

I would say they [Harney and O'Connor] probably were talking to consultants who might have been involved in private hospitals (IV 18).

Another representative of one of the medical bodies thought there was lobbying although he had no specific evidence to back up the claim.

I would suspect that there were developers in there saying, 'If you give us those tax breaks we can build those 1,000 beds on those sites for you' (IV 14).

Another chief executive of one of the private hospitals when asked if there was lobbying said:

I really do not think so... It [co-location] landed out of the blue; it was not something that was the subject of speculation or lobbying that I was aware of... My own take on it was that there was no lobbying for that... (IV 4).

An interviewee who worked for the Independent Hospitals Association of Ireland (IHAI) in 2005 said they did not lobby corporately but individual members may have done so.

Not the IHAI is my memory of it. But again [individual] people like x, x, x might have been asked for their views, they could have been... (IV 17).

So while there was a belief that co-location was lobbied for by hospital doctors and developers, it would appear that consultants' and private hospital lobbying took place informally or on an individual ad hoc basis, rather than by their representative groups. There is no evidence to back up developers formally lobbying for co-location in advance of its announcement.

One interviewee who bid for a co-located hospital, when asked if he ever lobbied, responded as follows:

*I never met McCreevy; I met Cowen once, after the May '07 election. We had just tendered – it was a big election issue... So after the election, I got a call one day to here saying, 'This is Fianna Fáil headquarters, Brian Cowen would like to meet you.' So I said 'when?' [They said] 'Come in now, we'd like to talk to you about co-location.' This was when he was negotiating with Gormley [the Green Party leader, with whom they were about to go into coalition with after the 2007 election]. I met him at three o'clock for an hour and a half. He said, 'I want you to explain to me about co-location, I am hearing all sorts of things about it, why should we do it?' I said capacity... all the arguments for it. He said, 'I think this is a f***ing good idea. I am going to give Gormley some smoke and sh*te like that.' And I said, 'Thanks be to god because I have spent a fortune doing these tenders.' We opened the hospital in November '06 but we had started the tender process the previous April and then there was 6 months of competitive dialogue ...* (IV 19).

This meeting took place nearly two years after co-location was announced so while it does not show that private hospitals lobbied in advance of the decision to co-locate, it demonstrates a particular type of personalised politics, whereby ministers sought the advice of owners of private hospitals on health policy matters. It also shows the readiness with which a hospital owner will seek to influence a minister to continue a project on which he has 'spent a fortune'.

8.4 Political contexts

8.4.1 Ideology/political institutions

The vast majority of interviewees who responded to questions on co-location felt that the co-location project was very clearly a politically driven one, by the then Minister for Health, Mary Harney, and her adviser, Oliver O'Connor (see section 8.3.2 on policy entrepreneurs for more on this). A minority of interviewees, all of whom worked in the health department, spoke about the ideology that drove the project and the importance of coalition politics in enabling it to happen.

> *I don't believe there was any degree of rigorous analysis behind it [co-location] and I suspect it was aligned very closely with the tax changes and the imperative of creating an investment climate... You can put any policy choice on the axis with co-location as an example of a purely political process... Don't expect to hear too much about policy involvement... Co-location: that just arrived* (IV 1).

Another departmental official felt Harney and her belief in the private sector were key to its adoption.

> *Look, number one, we have Mary Harney as minister and Tánaiste: we had therefore a much more overtly... private-sector sympathetic person in the department, who said, 'Why are we looking to the public sector the whole time to produce it – why don't we harness the private sector?'* (IV 5).

An additional departmental official agreed that the decision to adopt co-location was

> *a political one... it was ideologically driven, it did not come from the ground up in the Department of Health and Children* (IV 18).

Other interviewees felt that coalition politics, and specifically the PDs, played an important role.

> *It is a great example: it's something where, a powerful minister, with a powerful position, in a relatively precarious government, uses that power... (IV 4)*

It was politically motivated. Here was very definitely a political solution to another medical problem. It had advantages for a range of people who would have been closely aligned for the prevailing political wind at the time, primarily builders and financiers (IV 8).

Obviously, the minister and Oliver and her advisers said: 'This is the plan' (IV 9).

As far as I know it was Mary Harney's – it was a PD proposal (IV 11).

And I think it was a PD initiative rather than it came out of the civil servants (IV 17).

The ideology of Harney was referred to by a few interviewees and in terms contrary to her Harney's inaugural statement as Minister for Health:

She was the one who paraphrased Thatcher... She said, 'I am not interested in ideology, it's about what works.' That's almost word for word what Margaret Thatcher said. She was pursuing all this 'cause she believed it worked, and she's not alone in that. Lots of people believe that the public sector is not the way to deliver anything, never mind healthcare, and particularly not healthcare where there is lots of profit to be made. And therefore it's an attractive thing to privatise... We already had a private sector... and I think she pursued that, she really progressed that along (IV 14).

It's the same old thing... Harney and Oliver were deeply ideological. I have no doubt about that... (IV 6)

Ideology was also brought up in relation to the Department of Health.

I can distinctly record one session, where I think the department officials view was this [co-location] was ideology... eventually it was verbalised, they felt they were non-ideological, and that this was ideological... I think the feeling in the department was that they were neutral and this was, we were radical, 'right-wing' things coming in, whereas actually I think they were not... (IV10).

This same interviewee who had close relations with Oliver O'Connor and described how co-location fitted with O'Connor's view of the world:

If you look at in a political way, what is the problem, run down the problem list... maybe that's how it came about... You do your risk matrix. I think it would fit Oliver's 'positive destructive' model, the rationale works on a few levels, doesn't it? I think that it challenged the system because as Harney often argued, it was arguably more pro public patient than against. The state had forever been subsidising private patients and private practice within the public system, which was cracked, and then not even invigilating it (IV 10).

Another senior departmental official also believed the policy was proposed in the public interest:

> *I can honestly say in my conversations with Oliver and Mary Harney, when she was minister, I have always felt very strongly listening to her in particular, that she had a real strong commitment for the public patient to be treated as quickly as possible and that there was an appalling inequality going on in the public system. And one way of dealing with it was to accept the reality of it, of everything that I have said* (IV 11).

Another private hospital chief executive explained how what emerged was so skewed in the public interest that they did not bid for it.

> *I always thought it was funny that while ideologically there was a debate, a storm raging, that this is a terrible mortgaging of the health service to the private sector... To me the issue was that had already been done... with the tax breaks, where hospitals were built wherever people happened to have land. In fact, co-location, this was more measured more controlled and ultimately too protecting to the public interest to the detriment such that we effectively withdrew – we said this won't work we won't be able to make money from this at all, and some of the stuff you were requiring us to do is just mad* (IV 4).

There was a strong consensus among interviewees that co-location was a political project. Some believed it was made possible by the powerful position of Mary Harney and the PDs in coalition government despite their small size and that it was ideologically driven, in line with PD's politics. Many felt it was driven by the minister's and her adviser's belief in the private sector, while a small minority of interviewees believed their intention was in the public interest.

8.4.2 Policy process/window

A majority of interviewees with knowledge of the co-location policy who were outside of the Department of Health expressed a surprise at the announcement of co-location, with most stating that they did not know about it until the day of its pronouncement.

Two private hospital chief executives recall the day the project was announced:

> *I was around when that letter landed; it landed out of the blue... I can remember reading the letter from Mary Harney to Liam Downey. The reason it sticks, it was July 2005, is because I can remember reading it thinking this is remarkable, this is a turning point, this is official policy. It clearly has not been grown organically in the HSE and it was obvious when I started making phone calls that nobody knew how it was going to play out* (IV 4).

> *The first I heard of it was July 14, 2005, when I saw the note from Michael Scanlon to Liam Downey and the press release for it and I was terribly excited* (IV 19).

A senior official who was responsible for implementing the co-location strategy was asked if the HSE was involved in advance of its announcement. His response was as follows:

> *The co-location decision from the HSE's point of view was made by a letter from Michael Scanlon to Liam Downey saying this is the policy: this is how we want it implemented and implement it* (IV 9).

This verifies the detail in the documents published on the day and subsequently – that of a policy direction to the HSE – that the HSE management and board were completely unaware of the policy in advance of its announcement. Given that the HSE would be the main implementers of the policy, it is unusual that they were not involved in the policy's development.

The documents do not help establish the timing of when the policy originated. One official central to its implementation said he was asked to write a briefing paper on such a proposal. When I asked about the timing of the paper he wrote, he said

> *Co-location would have been dreamt up before that paper, it was always going to be the next NTPF.... in discussions with Oliver, between September and December 2004. At the end of 2004, I wrote, actually I wrote a paper on co-location for the department* (IV 9).

I requested the paper under Freedom of Information and through professional and personal contacts in the Department of Health. I was told it never existed. The author of it said he could not give it to me, so I am unable to verify its existence. However, the timing as suggested by this interviewee coincides with the arrival of Mary Harney to the Department of Health on 29 September 2004 and the timing specified by the management consultant who was commissioned by the department to do the work on co-location for them, as detailed in chapter five.

One senior official from the department who was aware of co-location concurred with this general timing:

> *Michael Scanlon was secretary general at that stage. He took up office in health in April 2005, so a lot of ground work was done at that stage. Himself and Oliver and the minister and people working in the acute hospital sector would have pulled together the whole argument and would have said look, this is the best way to do this* (IV 5).

One interviewee who worked for the management consultancy firm who won the tender to develop a 'strategic and investment appraisal framework' on co-location backed up this point – that a small group of people in the department worked on a proposal for their political masters and put out to tender for technical support on it.

> *When Harney took over and Oliver O'Connor moved with her into [the Department of]*

health. The first time, I became aware of the co-location... like many other people... around that time, we would have done a think piece, which Oliver would have received... One element was about estates, sweating the assets of the huge estates of the health boards, that there must be ways of putting this huge territory to more effective use... I recall Oliver O'Connor in discussion with me about this idea of fixing a few things... In fact one of them was by not having the free fire Wild West, Charlie McCreevy instigated that [by free fire Wild West, this interviewee meant the that the tax breaks allowed private developers to build private hospitals wherever they wanted and would be subsidised by public money]. They saw that, even at that early stage, as fragmenting... the good, so to speak. We certainly had an early discussion... so Oliver was developing the idea of doing more with the large campuses... we never suggested anything close to co-location... They brought the political idea to a certain point, I think I might have had two sessions with them, at which he was testing things which had more shape each time. So obviously he was working them up... They worked the idea up to a certain point (IV 10).

I asked who he meant by 'they'?

They, Oliver and I presume Mary Harney or whoever. But the only one I had visibility of was Oliver. What happened was that they worked up the political idea, the policy idea. It was worked it up as I understood it at a political level and the evidence of it is this: is that they then came to the market. There was a tender for support for the Department of Health to help them put policy framework around this political idea and we won that tender... When I say there was a tender, the only bit I saw was, we were asked to tender and we did. So it was a project for us, from them [the Department of Health]. I don't know who else was asked to tender but it was a formal process we went through... It was straight procurement; in that sense it was proper. What was interesting then was, in the first place, when you think about why did the department need to formulate policy around a topic like this ... Well you have the usual reasons. They said, 'We have to do it...' I can only guess that part of it was the political regime wanted it done fast... maybe they felt that people were too institutionalised in the mindset that we talked about I

Another interviewee, who subsequently put in a bid to build and run one of the co-located hospitals, backed up this version of events:

I think Mary Harney might have heard it from consultants and said it to Oliver 'let's work up this idea' and they commissioned xx [management consultants] to do a paper on it... xxx did some analysis for the minister and came and interviewed us in that he said he'd been asked by the minister to do the proposal going forward (IV 19).

The management consultant who did the co-location work for the department explained that what they submitted was virtually word for word what was published at the time of the announcement of co-location in July 2005.

> *The document that was issued on the 14 July 2005, which was the policy direction to the HSE around what became known as co-location, that was really the output from our advice from the project, with a harp stuck on it. I am not saying that is wrong – often the department would commission technical consultancy – though it has to be said, this was about policy with only one phrase altered as far as I can recall... the brief was a three-, four-week exercise, maybe six-* (IV 10).

While the quotations above draw heavily on this one interviewee, they are central to this specific policy-making process and every point used here is triangulated ie backed up by someone else who did not know I had this information from another source. Also, as outlined in the methods section, the two key proponents of the policy refused to be interviewed for this research. The point that this interviewee made is central to the policy window:

> *What happened was that, they worked up the political idea, the policy idea... it was worked it up as I understood it at a political level, that part of it was the political regime wanted it done fast... maybe they felt that people [in the Department of Health] were too institutionalised in the mindset that we talked about* (IV 10).

These quotes, along with the contents of the 'actor power' section, paint a clear picture – that co-location was proposed to the then Minister for Health, Mary Harney, by hospital consultants, that she asked her political adviser to consider the policy, that he talked it through and worked it up with a small number of departmental officials, and then it was put out to tender for technical advice as they were aware of the opposition to the policy within the Department of Health.

This is a good example of where the problem stream (the shortage of hospital beds), the policy stream (the co-located policy) and the political stream (the minister and her adviser prompted by hospital consultants) come together to create a policy window, motivated by Harney's and her advisor's belief that the private sector could assist in a solution to a public-sector problem.

Implementation of co-location

Many interviewees referred to the fact that the co-location policy was flawed from the outset. Even proponents of it, especially those in the private sector, believed it was deliberately sabotaged by its design and undermined by the Department of Health and the HSE.

Table 8.12 What interviewees said about the non-implementation of co-location

What they said	Who
It was a carefully crafted letter, really designed to have it fail, because the department never wanted it... and the CEO of the HSE never wanted it. I have always described the whole project as trying to push water up a hill.... A very senior official in the department in the beginning of this process, he [a Department of Health official] said to me, 'This competitive dialogue could be great for us now.' I said, 'what do you mean?' He said, 'there are all these different phases to it, we can let it roll along for as long as we like and then we can just kill it off'... So I don't believe that the HSE or the Department of Health acted in good faith on this project. The architects of this policy were going to come to a natural end anyway and if you sit on the fence long enough it too should go with it... It was hijacked at every shape and in every form... every single thing was put in to obstruct it...	*IV9*
I don't believe the HSE sabotaged co-location. I think it was the department. It was destined for failure the moment the tenders came out and we went and told them immediately	*IV15*
It was never ever going to happen, it was never ever going to happen...Everything worked against it and she [Harney] was not close enough to it or did not listen or whatever to make it happen. So that's the reality of what happened and it was really... a bit of a joke, it was very unprofessional the way it was done. They were changing the bid documents up to the last minute, they hadn't thought of this and had not thought of that... Ultimately then after the bids went in, they moved the goal posts again, having announced successful bidders; now they're being sued by the losers. It was just a mess, a real mess.	*IV16*
I think HSE... felt it would never happen and the feeling around people I knew was that this was going to be choked, this is not an initiative that the public sector would welcome, that some civil servants would welcome it either and the HSE might welcome it... and consequently it would be choked. It would be so slow... and so complex in its implementation that years would go by and there might be a change of government and that it would be forgotten about and that might be the game that some people would be playing. And in fact that's what happened, very effectively. Not alone did politics change, but of course the wherewithal that government had to support it changed as well	*IV17*
The HSE gave them the worst possible site. Who cried foul? You can always sabotage a government policy you don't like. Sure they [the Department of Health] have been doing	*IV21*

that since time immemorial.	

The level of hostility and opposition to co-location articulated by interviewees should not be underestimated. Even officials within the system acknowledged that the department and the HSE set out to scupper the implementation of co-location. A more detailed analysis of why co-location was never implemented provides a ripe area for research that could contribute to learning about what makes good policy and successful, or unsuccessful, implementation. This is beyond the scope of this research.

Interviewees also brought up the co-location bidding and contract process, which was ever changing, very slow and, in the opinion, of some unviable.

Table 8.23 What interviewees said about co-location bidding and contracts

Co-location, this was more measured, more controlled and ultimately too protecting to the public interest to the detriment that we effectively withdrew – we said this won't work, we won't be able to make money from this at all and some of the stuff you were requiring us to do is just mad.	*IV4*
But it wasn't a PPP at all, there was to be no contingent liability on the government balance sheet, no cost to the state other than the lost income from private health insurance...	*IV9*
We never got involved, we never bid for it, never entered any sort of discussions and in retrospect that was the right decision 'cause the process has been canned, a lot of people spent a lot of money on it...	*IV12*
they put in this clause that they could repossess, three strikes and you are out ... they can confiscate the hospital at the direction of the CEO of the public hospital who controlled it... The contract is so biased in favour of the public sector... With co-location, what they say is if we want to take it over, we can take it over, and you can get thrown out, and by the way we are just taking it over, we are not going to pay off your bank debt. And I thought: this is a misprint.	*IV19*

There was general agreement among interviewees about the failure to implement co-location, by the very fact that it had not happened, six years after its announcement, when the interviews took place.

However, quite a few interviewees felt that its non-implementation was more problematic than its implementation as co-location would have meant that private hospitals were configured in line with health policy and the public system rather than in an ad hoc, unplanned way.

> *You can argue we have ended up with the worst of all worlds, where co-location is now not happening, and what did get past the post are standalone, unconnected hospitals, over which the state has zip control...* (IV 4).

> *What the stalling of co-location allowed was the preservation of the [Charlie] McCreevy path, which was these things all over the place, in a vicious circle... that one of the rationales for the co-location thing was actually to tidy up the McCreevy work. It did not happen, so what did happen actually was several further versions of the McCreevy thing, and that power rolled on* (IV 10).

> *It is now worse where you have private hospitals all over the place, with no coherence to it at all: that's what we are left with* (IV 11).

While co-location never materialised and policy implementation is not the focus of this research, its non-implementation illuminates the policy-making processes. The fact that no co-located hospitals were built despite several contracts for them being signed possibly can be explained by the lack of institutional support for the policy from both the Department of Health and the HSE.

8.5 Conclusion

Co-location is a strong example of a politically imposed policy, where the idea was imposed on a government department and the HSE, by a minister and her adviser, who strongly believed in the project.

While there is reason to believe that individual hospital consultants looked for and lobbied for such an initiative, there is no evidence that there was concerted lobbying by either consultant representative bodies or private hospital developers in advance of its introduction.

International models were not examined until after the 'political idea' was conceived, and then they were used to back up the idea for the project. However, national examples of existing co-located hospitals influenced the policy.

Co-location was seen by its advocates as a way of harnessing the tax breaks given to developers in the Finance Act and of planning private hospital care in a more coherent way in line with the public health system. Both proponents and opponents of co-location believed that it built on the two-tier system of hospital care; the proponents felt in the public interest. Opposers believed it would further

institutionalise the unequal system of hospital care and was driven by a belief and support for private, for-profit healthcare development.

This case study indicates that the project changed between its inception and its realisation. While the minister firmly believed co-location was in the public interest at the time of its announcement, a majority of interviewees did not. They felt that private interests prevailed. When the project was handed over to departmental and HSE officials, contracts were designed which favoured the public interest, so much so that it was no longer viable for the private sector, and has not been implemented.

The non-implementation and the perceived sabotage of co-location by some departmental officials and the HSE, who were tasked with implementing it, demonstrate the power of civil and public servants. These officials are there permanently and can out-last their political masters and their advisers, whose positions, by their very nature, are time limited. It shows that while political leadership can lead to the introduction of a policy, political leadership alone may not see it implemented.

Chapter 9

Discussion of key themes arising from the documents and the interviews

9.1 Introduction

This chapter draws on the findings from chapters five, six, seven and eight. It looks across the three case studies, using the conceptual framework developed for this research, to identify the key themes and the similarities and differences across the cases. Chapter 10 looks at how these findings interact with my conceptual framework and relevant literature.

9.2 Policy Characteristics

9.2.1 Severity of the problem

A clear challenge facing the health system in Ireland between 2000 and 2005 was the shortage of public hospital beds and the long waits experienced by public patients for treatment in public hospitals. These two 'problems' emerge distinctly from the interviews which reveal a high level of consensus that these were among the biggest problems that needed to be addressed. Remedying the shortage of public hospital beds was one of the main drivers for the changes to the Finance Acts and the promotion of co-location, while reducing the long waits for hospital treatment for public patients was the central rationale behind the NTPF.

While there was a connection made between the causes of these two key problems, ie the shortage of hospital beds contributed to the long waits for public patients, further causes also emerged in the findings, indicating a divergence of opinion on the reasons for these problems.

There was agreement across the cases and the interviews that the primary cause of the shortage of public hospital beds was the failure to invest sufficient public money in building new public hospital bed stock. Many interviewees also highlighted the fact the shortage of beds was contributed to by the severe cutbacks and bed closures introduced during the economic crisis in the 1980s.

The budget was increased for health from €4.4 billion in 2000 to €11.9 billion in 2005, to €16 billion in 2009. Yet the documentary analysis shows that while the numbers of public health beds increased, they did not increase over the decade to anywhere near the promised 3,000 extra beds committed to in the health strategy in 2001. There were just 300 additional beds in public hospitals nine years after the 3,000 were promised. Consequently, it is consistent across the interviews and the cases that a failure

to provide an adequate capital public hospital budget was the main cause of the shortage of public hospital beds between 2000 and 2005.

Other views were also given on the causes of the public hospital bed shortage. A strong finding emerging from across the cases was the failure to reform the public hospital sector. There was a strong perception that public hospitals were of poor quality, inefficient, inaccessible and badly managed. Because of this, interviewees believed that these policies emerged as a way of seeking alternative beds and/or care in private hospitals instead of trying to fix the problems within the public hospital system. Interviewees from the Department of Health and HSE spoke with resignation about the inability to reform public hospitals, while private-sector people expected poor quality, inefficient public hospitals and looked to the private sector to provide an alternative. This suggests a certain resignation among these health policy makers to their inability to reform the Irish health system, especially its 'tricky' issues, such as extremely long waits for public patients.

While there is little if any specific Irish data to prove it, international research has shown that waiting a long time – more than three or six months for treatment – directly contributes to poorer health and higher mortality (Prentice and Pizer, 2007). In Ireland some public patients wait years for treatment. Such an institutional resignation to poor outcomes is a poor reflection of health system leadership.

When questioned specifically on the causes of long waits for public patients, the shortage of beds was mentioned, but other reasons came across stronger. In particular was the belief that there was a culture that accepted and even promoted long waits, which suited hospitals and consultants who got paid separately and additionally for treating private patients, and therefore long-waiting public patients were more likely to seek private care. Interviewees noted the poor information prevalent in the health system eg people did not actually know how many people were waiting for care in which specialities and for how long.

The public-private mix of hospital care was brought up by a majority of interviewees in a variety of different ways. Some felt that the public-private mix exacerbated the problem, as many more private patients than the 20% quota were treated in some public hospitals. This directly resulted in a reduced availability of beds for public patients. Other respondents spoke about how the status quo of having a messy, complicated public-private mix created fertile ground for private hospital initiatives, such as each of these three policies, to emerge and, critically, to be justified.

Another strong finding is the failure to deliver on policy commitments or to implement policy effectively. For example, co-location was justified on the basis that the 3,000 beds committed to in the health strategy were not provided and co-location was the quickest cheapest way to deliver the 1,000 beds. The 1,000 were never delivered either.

The NTPF looked to the private sector instead of the public sector to purchase care for long-waiting public patients and a key reason given for this was the failure of the Waiting list Initiative to substantially reduce waiting lists by investing money in public hospitals.

Co-location was proposed as a policy to provide additional beds, but in both the documents and from the interviews it was clearly seen as a way of harnessing the unwieldy nature of the tax reliefs given by the then Minister for Finance, Charlie McCreevy, in the changes to the Finance Act in 2001 and 2002. This is an acknowledgement of the weakness of these initial tax reliefs that allowed small private hospitals to open up wherever a developer sought to build them rather than in tandem with national health policy.

Findings for this variable – the severity of the problem – demonstrate some consensus that a failure to invest caused the shortage in public hospital beds. The consensus ends there. The findings reveal a variety of potential explanations for what caused the problems in the public hospital system. This lack of consensus is crucial as the solution and policy proposal to address the 'problem' will vary hugely depending on the definition of the problem in the first place. This absence of good information and agreement on key problems contributed to poor policy making in each of the cases.

9.2.2 Ideas for intervention

The ideas for intervention in all three cases were clearly driven by a belief that the private sector could provide hospital beds or treatment, more efficiently and effectively than the public hospital system. The proposed policy solutions for each of the three cases had private, for-profit provision at their core.

While the origins of the three policies lay in a political belief in the benefits of the increased role for the private sector, they emerged from different places. The Finance Act changes were the simple application of widely used property tax reliefs to the hospital sector. The NTPF was produced as an alternative to the proposal for a common waiting list which was an important component of the health strategy, 'Quality and Fairness', before it was politically rejected. In contrast, co-location had its origins in consultants' frustrations with the limitations on the amount of private work they could carry out. The existence of a co-located private hospital would allow them to carry out substantially more work 'on site'. It was rationalised on the basis that half the population had health insurance, while private patients in public hospitals were meant to be limited to 20% of the beds. The benefits of the role of the private, for-profit sector in healthcare and hospital care is widely contested, nationally and internationally, and many of these arguments were rehashed in Ireland when the three cases were debated politically and publicly (Devereaux et al, 2002; Touhy et al, 2004; Egan et al, 2007).

Interestingly, it was previous 'home-grown' policy initiatives that gave some inspiration to each of the policies – as stated above, the Finance Act changes were an application of the same economic model

of giving tax reliefs to developers, this time applied to healthcare. The NTPF was a much bigger version of a previous initiative which bought care in private hospitals at home and abroad for both adults and children who had been waiting a long time for cardiac surgery – an initiative which was deemed successful. And co-location was motivated by the existence of 'co-located' public and private hospitals on the same site, with both the Mater and St Vincent's cited as models.

The alternative to each of these policies was to invest in public hospitals. The Finance Act and co-location were seen as private-sector alternatives to public investment in public hospitals. The NTPF emerged as an alternative to a common waiting list, when a public-sector solution was rejected as part of the health-strategy development process.

All three policies were justified on the basis that they would free up public beds for public patients, which would in turn improve the position of public patients. The tax reliefs were motivated by the belief that half the population had private health insurance, so if there were more private hospital beds, there would be fewer private patients availing of beds in public hospitals which would 'free up beds'. The NTPF rationale was that long-waiting public patients would be treated in private hospitals, taking pressure off public hospitals and thus 'freeing up beds'. And co-location was justified on the same 'freeing up' basis as the changes to the Finance Act: that private patients in public hospital beds would be 'decanted' or 'migrated' to the private hospital, thus 'freeing up' beds for public patients.

As reflected in the documents and in the interviews, there was scepticism about this 'freeing up' argument. It was pointed out that private hospital beds could not replace public hospital beds on a one-for-one basis. For example, many private hospitals were elective facilities, often not providing critical care or care for people with long-term, serious illness (Tussing and Wren, 2005). To this day, if you have a stroke or a serious road traffic accident you will be brought by public ambulance to a public hospital. The private hospitals that have 'emergency departments' are not open on a 24/7 basis. They operate on a five- or six-day week, in daytime hours, and do not exist in most parts of the country. So in the cases of the private hospitals built by tax breaks or the planned co-located hospitals, not all patients could be transferred to a private facility.

Also, as experienced by the NTPF, patients with complicated or multiple conditions waited to be treated in their own public hospital. As a result, the NTPF got paid for treating patients with simpler, often cheaper, conditions, while patients with more complex and expensive conditions were treated in the public system (Tussing and Wren, 2005). The NTPF took some pressure off public hospitals by treating public patients, but public hospitals were left with treating the more complicated cases and the vast majority of all public hospital treatments. For example, in 2008, when the NTPF budget was at its highest at €104 million, the NTPF treated 20,829 patients, whereas 657,806 patients received elective care in the public hospital system (Comptroller and Auditor General, 2009).

The changes to the Finance Acts and co-location were also justified on the basis that there would be a 'redesignation' of private beds in public hospitals, which would also result in a 'freeing up' of public beds for public patients. The redesignation is explained in chapter two, but in essence, at the time, all beds in public hospitals were designated on an 80/20 basis – 80% were for public patients and 20% were for private patients. Both policies outlined how there should be a greater number of public beds once the policies were implemented. The planned 'redesignation' of beds never happened. The number of private beds increased by 900 in the nine years after the Finance Act changes, resulting in extra capacity for private patients, but many private patients continued to be treated in public hospitals, so this 'freeing up' rationale, which was a cornerstone of all three policies, never materialised.

Each of the policies was controversial. The changes to the Finance Act were contentious retrospectively, as they were passed without debate, at the time, without any political or public debate, whereas, the NTPF and co-location created a lot of debate and disagreement upon their announcement. There were concerns that the changes to the Finance Act would result in a plethora of small private hospitals built wherever the developers wanted them and outside of any health policy planning or quality or safety standards. This is exactly what happened. As national health policy was rationalising public hospitals into fewer, larger specialist centres, the Finance Act was incentivising the growth of smaller hospitals (Department of Health and Children 2003c, FoI3).

Within a year of their announcement, eight developers and international chains had expressed an interest in building private, profitable hospitals in Ireland and, as shown earlier, by 2010, there was a substantial increase in private hospital beds (Wren, 2003). There are still no standards for or regulation of private hospitals. Plans are in place for regulation of quality and standards in all hospitals but this remains years away from being in place for private hospitals.

Opposition to the NTPF and co-location was centered on the fact that both policies exacerbated the two-tier nature of hospital care rather than remedying it. In particular with the NTPF, there was concern that it made the perverse incentives already in place for hospitals and doctors even worse; that it further motivated consultants to have long public waiting lists, as the longer the list, the more likely that patients would be treated privately under the NTPF, where the consultants would be paid privately. With co-location the concern was that private patients would end up in the new high-tech private hospitals and public patients would be left in the older, poorer-quality public hospitals.

Even though the NTPF was controversial at the time of its announcement and many interviewees opposed it then, with hindsight most interviewees deemed it a success. Critical to its success factors were its ring-fenced budget, the high level of funding and political support for it, and the fact that it was set up as a standalone agency with a single remit, initially at least. It is widely acknowledged that

speedier treatment was good for the patients who received care under the NTPF. However, in April 2012, a decade after its establishment, there were more people waiting for treatment than when the fund was established, proof that the NTPF failed to address the causes of the long waits in the first place. (In April 2012, there were still 27,465 adults and children waiting for more than three months for treatment, and more than 12,000 adults waiting longer than six months (HSE, 2012a)).

Many interviewees argued that co-location was a way of remedying the flaws of the initial tax breaks as co-location tied private hospital development to public hospitals and therefore allowed for higher volumes of activity as they would be linked to the public hospital. Plus co-location could ensure that new private hospitals could be planned in line with public health policy rather than outside of it, as had happened up to then.

A conundrum facing policy makers then and now was how to reconcile the fact that half the population had private health insurance, while 20% of beds in public hospitals were designated for private patients. The bed number figures as produced by the Department of Health's Expert Group on Resource Allocation, as detailed in chapter five, show that the numbers of public hospital beds available increased by 3.5% between 2002 and 2010, whereas the numbers of private beds increased by 34% between 2002 and 2010, debunking any 'freeing up' argument.

Table 9.1 Numbers of public and private beds in 2002, 2005 and 2010

Year	Public beds in public hospitals	Private beds in public hospitals	Private hospitals beds
2002	9,138	2,444	2,626
2005	9,884	2,509	2,600
2010	9,459	2,413	3,525
Net growth	+321	-31	+899

These figures show that in 2002, there were 9,138 public beds for public patients in public hospitals and there were a total of 5,070 private beds available. For 2005, the figures are 9,844 public beds and 5,109 private beds, in 2010, 9,459 public beds and 5,938 private beds. This illustrates that throughout this period there was an increase in the beds available to private patients. These figures do not show the beds designated as public that are actually used for private patients. Overall, in June 2012, the figures stood at 77.8% public and 22.3% private, however some hospitals were still treating significantly above the 20% designation, with one hospital providing more than 50% private care (St John's in Limerick) and many providing more than 30%, such as the National Maternity Hospital on Holles Street and Our Lady's Hospital, Crumlin children's hospital in Dublin.

This all shows that while the intention of the each of these policies was to improve the experience and wait time of public patients, apart from those who received treatment under the NTPF, there is little to show that this happened. In fact, the numbers of beds available to public patients in the 10 years after 2000 show that the contrary is true, as there is only a slightly higher number of public beds available to a growing, ageing, population, with a greater burden of chronic disease alongside declining numbers covered by health insurance,. This in turn put more pressure on the public health system.

Bed numbers are critiqued as a crude, irrelevant measure of activity due to the more efficient use of beds with medical and technological advances and increases in day cases. If one looks at other measures over the period 2006 to 2011 (five years after the policies were implemented, which gives time to see their effect), a similar picture emerges: inpatient cases remained static at about 588,000 people treated in both 2006 and 2011 in the public health system (HSE, 2006; HSE, 2012a). For day cases there was a significant increase from 559,000 to 804,000 cases treated in public hospitals – a 9% increase (HSE, 2006; HSE, 2012a). However, HSE figures also show a 5% increase in the numbers of adults waiting for day cases for more than six months and a 10% increase for inpatient care between 2008 and 2011 (HSE, 2012a). Emergency Department presentations went up by 5% between 2006 and 2011 (HSE, 2012). Census figures show an 8% growth in population between 2006 and 2011 (HSE, 2012a). These figures confirm an increased demand for public hospital care from a growing, ageing population and a public system without sufficient capacity to cope with the increased demand (HSE, 2012a).

Despite the official intention of the three cases – to improve access to care for public patients in hospital care – 10 years after the introduction of the policies, there is no evidence to show they achieved their stated goal. While other factors come into play, it is evident that these three policies had little if any impact on improving public patients' care, apart from perhaps care for those who received treatment under the NTPF. What is also clear is that the policies resulted in large increases in private hospital beds, partially subsidised by public money, which still remain outside of any statutory regulation or safety standards. These are of benefit only to those who are covered by health insurance or who can afford to pay privately. The policies also resulted in a €680 million being spent in public and private hospitals to pay for public patients' treatment, the majority of treatment took place in private for-profit hospitals. While the NTPF was of benefit to public patients who received care from it, the establishment of the NTPF failed to address the causes of the long waits in public hospitals in the first place.

Another knock-on effect of the Finance Act changes and NTPF was to further ingrain the complex, historical public-private mix of hospital care in Ireland. Through increased availability of private hospital beds, continued privileged access for private patients in public hospitals and few

improvements in access to or quality of the public hospital system, these policies contributed the continuation of this complicated public private mix.

9.3 Actor power

9.3.1 Guiding institutions

These three policies received very different levels of priority from both politicians and the relevant government departments.

While the Department of Health should emerge as the most important guiding institution and government department in each of these policies, it is the lack of influence of the Department of Health which emerges most strongly. . Documents and interviews reveal opposition from both the Departments of Health and Finance to the changes to the Finance Act. They also reveal Department of Health opposition to the NTPF and co-location. It is notable that government department officials opposed the policies, yet two out of three were implemented, indicating the level of political support there was for these policies.

This also demonstrates the lack of influence of these government officials and, up to 2004, a perceived weakness of the then Minister for Health, Micheál Martin. In 2001 and 2002, the changes to the Finance Act went through despite advice to the contrary, which was ignored by a powerful Minister for Finance, Charlie McCreevy. The NTPF ended up in the health strategy despite opposition from the Department of Health and its minister. Co-location was announced, despite significant resistance and hostility from the Department that oversaw its announcement, although it was driven by the then Minister for Health, Mary Harney.

A key issue that arose out of the interviews was how these policies went through when they were strongly opposed by government officials and in particular by the officials in the Department of Health who opposed all three. A persistent answer to this question was that there were low levels of competence and leadership in the department, in particular to deal with 'tricky' issues and also in being able to secure support for departmental initiatives. Another reason given by interviewees, usually officials from the department or politicians who worked with them, was that there was a range of other priorities in the department with which they were dealing. Further, the three cases under examination for this research were not the most important and therefore were not the priority with officials and the ministers, who were struggling with bigger policy challenges or the never ending stream of crises that seemed to emerge from the Department of Health. During this time the main policy challenges were implementing the health and primary care strategies, the dissolution of the health boards and the establishment of the Health Service Executive while some of the crises

occupying the time of health officials included trolleys in Emergency Departments, Foot and Mouth disease and SARS.

Another issue that emerged unequivocally from the interviews was the Department of Health's belief that it was responsible only for the public health system and an associated 'head in the sand' mentality in relation to the private health sector. People interviewed from outside of the Department of Health spoke about its hostility to private health sector interests, especially those which were profitable. Those interviewed who had worked in the department acknowledged some antagonism towards the private health sector but explained it on the basis that they did not believe the private sector came within their remit.

Some ex-departmental officials even expressed remorse that they had not taken responsibility for the entire health sector, speculating that if they had, the health system may have emerged quite differently and in a more co-ordinated manner between public and private providers. Some interviewees felt that if the department had taken on this remit, the three cases could have evolved in a different way and that the absence of any policy on private provisions meant policies could emerge and be adopted in any shape or form, not necessarily in line with public health policy.

This lack of responsibility by the Department of Health for private healthcare was identified in the 2010 Report of the Expert Group on Resource Allocation. This was the first time an official report emanating from the Department of Health acknowledged this deficiency.

The Department of Health's failure to take control over private healthcare developments is full of contradictions. Firstly the department oversaw and perpetuated a public-private mix of healthcare for decades and yet it felt responsible only for the public aspects. Secondly, while the department saw itself as responsible only for the public side, many private healthcare developments were facilitated by the department, as evident in the NTPF and co-location. This facilitating of private care was much more evident in other parts of the department, which became hugely reliant on private delivery, eg nursing home care. Even then, the Department of Health failed to regulate or ensure standards in that care on which it was dependent and which it was promoting.

Some interviewees from the private sector identify a notable shift in policy towards the private sector in 2004, when Mary Harney became the Minister for Health, stating that she was much more in favour of private healthcare than previous ministers, and therefore there was a greater openness to collaboration.

The issue of 'degree of priority given to the issue' is difficult to explore in relation to these policies without considering *whose* priority. While the changes to the Finance Act gained little priority from the Department of Health or publicly or politically, they must have got considerable priority from

Charlie McCreevy as Minister for Finance, who pushed the changes to the Finance Act through two years in a row.

The NTPF gained political attention with its controversial introduction to the health strategy. It was named as one of 121 actions in the health strategy, yet the NTPF went on to acquire significant political capital and traction and was implemented with speed and priority, way beyond any other element of the health strategy.

Co-location was widely resisted by officials in the department, politically and publicly, yet it had significant political priority as it became one of the flagship projects of Mary Harney within a year of her becoming Minister for Health. The fact that the technical policy work on it was contracted out to a private management consultancy firm indicates the low priority the idea was getting or the lack of interest and support for it in the Department of Health. The fact that it was never implemented suggests that there needs to be some institutional priority and support for a policy from the responsible government department or state agency, as well as political priority, for it to be introduced successfully.

The documents and interviews reveal a Department of Health with flawed policy-making processes in each of the cases examined. The inability of the Department to have oversight of a private health system, yet promote the public-private mix at the same time, indicates a 'head in the sand' mentality in both departmental officials and their ministers. .

9.3.2 The role of policy entrepreneurs

Five policy entrepreneurs emerge unmistakably from the documents and the interviews from across the three cases. One of them, Mary Harney, who was Minister for Enterprise, Trade and Employment until 2004, when she became Minister for Health, was identified as a policy entrepreneur in all three cases. She emerged very visibly as the chief policy champion in two out of three of the cases (NTPF and co-location), and in a background, supportive, but less visible role in Case Study 1 (the changes to the Finance Act).

In relation to the Finance Act, there was a strong consensus that the then Minister for Finance, Charlie McCreevy, was the main political policy entrepreneur. As Minister for Finance, he had chief responsibility for the Finance Act and was motivated to include hospitals in tax reliefs in 2001 and 2002 after being effectively lobbied by at least two private hospital developers (the FoIs confirm it was more than two but only two are identifiable). These two private hospital owners are also considered to be policy entrepreneurs given their successful lobbying which resulted in McCreevy making the changes over two successive years.

As detailed in the policy-window section, one private hospital owner, who had made representations to McCreevy, was invited into the Department of Finance to assist in drafting the relevant section of the 2001 Finance Act. The documentary analysis clearly shows this private hospital owner lobbied for tax reliefs to be given to not-for-profit or charitable hospitals. He was interviewed for this research and said that he is proud of the role he played in this policy change. Following the changes included in the 2001 Finance Act in March 2001, McCreevy was lobbied again. This lobbying was by another private hospital owner who also acted as chairman of the representative body for private hospitals, the IHAI, as detailed in the chapter five. He sought the tax reliefs to be extended to for-profit hospitals. McCreevy obliged by removing the 'charitable' requirement from the Finance Act.

A small number of interviewees also named Mary Harney as a secondary policy entrepreneur for the changes to the Finance Act, describing McCreevy and Harney as close allies in cabinet who promoted the same economic model, of which tax reliefs were a critical component. The documents suggest a 'McCreevy/Harney axis' which exercised considerable power at cabinet, even though they were from different political parties within the coalition. Interviewees spoke about McCreevy's politics being closer to the PDs, of which Mary Harney was the leader, than his own party, Fianna Fáil.

Oliver O'Connor and Mary Harney were identified as the two chief policy entrepreneurs of the NTPF. In particular, O'Connor was named as the 'chief ideologue' and 'architect' who conceived the idea. O'Connor was then working as Mary Harney's adviser in the Department of Enterprise, Trade and Employment, when she was also the Tánaiste and the PD leader, holding considerable weight at the cabinet table. O'Connor and Harney were involved as government partners in the health-strategy development and it was during this process that they proposed the idea of the NTPF, as an alternative to a much more radical policy proposal of introducing a common waiting list for all patients in public hospitals. Nobody else was identified by any interviewee as a policy entrepreneur for the NTPF, although McCreevy was named as an ally at cabinet meetings who rejected the proposal for a common waiting list and supported the PD proposal.

Interviewees were unanimous that Harney and O'Connor were the chief policy champions of the co-location policy. By 2005, when co-location was announced, Harney was the Minister for Health and O'Connor worked as her senior political adviser in the Department of Health. Some interviewees mentioned them both, while others named one or the other of them, as the policy champions of co-location. The PDs had doubled their number of seats in the 2002 election, from four to eight, and therefore held more power at cabinet than they had in the first government between 1997 and 2001.

A few interviewees suggested that Harney got the idea for co-location from hospital consultants and she in turn got O'Connor to put shape on the idea. Co-location was clearly identified as a PD proposal, initiated and driven by Harney and O'Connor.

Harney is named as a policy champion in all three policies, even though two of them took place while she was Minister for Enterprise, Trade and Employment. In one of these, the Finance Act, she is mentioned in a secondary role to McCreevy but it is noteworthy that she was viewed as a policy champion in the first two cases, although she had no responsibilities for health at the time – an extraordinary achievement in policy making. It is indicative of the powerful role she held at the cabinet table as both PD leader and Tánaiste from 1997 to 2006.

O'Connor, Harney's adviser, was identified as the central architect of two of three policies – the NTPF and co-location. Charlie McCreevy is identified as the chief political policy entrepreneur of the changes to the Finance Act, alongside two private hospital owners who lobbied effectively for such changes. This research finds these hospital developers went on to benefit from the introduction of tax reliefs for private hospitals.

These cases are not examples of what is considered 'rational' policy-making processes, where a problem is defined and government seeks to find the solution, consulting with a wide range of interests. It is often from such interests as networks or advocacy groups that policy entrepreneurs emerge. However, in these three cases, three of the five the policy makers were in senior political positions – although, importantly, not in the health ministry in two out of the three cases. The two other policy entrepreneurs identified were private hospital developers who advantageously lobbied for state subsidy for future hospital developments.

What is most striking in this section is that the policy entrepreneurs emerge from two very particular areas: three are in senior political roles, the other two were high-profile owners of private hospitals. Much has been written in an Irish context of the close links of the Fianna Fáil/PD government to business and construction interests and how this skewed economic policy at the time (Leahy, 2009; Kitchin, 2012). Notable is the personal access these hospital developers had to senior ministers and how this resulted in policies which contributed public money to private for-profit hospitals.

9.3.3 Private sector interests

The degree and influence of private sector interests and the extent of lobbying is perhaps the hardest variable to gauge in this research. While the documentary analysis has uncovered evidence of concerted lobbying on behalf of individuals and interest groups, in this instance the representative body of private hospitals, it is difficult to be exact about how much of it was taking place.

Two things are evident from both the documents and the interview content: firstly, the lobbying that took place was very effective, especially in the case of the Finance Act, where McCreevy willingly twice implemented the suggested amendments to the Act, to the benefit of private hospital developers.

Secondly, the interviews clearly demonstrate the level of access that consultants, private hospital owners and developers had to politicians and the closed personalised nature of policy making in these incidents. Again, this is hard to quantify, but in the case of the Finance Act, documents and interviews prove that concerted lobbying took place. For the NTPF, while there is no specific evidence of lobbying for such an initiative, the IHAI met the Secretary General of the Department of Health to suggest ways private hospitals, which had lots of spare capacity, could assist the over-burdened public hospitals. It is also probable that senior policy makers and politicians would have been aware of the extra capacity within the private hospitals. And in relation to co-location, the then Minister for Health, Mary Harney, admitted getting the idea for the policy from consultants. It was suggested by a handful of interviewees that certain consultants would have been lobbying government and sympathetic ministers to find ways to increase the amount of private work that they could do.

The difficulty in being able to quantify and assess the extent of lobbying involved in the policy-making process is telling. For example, Harney spoke publicly about hospital consultants suggesting to her at a dinner party the idea for co-location. Another private hospital owner said he was not the 'lobbying type' and then went on to detail a meeting he had had with then Taoiseach, Brian Cowen, looking for the continued support for co-location (this is detailed in chapter eight). This meeting was years after all three of these policies choices were made, so it is not directly relevant to this thesis but it shows a level of access and the personal influence private hospital owners, developers and hospital consultants could have on those who held high political office.

Some interviewees were working in a government department, as politicians and political advisers, and spoke about their direct experience of being lobbied by private sector interests. Officials from the Department of Health, interviewed for this research were eager to point out that they were not lobbied but were aware that it was taking place, often stating that it happened in the political sphere. One departmental official acknowledged that the Department of Health would have been included in the 'circuit of developers and operators'.

Four interviewees mentioned that McCreevy was specifically influenced by a constituent who wanted to build a private facility in his constituency and also by people developing a specific sports clinic, and that this influenced the 2002 changes which reduced the bed numbers required to qualify for the tax breaks and made provisions for sports clinics to be included. I was unable to verify this information. Whether this is true or not, it shows that there was a perception among interviewees of the powerful influence private-sector interests could have on policy choices.

What is easier to draw from the documents and interviews is the benefit, or potential benefit, of these three policies to private-sector interests. Private hospital owners and consultants, some of whom were key investors in new private for-profit hospitals, benefited from €150 million of tax breaks for

building private for-profit hospitals. Between 2002 and 2011, €682 million was allocated to the NTPF, the majority of which was spent on care in private, for-profit hospitals. A few interviewees pointed out how the NTPF made what were unprofitable private hospitals profitable. One interviewee told the story of how people joked that one chief executive of a private hospital had the number plate 'NTPF1K' on his new sports car. Even though co-location never happened, if executed, as pointed out by the interviewees, private hospitals would have benefited significantly from a ready-made cohort of patients and consultants who would have 'migrated' from the onsite public hospitals.

The interview content suggests personalised, closed policy-making processes. The interviews also show how effective such informal and covert lobbying can be. They demonstrate how these policies were chosen in the knowledge that they would have significant financial benefit to private-sector interests, which is what materialised in two out of the three cases.

9.4 Political contexts

9.4.1 Political ideology/institutions

The strongest finding emanating from this research, which was particularly prevalent in the interviews, is the strength and depth of the role that political ideology and political institutions played in the policy-making process for all three cases and the interrelationship between them. This manifested itself in different ways for the different cases, yet they were the strongest determinant of these policy choices.

The powerful role of the PDs and its ideology, even as the smaller party in a coalition government, emerged as the most common political finding from the interviews for all three cases. It is therefore necessary to consider the 'actor power' variables when looking at 'political ideology/ institutions' variables, recognising the high level of influence of two senior politicians and one of their advisers.

As outlined in the 'policy entrepreneur' section, Mary Harney played a role in each of the policies and particularly had a central role in the genesis of the NTPF and co-location policies, along with her adviser Oliver O'Connor. This is relevant here as she was the leader of the PDs and Tánaiste from 1997 and therefore carried a lot of weight in government decisions. She and O'Connor held a critical role in the adoption of the NTPF and a supportive role in the changes to the Finance Act, years before she became Minister for Health. Up to 2004, the PDs appeared more interested in and were allocated economic ministries, yet they still managed to impact on health-policy choices (Collins, 2005).

The changes to the Finance Act in 2001 were a straightforward application of the much-used property tax reliefs to hospital development. Tax reliefs were a core component of government economic policy at the time, propagated by the PDs and the Minister for Finance and PD ally Charlie

McCreevy. The Fianna Fáil/PD coalition had been in power since 1997, extending tax reliefs year on year as part of an economic policy that, in time, would turn out to be disastrous for the Irish economy and society (Kirby, 2010; Kitchin, 2012; Hardiman, 2012).

Even though they were a small party, the PDs held much authority in the government, especially when it came to economic policy. And although PD leader Mary Harney was Minister for Enterprise, Trade and Employment in 2001/2, she exerted major influence over economic policy choices and was supportive of McCreevy's extension of the tax reliefs to the health arena. This was an economic model driven by an ideological position which believed in the low regulation of the market and increased competition as the key generator of economic, and in some instances, social development (Kirby, 2010; Kitchin, 2012).

This same ideology was behind the NTPF and co-location, which, as detailed in chapters seven and eight, were viewed as private sector solutions to public sector 'problems', without necessarily addressing the causes of the public sector problems in the first instance. However, while this ideology was a driving force behind the three cases, they were by no means a straightforward example of 'privatisation'. All three of the policies proposed an element of enhancing the private element of public provision – in Case Studies 1 and 3, promoting and subsidising private investment in building private hospitals through use of public money in the form of tax reliefs, and in Case Study 2, by buying private care for public patients with public money. In all three instances private providers were chosen above investment in public provision. But what was also happening at the same time was the significant increase in spending on the public health system. As stated earlier, the health budget went from €4.4 billion in 2000 to €11.9 billion in 2005, a nearly threefold budgetary increase while the three cases were being adopted as policies.

What happened was not a 'privatisation' policy but a parallel development of enhanced investment in the public health system, alongside a more explicit encouragement of the private for-profit sector in healthcare. One of the main criticisms of the increased investment in the public health budget was that it was spent without any real reform of the public system and therefore not used in a cost effective way (Burke, 2009; Finn and Hardiman, 2012). To the contrary, the investment in private hospital care, although a fraction of overall health budget, was seen as effective, tangible use of public money. For example, there was an increase of 900 private hospital beds, which cost the state €150 million, while more than 217,000 patients were treated under the NTPF for €682 million between 2002 and 2011 (NTPF, 2012).

Politics was also vital to these ideological and policy choices. Had Fianna Fáil been in government with a small party of a different ideology, different policy choices might have emerged. But because Fianna Fáil were dependent on the support of the PDs, and its leader Mary Harney was held in such

high esteem, she was made Tánaiste when the coalition was formed. The PD ideology, as detailed in chapters two and five, played a particularly significant role in influencing government policy, even health policy, and even before Harney became the Minister for Health in September 2004.

The power of the PDs is evident in the fact it managed to stop the proposal for a common waiting list, which potentially had the capacity of ending the two-tier, unfair nature of hospital care in Ireland. And instead the party secured its proposal of the NTPF into the health strategy, despite the unorthodox way in which the proposal emerged: the PDs announced the policy publicly without first informing the then Minister for Health, Micheál Martin, with whom they were in coalition government. A few interviewees commented that this was an inevitability of coalition governments, where the big party who held the ministry often had to capitulate to proposals from the smaller party when a significant, new policy was being developed. Nevertheless, the fact that their proposal was included in the health strategy despite opposition from the then Minister for Health and his department officials shows their high level of influence on government decisions.

It is also evident in the ability of the PDs to politically impose the co-location policy, against the wishes of a majority of Department of Health senior officials. This was made possible only by the fact that Mary Harney was Tánaiste and in 2004 appointed Minister for Health and exerted considerable influence at the cabinet table. This is a reflection of coalition politics, whereby the larger party is dependent on the smaller party for support and in the case of the Fianna Fail/PD coalition, the PD party wielded influence well above its representation in government (Collins, 2005, Leahy, 2009). Although ultimately it paid the price for its role in government when it lost all but two if its seats in the 2007 general election (Gallagher and Marsh, 2008).

Another critical contextual factor identified in the interviews was the public-private provision of healthcare in Ireland. Ireland is unusual in the extent of the mix of public and private care in the public hospital system, which has multiple perverse incentives which facilitate the speedier access and preferential treatment for private patients. While each of the three cases in this research is about private care in private hospitals, they were proposed on the basis of public investment in this private care, which was meant to benefit the public patient. Many interviewees pointed out how Ireland's long tradition of public private mix of healthcare, facilitated these three cases' to emerge as policies.

The public-private mix perspective is most important in the case of the NTPF. The NTPF emerged as a policy alternative when politicians, including Mary Harney and Charlie McCreevy, rejected a proposal for a common waiting list. The common waiting list could have been a first but significant step to curtailing the inequitable effect of the two-tier hospital system as it was a proposal to introduce a common waiting list for all patients – public and private – in public hospitals. In effect, this could have helped to undo the two-tier system, or at least it would have removed one of the key pillars of it.

A new consultants' contract would also have been necessary to achieve this, but a common waiting list would have been a first and crucial step towards equitable access. However, this was rejected politically as it was seen as too politically damaging to alienate the half of the population who had private health insurance, who are usually the richer and older section of society, who are more influential and more likely to vote than the poorer half of the population without health insurance.

The then Taoiseach, Bertie Ahern, came down in favour of Harney and McCreevy warning that a common waiting list would be blocked by consultants and that was not a battle worth fighting. Mary Harney and the PDs were an important part of the group of politicians that rejected the common waiting list. And it was in their rejection of this that the PDs then came up with the idea for the NTPF. So not only did they prevent the introduction of more equitable access to public hospital care being introduced as part of the health strategy, they also deflected public money from the public system, and bought private care for long-waiting public patients. Instead, as evident in the numbers still waiting for treatment (detailed in chapter five), the NTPF policy failed to address inequitable access to public hospital care or the causes of the long waits in the public system in the first place.

The documents and interviews demonstrate the inherently political nature that influenced the adoption of the three policies. The first two cases show how two powerful ministers – McCreevy and Harney – influenced health policy even though neither of them were in the health ministry at the time. In the third case, Harney as Minister for Health drove through the co-location policy. All three of these policies were driven by the PD ideology and 'McCreevy/Harney axis', which believed in a greater role for private providers and for competition, and that this could solve the ills of a dysfunctional, underperforming public health system. While two out of three of the policies came into effect, they did not do what they were heralded to do – improve access and quality of care for public patients – except for a small number of public patients. But crucially, they increased the number and availability of private, for-profit hospitals and transferred some public money into those hospitals, thereby rejuvenating what, up to then, had been a struggling private for-profit hospital sector.

9.4.2 Policy process/window

The three cases outlined in this research in chapters, five, six, seven and eight tell the story of three very different policy making processes and policy windows. Common to each of the cases is that they were politically imposed 'solutions', utilising the private sector, and the adoption of the policies was influenced by private sector lobbying and interests. These politically imposed policy proposals in all instances were opposed by officials in the Department of Health. In the cases of the Finance Act changes and the NTPF, they were also opposed by the then Minister for Health, Micheál Martin.

The Finance Act changes emerge from the interviews as a closed, personalised policy-making process, pushed through by a sympathetic Minister for Finance who was actively lobbied by private

hospital interests. It was an economic policy, which the then Minister for Finance, Charlie McCreevy, was prompted to apply to the hospital sector after being lobbied by private hospital developers. The NTPF emerged 'out of the ashes' as politicians rejected a proposal for the common waiting list in the health strategy development process. The NTPF was a PD proposal, to which they secured as a commitment in the health strategy at the last moment, even though the PDs did not hold the health ministry. It was initially opposed by the Minister for Health and senior Department of Health officials. Co-location was another PD proposal, driven by the then Minister for Health, Mary Harney, and her political adviser, Oliver O'Connor, and imposed on the Department of Health, which opposed the policy proposal.

All three cases show how in these instances policy making was personalised, driven by a senior minister, who in two out of the three cases was not the Minister for Health.

Connected, although not central, to all the policy processes discussed in this thesis was the health strategy. The Finance Act changes happened just before and after the strategy was published and although they changes were largely contrary to the health strategy's recommendations of public hospital investment and rationalising hospitals, they were enacted anyway. The NTPF emerged directly from the health-strategy process, when another policy proposal – that of a common waiting list – was rejected. The health strategy committed to 3,000 additional hospital beds, most of which had not happened by 2005, so co-location was devised as a way of providing 1,000 of those beds through the private sector.

The policy windows which emerge from the interviews expose some interesting features. The changes to the Finance Act were facilitated by a Minister for Finance who did not want to adequately fund the health strategy. The failure to invest in the public health capital budget opened the space for McCreevy to be lobbied by private hospital owners, which resulted in the changes to the Finance Acts. Similarly, it was the rejection of a common waiting list, which would have been a fundamental reform of the public health system, which created the space for a private sector alternative in the form of the NTPF to emerge. Likewise for co-location, the failure of the government to deliver on commitments in the health strategy of 3,000 hospital beds, opened up the policy and political space for the political proposal of co-location to emerge.

It was pointed out in some of the interviews, and I was aware upon selection of the three cases, that the three policies researched here are not 'typical' policy-making processes. This raises the questions of what is typical and why the selection of these three cases? A 'typical' policy-making process might involve the announcement of a policy's development, a wide-ranging consultation process, engagement of a key stakeholder, the weighing up of best practice, and international and national evidence for choosing the best policy option (Gilson, 2012).

However, what these three cases clearly show is that often policy does not get made this way and perhaps it is policy that is not so 'typical' that is more likely to be implemented. This is true in two out of the three cases. Obviously the fact that co-location was never implemented raises questions about the nature of that policy-making process. In all three policies, the ideas were politically decided and then the policy idea was worked up, so to a large extent the policy making took place after the decision had been made to adopt the policy.

Another theme that emerged clearly from the policy processes/windows across the cases is the busyness of the Department of Health and how the cases considered here were not the most important issue facing the department and therefore were adopted despite the departmental opposition to them. Officials and politicians explained how there were many other crises and battles going on at that time that needed greater attention than the three cases selected for this research. Some interviewees, mostly those from the private sector or working outside the Department of Health, questioned the capacity of the Department of Health to tackle complex policy problems with many believing the capability did not exist in the department.

The level and extent of involvement of the Department of Health in each of the policies' development varied across the cases. The Department of Health had little involvement in the changes to the Finance Act with the Department of Finance seeking clarification and back up on technical details from the Department of Health, often ignoring any concerns or opposition presented by them. In relation to the NTPF, it was involved in establishing it but had initially opposed it as it emerged as an idea from the PDs. The Department of Health was sidelined in the development of the co-location policy. The policy was largely politically driven and developed, and technical policy work on it was contracted out for co-location. Co-location was the only policy of the three cases not to be implemented and many interviewees believed that the enmity of department officials and the HSE to the policy caused its non-implementation.

Common to each of the policies is their intention to increase the number of private for-profit hospital beds and to use them to treat public patients or result in more beds for public patients. Case Study 1 resulted in a large increase in private for-profit hospital beds; Case Study 2 ensured that hundreds of millions of public money was directed towards private hospitals to care for public patients; and while Case Study 3 never materialised, its intention was to increase private for-profit hospital capacity.

Furthermore, each of the cases shares the involvement of senior political figures Charlie McCreevy and Mary Harney, and her political adviser Oliver O'Connor. In addition, despite the fact that the three cases were health policies, Department of Health officials were either largely ignored or tangential to each of these policy-making processes.

9.5 Conclusion

These policy-making processes expose the political nature of these health policy-making processes in Ireland. They show a system that is open to being strongly influenced by vested interests ie hospital consultants and/or private hospital owners. They expose how a handful of politically or economically powerful people can determine the policy decision.

The cases also demonstrate the personalised nature of policy making in Ireland, and in some instances the covert nature of these processes. They expose a Department of Health and, and pre-2004, a health minister who failed to stop policies they did not agree with or which were not in line with government health policy. They show the power of an alliance of strong ministers and their potential to impact on health policy even if they are not the Minister for Health.

The findings demonstrate that the three policy-making processes in this thesis were most influenced by the broader political economy, ideology and powerful political leaders.

Chapter 10

Reflecting on the conceptual framework, Kingdon's multiple streams and proposing alternatives

10. 1 Introduction

The conceptual framework was developed drawing on the literature outlined in chapter four, which in turn influenced the interview schedule and the coding through which the interviews were initially analysed. See table 4.2 and figure 4.4. In this chapter, I reflect on how the literature interacts with my findings and the conceptual framework. I propose a revised conceptual framework and a 'macro-dynamic' version of Kingdon's multiple-streams model.

10.2 Reflections on the components of the conceptual framework

For this research, I chose fewer rather than more variables in the conceptual framework. For example, Shiffman's framework has 11 variables, Grindle and Thomas's has more than two dozen, whereas I have seven. Some variables were not relevant to my research, such as 'global governance structures', whereas others, such as 'severity of the problem' and 'ideas for intervention', were used by merging of some of Shiffman's variables with those of Grindle and Thomas, Kingdon, and Gilson and Walt, and then adapted them for this research.

These are detailed in Table 10.1. In column two, the relevant issues raised in the literature for each variable is listed and then the following key refers to what literature it came from: Kingdon – K, Shiffman and Smith – S&S, Walt and Gilson – W&G, Grindle and Thomas – G&T.

Table 10. 1 Variables of the conceptual framework, what they literature says and how this compares with findings

Theme, variable and explanation	***What the literature says***	***What my findings say and how it interacts with literature***
Policy characteristic		
Severity of problem Clear measures to show the extent and level of the problem	Credible indicators that show extent of the problem are important (S&S) Characteristics of the issue may determine the level of priority given to any issue (S&S, G&W) Consensus on the issue of concern (K) If an issue is identified as a persistent or severe, as 'compelling' problem, it's more likely to get addressed (K) Some areas get attention and others do not – need to understand why eg funding v mental health (K, S&S) The more uncertainty on issue, the less radical or more incremental the response (G&T)	Few, if any indicators to show the extent of the problem, total absence of good information on the Irish health system in 2000-2005 Different takes on what causes the problem, often determined by world view or ideological position, need for more methodological and theoretical work to deal with this General consensus on the problems but not on the causes of the problems Politicians and policy makers unwilling to address public private mix which might have required a 'radical solution' and would have been unpopular with those who have private health insurance and those who vote Instead of undoing the public private mix, addressing the long waiting public patients became the focus of attention in place of trying to solve the causes of the long waits in the first place
Ideas for intervention	Consensus on and characteristics of policy solution may influence	Differences between interviewees as to the 'solution'. Proponents of the policies believed that the private sector could provide hospital beds or hospital

The proposed policy solution, the degree of agreement on solution, origins of solution including policy transfer, opposition and alternatives	support or opposition for a policy change (S&S,) Need to focus on what generates political support for a particular policy, the power of the ideas used to frame the policy (S&S, G&T) Extent that policy is explained, cost effective and backed by scientific evidence (S&S, W&G) Often alternative selected over political proposals. If policy redistributes to poor its more likely to be politically contentious (K) Might be more influenced by past policies than proposed solutions (W&G)	care more efficiently or effectively. Opponents felt solutions lay in reforming and investing in the public sector. There were strong differences of opinion among interviewees and documents as to the proposed solution There was little if any evidence used to inform any of the policies and no attempts to cost them in advance of their introduction All of the policies could be seen as an alternative to policy solutions. They each emerged as an alternative to public investment in the public hospital system and or reforming the public hospital system. Each was proposed as political alternatives to public sector solutions. Each of the policies' processes was made possible by the existing public private mix. They were justified as in the public interest although figures revealed in this research show this was not the outcome.
Actor power		
Guiding institutions The degree of priority given to the issue, role of government	Important role of all actors including government officials and private sector personnel in policy making (W&G, S&S. K) Alternatives often come from permanent civil servants and be more successful than political policy proposals (K, G&T) The effectiveness of government department to lead on an issue may affect degree of priority given to it (S&S)	The role of officials in the Department of Health emerges as a key finding from the research, in particular their failure to have oversight of private healthcare developments, their opposition to the policies, their perceived inability to deal with the complexity of the problems on hand. Most strikingly, despite overt opposition from the Department of Health officials and in the first two policies from the then Minister for Health Micheál Martin, they policies were introduced

departments	Policy community cohesion is important (S&S) Government policy makers operating in the public interest (G&T)	There was little if any policy community cohesion in these policies. This research shows that this is not necessary for policy to be adopted and implemented. Government officials may have thought they were working in the public interest by opposing private for-profit solutions, yet in fact their approach may have created the space for the policies to emerge.
The role of policy entrepreneurs The role and influence of policy entrepreneurs	Policy entrepreneurs can come from anywhere and play a critical role in opening up the policy window (K, S&S) Policy elites – often initiating reform by getting issues on the policy agenda (G&T) The presence of individuals known as political entrepreneurs or policy elites influence and their capability of uniting a policy community (S&S) Policy entrepreneurs come from people in positions of power eg politicians, rich individuals, powerful lobby groups (K, G&T)	Policy entrepreneurs played a key role in the policy making processes and the adoption of these policies. Five key policy entrepreneurs emerge – two of whom were government ministers, one a senior political advisor and two owners of private hospitals. This verifies the literature which says that it is usual for people in positions of power to have such influence. All five of the policy entrepreneurs which emerge from this research were in very powerful position and wielded great influence.
Private sector interests and lobbying	Need to pay attention to private sector interests (W&G) Need to watch increased role of private sector and how it impacts on public policy making (G&T)	Private sector interests played a significant, although hard to quantify, role in influencing the policies' development. This is particularly true of the changes to the Finance Act, which the documents and interviews show lobbying by two or more private sector interests directly influenced the minister's decision to introduce the changes. It is harder to quantify extent of lobbying in NTPF and

		co-location, although there was unanimity that private sector interests benefitted from the NTP and would have benefitted from co-location as it was initially proposed.
Political contexts		
Political ideology and institutions The degree that contextual and political institutions influence policy choices	Changes in government, organised political interests, shift in the national mood, ideological make up of government each affect policy processes can influence policy making processes and choices (K) Political acceptability of solutions is important (K) Importance of relationship between state and the market and where market values dominate (W&G, G&T) Pluralist societies power more widely distributed, country ruled by elite pick policies choices preferential to them (W&G) Policy choices can vary depending on time of crisis or not ie just politics as usual (G&T) How political pressures can alter policies (G&T) The degree that norms and institutions affect policy processes and	The strongest finding emerging from this research is the extent of political influence on each of the policies' development and selection. Specifically the Fianna Fail/PD government, the role of Fianna Fail finance minister Charlie McCreevy and PD leader Mary Harney and her political advisor were very important influencing each of the policies. Even though none of the policies were politically acceptable, they were developed and in two out three instances, implemented. They each represented a shift from state to the market, which was politically and economically acceptable at that time. Despite Ireland appearing as a pluralist society, these policies seem more like examples where the elite pick policies which are advantageous to them. Each of these policies was a divergence from official state health policy yet they occurred in a time of politics as usual. Political pressure resulted in the rejection of a common waiting list and the

	choices (S&S)	proposal of the NTPF, thus reinforcing the ability of political pressure to alter policies. Previous policies and institutional norms greatly facilitated the emergence and adoption of these policies.
Policy process/ windows Moment when policy, political and problem stream come together	When political, problem and policy stream come together, often initiated by policy entrepreneur (K, S&S) Continued interaction of ideas, institutions, and interests (W&G) As much about what is not done as what is done also (W&G) Importance of role of power, how money and access to authority can influences policy processes and choices (K, S&S, G&T) Personalised, covert nature of policy making in post colonial countries (G&W, G&T) Decision making can be based on poor information, where decision making is closed and centralised, governments weak and open to outside influence (G&T)	Policy entrepreneur played a key role in bringing streams together, the focus on the policy window exposed unknown information about each policy process Power, in particular the role of two powerful ministers, a political advisor, two private hospital developers and the powerlessness of the Department of Health are central findings to this research The failure to reform the public hospital system, the two tier nature of public hospital care and to have oversight of private healthcare developments all created space for these policies to emerge, thus backing up the findings that its as much about what's not done as what is done Each of these policy making processes were personalised and two out of three cases took place behind the scenes reinforcing the finding of such policy making in small post colonial countries, likewise the finding that policy making is based on poor information, where decision making is closed and centralised and open to outside influence.

10.2.1 Policy characteristics

In policy characteristics, the two variables of 'severity of the problem' and 'ideas for intervention' gleaned a lot of data. This is partly because these issues came up early in the interview and people were more willing to talk about the problem, rather than their role in the process. This is particularly true for political people and officials from the Department of Health. As a tactic to get them relaxed, I often let them talk on these issues for longer than necessary.

Severity of the problem

There was a general consensus that each of the policies was motivated by the 'problem' of the shortage of public hospital beds and that the shortage of public hospital beds contributed to the long waits for public patients. Shiffman's work in the developing world found that having a high level of consensus on the problem contributed to it gaining political priority (Shiffman, et al, 2004; Shiffman et al, 2007). While there was consensus among the interviewees in this research about the shortage of public hospital beds, there was widespread disagreement on the causes of the shortage, depending on the worldview or ideological position of the interviewee. This may explain some of the difficulties the policies encountered upon their announcement and with their implementation.

It is clear from the interviews and some of the documentation that officials in the Department of Health did not think that giving tax reliefs to private developers or the co-location policy was the right way to resolve the shortage of public hospital beds, whereas private developers and the ministers who introduced them, Charlie McCreevy and Mary Harney, believed they were the correct way to proceed.

Shiffman's work also found that the level of political priority given to a problem could be related to the extent of credible indicators that show the extent of the problem (Shiffman et al, 2007). Kingdon's research on agenda-setting in the USA also found this (Kingdon, 1995). A central finding in this research is the absence of good information eg no one actually knew how many people were waiting for hospital treatment in 2001. And throughout this period, there was no centralised information source on the numbers of hospital beds. This absence of good, or, in some circumstances, any information, is likely to have contributed to the lack of consensus on the problems and the causes of the problems.

Kingdon's work highlighted how some issues such as funding always get on the agenda, while others such as mental health were always close to the bottom of the list of priorities (Kingdon, 1995). He also found that if an issue was 'compelling' it was more likely to get addressed. The public-private mix in public hospital care is pertinent to each of the

'problems' to which these three policies were a response. Even though this was considered by many to be a priority issue that should be addressed (Department of Health and Children, 2001c) but as outlined by interviewees, it was not allowed to be discussed during health-strategy negotiations, indicating that it was too sensitive an issue to be taken on politically.

A point made by a few interviewees on this was that the government did not want to upset the half of the population with health insurance, who also happen to be those who are most likely to vote, with the possibility of introducing a common waiting list for all patients. Recent work in an Irish context, trying to explain the economic crisis, refers to Ireland's policy environment as one of 'emergent neo-liberalism', where

> *much of policy transformations of the Celtic Tiger era movements were, then, to an extent the outcome of a certain political pragmatism – doing what was necessary at the time to satisfy the needs of various sectors of the voting public – rather than being characterised by clearly delineated periods of 'roll back' and 'roll out' neo-liberalism* (Kitchin et al. 2012: 1307).

Each of the policies was announced with the intention of improving the circumstances of long-waiting public patients, as detailed in the previous chapters. However, an important finding of this research, through the documentary analysis and unearthing previously unknown figures, is that apart from the patients who received care under the NTPF, it was people with private health insurance or those who ran private hospitals who benefited from the introduction of these policies.

The main difficulty that arose with this specific variable 'severity of the problem' was the different takes from different interviewees on what the 'problem' was. These are outlined in detail in the chapters on the specific policies (chapters six to eight) and in my reflection on Kingdon later in this chapter. Perhaps this is less of an issue about the conceptual framework and more relevant to my methods – whether I should have asked different questions or looked for a ranking of problems or had more sub-categories in this category.

Ideas for intervention

A key finding from this research is the absence of evidence used to develop specific solutions. Grindle and Thomas, Kingdon, and Shiffman et al each outline how having strong scientific evidence and a cost analysis of any policy proposal can strongly influence the policy-making process and adoption of a policy (Grindle and Thomas, 1991; Kingdon, 1995; Shiffman, et al, 2007). My findings are contrary to this: there no proof of any costings of the proposals in advance of their development. And it is apparent

from the interviews that any evidence for any of the policies was gathered after a political decision had been made to adopt these policies. There was little evidence of learning from abroad or policy transfer in advance of the policy decision being made. This indicates little technical policy-making or analysis took place in advance of the political decision being made to adopt these policies. This is contrary to what is considered good practice in policy-making processes (Walt et al, 2008).

Other literature suggests that evidence only comes into play when the policy idea or proposals are contentious (Exworthy et al, 2012). However, each of these policies was contentious and opposition to them was challenged with available evidence, albeit retrospectively,

Kingdon's extensive research found that alternatives proposed by permanent civil servants were often selected over political proposals (Kingdon, 1995). Again my research finds, to the contrary, that it was policies developed by government officials that were rejected and the alternatives put forward by politicians which formed the basis of each of the policies. However, each of the 'solutions' that emerged was an alternative to either public investment in public hospitals or reforming the public hospital system. This research strongly indicates that it was this failure to reform the public system that enabled the justification and adoption of private-sector solutions.

Kingdon's work also reflected on Olsen's findings, which found that policies that redistribute to the poor are more likely to be politically contentious (Kingdon, 1995). Again, this is a key finding from this research that politicians rejected a common waiting list which could have recalibrated access to hospital care in favour of the poorer half of the population who did not have private health insurance. Instead, the proposal of the NTPF emerged, which ensured that the status quo of privileged privately insured patients remained, while simultaneously seeking to address long waits for public patients by buying care in private hospitals through the NTPF.

Analysis of UK policies has shown that policies which go with the grain of existing arrangements are more likely to succeed than those that challenge the status quo (Department of Health, England, 1997). Comparative analysis across Canada, Britain and the USA also found that 'policy options which involve significant shifts in the structural balance or in institutional mix are not likely to succeed' (Touhy, 1999: 264).

There was consensus among the proponents of the three policies that the solutions to the problems of the shortage of public hospital beds and long waiting public patients lay in the private sector. Correspondingly, those who opposed the policies' introduction believed that the solution lay in reforming and investing in the public hospital system.

Shiffman et al found that the consensus on the solution influenced the support or opposition for policy change (Shiffman, et al, 2007).

John identified that a lack of consensus on the 'problem' in turn may have contributed to the lack of consensus on the 'solution' (John, 2012). This is certainly reinforced by the findings in this research, as no such consensus existed on any of the policies under scrutiny.

Grindle and Thomas's work, situated in developing countries, found that the greater the certainty on the issue and solution, the more radical the response (Grindle and Thomas, 1991). This might explain the development of the NTPF as a response to long waits for public patients. The initial proposal to address this was a common waiting list, but it was rejected politically as being too radical a response to the issue and instead the idea of a treatment purchase fund involving the private sector was proposed by the PDs. So the level of uncertainty and ultimately rejection of the 'solution' led to a less radical response. Wildavsky's research found that some citizens have more choice than others and that this threatens solidarity but that governments often acted in the interests of those who already had that choice (1979). He observed 'the rich don't like waiting, the poor don't like high prices, and those in the middle tend to complain about both' (Wildavsky, 1979: 285).

It was sometimes hard to gauge the extent of support for a policy. For example with the NTPF, people said they were opposed to it at the time of its announcement but now deemed it a great success, so it was difficult to categorise that. This is a dilemma faced by policy analysts especially when the policies were formulated many years previously (Gilson et al, 2008). It is also a problem identified in the case study research (Yin, 2009). It was dealt with by clearly explaining this and if possible triangulating the findings. With co-location, people were quite negative about it, but again it was hard to tell how much of that was them retrospectively rewriting history and defending their reputation, as the co-location project never happened and is widely viewed as a failure of the then Minister for Health, Mary Harney.

Another finding in the literature was the importance of previous policies and how they can determine future policies (Walt and Gilson, 1994 and 2008). This emerged as a finding from the interviews, that the existence of Ireland's unique public-private mix of healthcare allowed the justification of adding more layers to it rather than undoing the complicated, unfair system and introducing a universal system.

This finding is very relevant to the work of David Wilsford and others on 'path dependency'. 'Path dependency' is a term used when a set of decisions for any given

circumstance is limited by the decisions made in the past, even though past circumstances may no longer be relevant. For Wilsford 'a path dependent sequence of political changes is one that is tied to previous decisions and existing institutions' (Wilsford, 1994: 252).

Wilsford sought to explain policy change by seeking to understand how 'existing institutions are hemmed in by existing institutions and structures that channel them along established policy paths' (Wilsford, 1994: 251). When path dependency is influencing health policy reform, structural forces dominate and therefore major change is unlikely and policy development is more likely to be incremental (Rochaix and Wilsford, 2005). Other subsequent work across European countries reinforced these findings, that 'radical, effective health care reform in those countries studied is rare'. However this work was inconclusive as to the impact of path dependency on policy choices (Oliver and Mossialos, 2005). Wilsford's work also found that certain policies create conditions for their own continuation and how they become self reinforcing and in other instances major change can occur (Wilsford, 1994).

Wilsford's work and others that draw on his work, is very relevant to this research as Ireland's historical public private mix laid the ground work and influenced each of the three cases in this research.

Touhy's comparative analysis referred to the importance of 'legatory' effects, 'not simply by habit or accustomation, but rather through the logics that they establish, logics of their own dynamics that over time can either reinforce or transform the structural and institutional characteristics of the healthcare system' (Touhy, 1999: 124). She also emphasises the importance of national context in which the legacy of past policy failures condition policy makers to adopt an incremental approach which can sew the seeds of future policy failures.

A similar finding emerges from 'historical institutionalism which 'emphasises the importance of decisions taken at crucial points in time, decisions become crystallised in the formal and informal rules governing behaviour, and that establish the context in which subsequent decisions will be made' (Touhy, 1999: 107). This finding is equally applicable to the three policies under examination here where previous decisions or non decisions, influenced the adoption of each of these three policies.

However, other researching this area across countries conclude that a 'single explanation theory [of path dependency] cannot account for all of the health sector developments that have occurred within any individual country, let alone across many different countries with diverse cultures, histories, institutions and interests' (Oliver and Mossialos, 2005). Path dependency theory is a useful lens for this research, However it is just one

explanatory framework useful to gaining an understanding of the process of policy change.

10.2.2 Actor power

Guiding Institutions

The Department of Health emerges as the central institution in these policy-making processes more for what it did not do, than what it did. A few interesting findings emerge in relation to the Department of Health. Firstly, the point that many officials from the department made, that the three policies under scrutiny were not the most important or priority issues in the Department of Health at the time and that this may have influenced their failure to oppose them successfully. Secondly, there were many other developments and concerns the Department of Health were addressing simultaneously. And, thirdly the lack of oversight by the Department of Health of the private sector contributed to the development of these policies.

The power struggle between the Departments of Health and Finance emerges clearly from the case of the Finance Act changes. This is probably true for most governments, that ultimately it is the Department of Finance which holds the purse strings and therefore the power. Health policy analysis in South Africa found similar struggles, ultimately with Finance being the 'winner' (McIntyre et al, 2004).

Grindle and Thomas's work found well-intended officials who were capable of effective policy making (Grindle and Thomas, 1991). My findings both support and contradict this. This research shows the officials in the Department of Health were well-intended; the documents and interviews show they pursued their work in what they perceived as in the public interest. They explain their opposition to private healthcare is explained in two ways. Firstly, they did not support for-profit healthcare, and secondly, they felt it was outside the remit of their department. In other words, they believed the public system was their responsibility and therefore they sought to protect it, as they saw it. Ironically, by ignoring private sector developments and failing to regulate or control it, they may have created the very space in which it could thrive.

Contrary to some of Grindle and Thomas's findings, this research does not find a particularly competent Department of Health in relation to these policies. It is impossible to generalise but examination of these specific policies draws attention to the non-implementation of the health strategy and the primary-care strategy, which were priorities of the Department of Health during the early 2000s. . Another of the main preoccupations of officials of the time under scrutiny was the establishment of the HSE. This is generally

regarded as an exemplar of how not to reform a health system (Burke, 2009; McDaid et al 2009).

Shiffman et al's work found that the level of policy community cohesion was important and that the effectiveness of a government department to lead on an issue may affect the degree of priority given to it (Shiffman et al, 2007). This research found the opposite: that there was little policy cohesion, yet two of the three policies' were effectively implemented and the third was chosen despite the lack of unity or support for it in the Department of Health.

The degree of priority was hard to gauge. None of the policies had strong support from the Department of Health but all of them had considerable support of their sponsoring ministers, McCreevy and Harney, even though in two instances they were opposed by the then Minister for Health, Micheál Martin. This raises the issue of whose priority is important: is it the sponsoring minister's or the guiding institution's? I am not sure how to resolve this issue of 'whose priority is it', except to spell it out. Any attempt to rank or quantify who or how many supported which policy could inevitably be skewed by the interviewees' status. This issue of whose priority and 'political priority' may need further exploration.

This research reinforces the emphasis Walt and Gilson put on the importance of the role of actors (Walt and Gilson, 1994 and 2008). Critical to each of the processes were senior political figures, while individual consultants and private hospital developers also held considerable influence.

Touhy's comparative work examining why change occurs in some places at particular time and does not in others, also identifies the critical role of actors in healthcare reform (Touhy, 1999). In particular, she singles out the role of the medical professions and concludes that 'few areas are as strongly marked by the influence of professional actors and collegial instruments as in healthcare' (Touhy, 1999: 267).

Immergut also identified the influence of the medical profession. However, her research on Switzerland, France and Sweden found 'the medical profession has had less impact on health policy than is generally believed to be the case. To the extent that it has an impact, this has been caused by opportunities presented by particular political systems' (Immergut: 1990: 413).

Medical professions, especially hospital consultants, emerged from this research as have a specific influence on two of the three policies under consideration. This issue is dealt with in the next section on policy entrepreneurs.

Five people emerged as policy entrepreneurs, with overlap between the cases and the policy champions. There are some differences in the literature on policy 'elites' and 'entrepreneurs'. Kingdon's definition is drawn on for this research, and it encapsulates much of the literature on both definitions (see section 5.1). Interestingly, in all three cases, the policy entrepreneurs could also be considered part of the policy elites as they were people in high political office or powerful private-sector interests (Kingdon, 1995). I am aware that in other policy processes, policy entrepreneurs might not be 'elites'. However the definition used in this research is broad enough to incorporate both.

In Kingdon's work, the policy entrepreneur is critical to opening up the policy window. He uses the analogy of them being like surfers, who lie in wait for the wave to come along. This seems apt for this research. Shiffman et al use a similar concept, albeit with different titles (Shiffman et al, 2007). They describe the powerful role that 'political entrepreneurs' can play in influencing an issue becoming a political priority. Each of the five policy entrepreneurs was strategic and opportunistic in the moments they choose to 'ride the wave'. Each was successful in that each of the policies was chosen as policy despite widespread opposition to them, although co-location never materialised.

Three of them were political policy entrepreneurs, two ministers – who would be expected to hold considerable power. The other was a senior political adviser to Mary Harney. As she was Tánaiste and a senior cabinet minister, he too wielded considerable power. There is a growing body of knowledge internationally on the role of political advisers, especially at a European level and in foreign policy (John, 2012). Research on the formulation of the English NHS Plan 2000 found policy development that was tightly controlled and personally led by the Secretary of State for Health and his close advisors (Alvarez-Rosete and Mays, 2013). However, I found little theoretical or empirical research dealing specifically with the role of advisors and their influence on policy making processes.

Grindle and Thomas's research found that policy elites were good at getting their issue on the policy agenda (Grindle and Thomas, 1991). This was also found in this research. They and Kingdon find that policy entrepreneurs often come from positions of power; this too was a finding in this research. A study of policy making on health inequity in Norway found how policy entrepreneurs were effective by 'demonstrating their recognition of the problem, developing alternative policy options and linking the policies and the politics' (Strand et al, 2009: 21/2). Such a finding is equally applicable to this research.

Policy making by its nature is a messy process, involving many actors, who are influenced by different pressures and power, which is recognised in the Kingdon model. Kingdon's theory also takes in to account policy entrepreneurs who are driving the policy processes. Kingdon found that no single set of actors dominated the policy process. However, he found that elected politicians come closer to dominating more than any other group: 'elected officials dominated all of the processes under study… Elected officials loom very large' (Kingdon, 1995: 44). The dominant role of elected politicians and their advisers emerged as a key finding from my research.

Private sector interests

The 'private sector interests' variable revealed clear findings although less material emerged on this variable than from all others. This research found that private sector interests played a significant although hard to quantify role in influencing the policies' development.

The role of private hospital developers in the changes to the Finance Act is certain from the documents and the interviews and they had a huge impact on the changes introduced by the then Minister for Finance, Charlie McCreevy. It was harder to establish what if any role private-sector interest had, specifically in the policy development processes of the NTPF and co-location. Nonetheless interviews revealed that in each policy considered, some politicians and their advisors represented private sector interests during the policies' development. Touhy's cross country analysis also found it hard to 'separate the influence of organised medicine from political party influence' (Touhy, 1999: 117).

Walt et al, and Grindle and Thomas, found that access to senior politicians by elites is more likely to happen in small, often post-colonial, countries where powerful vested interests such as management consultants and private hospital owners have easy access to senior politicians; in countries which 'generally have structural roots in the colonial past' (Grindle and Thomas, 1991; 51).

This was also found in this research and suggests that further research is needed on this matter in an Irish context and that of high-income countries. Is this just typical of young, post-colonial countries or is it true of other smaller, high-income countries too?

The issue of private hospital owners is dealt with in detail and the significant influence they had on the policies' development is outlined in the policy entrepreneurs section. The role of hospital consultants was less obvious and harder to quantify although some hospital developers are also hospital consultants. This research found that hospital consultants had a role in lobbying McCreevy for the tax breaks, suggesting that they could assist in alleviating long-waiting public patients if the state paid for them to be

treated privately and lobbying for co-location. This backs up the findings of Walt et al, Grindle and Thomas, and Kingdon on the powerful role of elites on policy-making processes.

Touhy and Immergut both found that health policies are often the outcome of institutions that channel the influence of the medical profession at different points in the policy process (Touhy, 1999, Immergut, 1990). Touhy's comparative work on the USA, Canada and Britain characterised alliances between the medical profession and private corporations as 'structural ambiguities' where they had conflicting as well as common interests (Touhy, 1999: 30). She found that 'collegial mechanisms' of the medical profession allowed for entrepreneurial discretion. Touhy's findings resonate strongly with this research's findings, where in some instances the medical profession were acting as representatives of private hospitals or private sector interests, reflecting the collegial mechanisms similar to those in Canada and Britain.

It was also hard to quantify in a systematic way, the level of lobbying that took place. In the instance of the Finance Act, it is clear that effective lobbying took place which influenced the changes to the acts. Some of this information was stumbled across in both the documentary analysis and the interviews. Although, it is hard to quantify the extent and nature of lobbying that took place, it is not hard to show the closed and personalised nature of lobbying in Ireland. The documentary analysis revealed that hundreds of millions of euro were transferred to the private for-profit sector under the two of the three policies that were implemented, and in some instances it was thought that they made some of these private hospitals viable. Also it is clear from the interviews with private hospital owners that if co-location was introduced, as it was first announced, they would have benefited from it. International work in this area has shown that 'private hospitals competed for specialists as much as they did for patients' (Touhy, 1999: 191). Therefore the fact that co-located private hospitals would get both patients and specialists from the co-located public hospital from day one would have been a strong incentive to private developers to get involved in co-location. Private sector interests, including consultants who practice privately, and private, for-profit hospital owners clearly benefited from these policy changes.

10.2.3 Political contexts

Other conceptual frameworks, such as Shiffman's, separate out 'political ideology' and 'political institutions', whereas I merged them in to one variable of 'political ideology/institutions' variable.

In all three cases, political ideology and institutions came out as the strongest influences in the policy processes. In each of them, political ideology was inherently linked to the political institutions, in this instance the politics of the coalition government in place. In particular, the role of the PDs in the coalition and its powerful influence – and that of specific ministers – on government ideology and policy emerged as one of the most robust findings in this research.

Kingdon's extensive research in the USA found that changes in government, organised political interests, a shift in the national mood and the ideological make up of a government are important influences on policy-making processes and choices (Kingdon, 1995). This research clearly found the ideological make up of the government was an essential factor in influencing these policy processes (Kirby, 2010; Kitchin, 2012). The continuity of the government in power from 1997 to 2007 was more of a factor than government change. Organised political interests did not emerge in the findings but the national mood could have played a subtle, although undetected influence in that dissatisfaction with the public sector could have created a space for such private developments.

Touhy's work found that episodes of health policy change were brought about by windows of opportunity created by events in the broader political arena, not in healthcare per se (Touhy, 1999). She found that when governments had a majority, which 'were swept into power by broad current opinion, that establishes the broad outlines for change' (Touhy, 1999: 114). Her work focuses on the 'timing of episodes of policy change that occur when a set of political actors has the ability to consolidate political authority necessary to accomplish change and the political will to focus those resources on change in the health care arena. Differences in political institutions establish different degrees of constraint on the ability of any given set of actors to consolidate authority, hence major episodes of policy change are more rare in some nations than in others' (Touhy, 1999: 123).

Touhy's work entitled 'accidental logics' concluded that it was these 'accidental logics that drive the dynamics of change', ie that many policy choices were accidents of their timing of birth (Touhy, 1999: 239). This resonates strongly with the findings in this research, that these policies were born out of the political arena of the time, not out of specific health policy developments, they were enabled by a strong, stable government and each could be considered 'accidental logics'.

Other research in a developing-world context has also emphasised the importance of the political sphere. Reich argues that 'policy reform is a profoundly political process, affecting the origins, formulation and implementation of policy' (Reich, 1995: 48). Reich differentiated between two emerging approaches strongly influenced by ideology – one where the government plays a strong role in providing care and in regulating the 'free' market', and another where the government's role is rejected and where market forces and the private sector play a central role in delivering healthcare (Reich, 1995). Again, this reflects the findings of this thesis as the cases under scrutiny are examples of the government shifting from being the main provider of care to facilitating the private sector doing what traditionally the state did ie building additional hospital capacity and providing hospital care for public patients.

Kirby's work on the political economy of recent policy in Ireland does not look specifically at health as it is focused on economic policy, however many of his findings are relevant to health. He categorises Ireland as a 'free-market economy with a shrinking state owned sector… where the state played a key role in creating the conditions in which the private sector operates… yet the role of the state remains crucial' (Kirby, 2012: 146) .

Walt and Gilson's 1994 research reviewed health policy analysis in developing countries up to that point and they observed a change in health policy from consensus to conflict, particularly due to neo-liberal reforms of the 1980s. The 1980s saw an increased preference for private-sector solutions in low- and middle-income countries and a focus on 'cost containment' and 'efficiency' in higher-income countries. Again this is pertinent to this research given the ideology which influenced the cases and the types of cases that sought private-sector solutions to public problems, often driven by justifications of efficiency and effectiveness of private providers. Irish health policy development's in the early 2000s reflect policy developments that were taking place in other high income countries in the 1990s where health policy introduced markets and competition into healthcare. This happened in different places in different ways but was a consistent theme (Klein, 1995, Touhy, 1999).

Kingdon also found that the political acceptability of policies was important. This did not emerge as a central finding in this research. In fact none of the policies was particularly acceptable politically, but each was driven by politicians who ensured its realisation.

Walt and Gilson found that more pluralist societies distribute power more widely, whereas societies ruled by an elite pick policies preferential to them (Walt and Gilson, 1994, Gilson et al, 2008). Despite Ireland appearing as a western European pluralist democracy, these policy-making processes are closer to those where elites pick policies

which are preferential to them. This is evident in that those who benefited most from these policies were those with health insurance, those who vote, those who run private hospitals, not the poorer, sicker half of the population who were public patients and less likely to vote.

Walt and Gilson, and Grindle and Thomas, outline how is it is important to assess the relationship between the state and the market where market values dominate. This is certainly true for Ireland for the period under consideration where the state played an important role in stimulating the market (Kirby, 2012; Hardiman, 2012).

Looking specifically at the Irish experience of privatisation through a lens of political economy, Kirby finds 'it reveals the non-ideological nature of Irish politics and indeed the Irish model. This has grown more through pragmatic experimentalism than according to any master plan and often reflects the interests and worldview of particular ministers, rather than a clear collective plan by government' (Kirby, 2010: 161). By the non ideological nature, Kirby is referring to how Irish political parties are largely defined by civil-war politics (Fianna Fáil and Fine Gael, the two largest parties up to 2011, both of which emerged from rival sides of the 1920 civil war) rather than a left-right divide as evident in other European and Anglo-Saxon countries.

This non-ideological take is also evident in the quotes from Mary Harney, who despite being leader of what is perceived as a 'neo-liberal' party, described herself as non-ideological, as detailed in chapters five and eight. Kitchin et al writing about neo-liberalism in Ireland and its contribution to the boom-and-bust economy, describe

> *four factors shaping Irish political landscape that have produced a certain species of neo-liberalism in Ireland which is perhaps best characterised as ideologically concealed, piecemeal, serendipitous, pragmatic and commonsensical. Indeed, successive Irish governments have never had an explicit neo-liberal ideology (apart from a small number of influential ministers)* (Kitchin et al. 2012: 1,306).

This is relevant to this research as the case studies show a significant growth in the state subsidy and provision of private, for-profit hospital care and the introduction of the policies was often justified as a 'common sense' and 'pragmatic' response. This research does not reflect the 'privatisation' of healthcare, as evidenced in other countries (Harvey, 2005). What happened in Ireland was more nuanced: there was a significant growth in private healthcare provision alongside a quadrupling of the public health budget and a 61% increase in the public health sector workforce between 1998 and 2008 (Burke,

2009). This dual path of concurrent public and private developments is described by Kirby as 'neo-liberalism Irish style' (Kirby, 2010: 147).

Kirby and Kitchin's assessment of Ireland fits well with the findings of this research. Kirby's recognition of the 'world view of particular ministers' is very relevant to each of these case studies as they were each driven through by ministers who firmly believed in them, even if they were contrary to government policy at the time.

Kirby also cites analysis of Ireland as a 'pay related welfare state' and as 'an anorexic welfare state', where there are minimal levels of universal entitlement, where middle classes benefit from public spending but supplement it through private spending to gain better or preferential access (Kirby, 2010: 131, 169). This is certainly the experience in Ireland's health system and is entirely relevant to this research. For example the 50% of the population who have private health insurance have access to the public health system and they often pay private health insurance in order to gain speedier access to subsidised private care in public hospitals. The NTPF was proposed only after a policy proposal to undo this preferential position of privately insured patients was politically rejected.

Kirby's work assesses the Irish welfare state as one that developed in an ad hoc and incremental way, 'a process of temporary responses to particular problems' (Kirby, 2010: 131). Although this quote refers to the social welfare system it could equally be applied to the health system as each of the cases are examples of 'temporary responses to specific problems'. Kirby's work also highlights other areas of social policy in Ireland which are path dependent. Again this is very relevant to health where shifting the status quo and implementing real reform proved impossible. He concludes that the Irish model is one where the state is subservient to the needs of market actors.

Kirby recommends paying attention to Ireland's populist style of politics, and in particular the dominant role of Fianna Fáil in shaping that. This research found that the PDs, which was a very small party in the coalition, had much greater influence on these health-policy processes than their much larger partner Fianna Fáil – although Fianna Fáil's 'populist style politics' could have been part of the reason they were willing to give into PD proposals.

Grindle and Thomas also found that policy choices can vary depending on whether it was a time of crisis or not ie just 'politics as usual'. Economically or politically, 2000-2005 in Ireland was not a time of crisis. Ireland was experiencing unparalleled and unsustainable economic growth and was stable politically, with the same government in power for nearly 14 years. However, it could be argued that the public health system was (and still is) in crisis and that the failure to effectively reform the public system created the

opportunity for the acceptability of private for profit elements of health policy. They also found that political pressures can alter policies (Grindle and Thomas, 1991). This was confirmed by the findings in this research: not just that policies were altered by political pressure but they were created by political pressure.

Shiffman et al found that norms and institutions affect policy processes ie what went before can have more influence than the new policies proposed. This is the case for much of Irish health policy's development (Barrington, 1987; Wren, 2003; Burke, 2009). It was also a key finding in this research. The historical context of how Ireland's two-tier health system facilitated these three policies to emerge was a strong theme emanating from the interviews.

The 'political ideology/ institutions' variable worked for these three policies, I think there is a case for separating these two in future frameworks. Also, it worked as one variable in these cases but, again, this could because of the particularly political nature of these policy-making processes. This variable allowed me to tell the political story which may not be reflected in a majority of policy-making processes.

There is an overlap between political contexts and path dependency. As Touhy found the political arena tended to have greatest influence on windows of opportunity for significant health policy change whereas continuity in health policy tends to be influenced by internal health system logics, where previous decisions lay the ground for future decisions. However as Touhy points out

> *understanding path dependency requires an understanding not just of political institutions but of the political economy of the policy arena as a whole. It means understanding the interactions of political and economic actors within the parameters established by public policy. Those interactions follow a logic as actors respond rationally to the incentives they face. And that logic is shaped not only by policy parameters but also by the microeconomic and technological characteristics of the particular arena* (Touhy, 1999: 261).

Given the path dependency of policy in Ireland and abroad, there is a case for a specific variable on this, as history matters and institutions matter, and they had a significant impact on these policy-making processes. This extra variable of 'path dependency' is being placed in the 'policy characteristic' category.

Policy process/window

I merged variables used in other frameworks into one variable of 'policy process/window'. All of the variables in my conceptual framework could be categorised

into a 'policy process' variable as all this research is about policy making. I situated this variable in the political contexts category as all of the literature I drew on emphasised the critical nature of political support for a policy to gain attention, adoption and implementation. Each of the cases revealed very different 'policy processes/windows', but again this is positive as it shows a flexibility of this variable and conceptual framework to deal with different policy-making processes.

Case Study 1(the Finance Act) could be categorised as a politically driven economic policy developed by the Department of Finance, which once implemented had significant impact on hospital care provision by radically increasing the amount of private for-profit hospital care. Case Study 2 (the NTPF) could be categorised as a politically driven health policy which, when implemented, resulted in public money being spent on private, for-profit hospitals, buying care for long-waiting public patients. Case Study 3 (co-location) could be categorised as a politically driven health policy, which was never implemented.

Kingdon's concept of a policy entrepreneur who defines the problems and/or solutions and connects them with a political agenda to open a policy window was very useful for this research (Kingdon, 1995). Touhy's work found that 'windows of opportunity' were created by external factors in the political system which may occur by accident of their timing. Between these policy windows, Touhy found health systems were shaped by their own internal logics and that 'across all systems, big reform is not the norm; it is usually quite difficult although not impossible' (Touhy, 1999: 113). According to Touhy, a 'focus on "windows of opportunity" provides an explanation of how, under extraordinary circumstances, policy legacies are established and particular policy paths are embarked upon' (Touhy, 1999: 123).

The inclusion of the 'policy window' in my conceptual framework allowed me to gain more insight and to utilise the interview content to explore the policy processes. Specific examination of the policy window for each policy process revealed unknown or unreported aspects of each of three policy making processes up until then.

For the changes to the Finance Act, the exploration of the policy window revealed that the Minister for Finance, who was lobbied by a private hospital developer, then invited him into the department to write the relevant sections of the act. For the NTPF, it revealed that the NTPF emerged as a policy proposal after a more radical proposal of a common waiting list was rejected. For co-location, it revealed that the policy development work on the idea was done after the political decision had been made to adopt co-location as a policy. These cases each expose aspects of Irish health policy making which should be explored in other research – the very personalised and closed nature of policy making, the

rejection of any consideration of universal or equitable access to public hospital care in the health-strategy development process, and posthoc policy development once a decision has been made.

The 'policy windows/process' variable reinforces the importance of examination of the interaction of interests, ideas and institutions as proposed by Walt and Gilson (1994). The findings also support the literature which advocates the study of policy should be as much about what was not done as what is done (Gilson et al, 2011; Walt et al, 2008; John, 2012; Lukes, 2005). A clear key finding from this research is that the failure to reform the public health system, to undo the public-private mix and to have oversight of private healthcare, allowed the unplanned and unregulated entry of private for-profit hospital care to take place.

Power, while hard to measure, played a very significant role in each of the policy-making processes (Lukes, 2005; Gilson et al, 2011). Each of them was driven by one or two people in powerful positions, either owners or representatives of private hospitals, politicians or senior political advisers. This research shows how people in positions of economic power (hospital owners and consultants) have ready access to people with political power.

As mentioned earlier in the section on private sector interests, the findings from this research reinforce similar findings in developing countries: that the closed, personalised nature of policy making was also found in an Irish context (Gilson et al, 2011; Grindle and Thomas, 1991). Grindle and Thomas also found that these countries tended to have policy-making processes based on poor information, where decision making is closed and centralised and not open to outside influence (Grindle and Thomas, 1991). These findings could also be applied to this research.

Many of the findings in this research resonate with the literature, although some find contrary to findings in other countries. Health policy-making processes are an under researched area of analysis and provide fertile ground for further analysis in Ireland and in a comparative context.

10.3 General reflections on my conceptual framework and recommendations for future use

There were naturally overlaps of the three headline themes of policy characteristics, actor power and political contexts and of the variables within each of these categories. As outlined by Touhy above, the policy window is inherently linked to the wider political

context. In the case of the Finance Act, the changes were politically led by a minister who applied an economic policy to the health sector. This was highly influenced by the government's economic policy, and specifically the PD's ideology. An interviewee's comment encapsulating those points could be coded in to each of the three categories and a range of variables. I tended to over-code the interviews, so when writing and rewriting the analysis a judgment had to be made as to which category and variable it was analysed under. This is probably true of any conceptual framework and is not a weakness or a strength, just an observation. And as each policy was written up as a narrative, with sub-themes and boxes, where a specific item should be placed tended to find itself a natural home. And in some cases it was necessary to duplicate as it was hard to separate them, eg it was impossible to separate the roles Mary Harney and Oliver O'Connor played as policy entrepreneurs from the political ideology of the PDs and the political institution of the coalition and the role they played in government.

Some comments made by interviewees were general rather than specific to a particular policy. These also tended to be (over-)coded into more than one policy, so for these I had to go back to the transcript and see the context and the policy in which it was cited in order to know where to place it in the analysis. In some instances the comments were general eg the issue of the Department of Health not taking responsibility for private health care policy or developments. Interviewees often brought this up in relation to a particular policy but they usually made the point as a general comment or criticism of the department.

When developing the framework, I struggled with whether or not to include power as a specific variable and opted not to. While all the researchers I drew on for the conceptual framework included the concepts and notions of power in their analyses, none of them specified it as a variable. Rather, it was categorised as 'actor power' and the power of different professions and interests rather than as a variable in its own right. Concepts of power are controversial and it is difficult to measure as it is often as much about perceptions of power as it is about actual power (Lukes, 2005). There is no question but that power played a critical role in the adoption of each of these three cases. For example, the power and influence of the PDs on health policy choices, even before they had the health ministry, played a critical role in the adoption of cases one and two. Similarly, in the Finance Act, the power of the Minister for Finance and the two private hospital personnel who lobbied him were critical. In co-location, the powerful interests of consultants and private sector interests played an important role in the adoption of this policy. While there is much literature on the role of power, I did not find any that

specified how to measure power in policy making processes. This provides grounds for future analysis.

I worried in advance of the analysis that it might differ vastly across the cases eg one case might yield much more data or results than other. This did not happen with more or less equal amounts of data and analysis for each of the cases. Also the tedious process of transcribing and coding, recoding and consolidation of codes, followed by writing up and organising, rewriting and reorganising of the analysis in the framework devised for this research, provided an adequate honing down and distilling of the huge amount of data acquired during the research process.

Overall I found the conceptual framework useful. Each of the policies emerged as very different policy processes from analysis through the conceptual framework which worked equally well for each of the three policies. Given the above comments on the specific variables, I think the following framework might be more useful for future policy making analysis. Ultimately, this can only be determined by further testing of it, which is beyond the scope of this research. However, if starting again, I would propose using the following framework as set out in table 10.2.

This includes two extra variables. It puts in a 'path dependency' variable in to the policy characteristics that could capture the extent that previous health policy and 'path dependency' influence future proposals. The other new area proposed is to split up 'political ideology' and 'political institutions' recognising that they are two separate variables and that for many policies it would be more useful to have them in different categories.

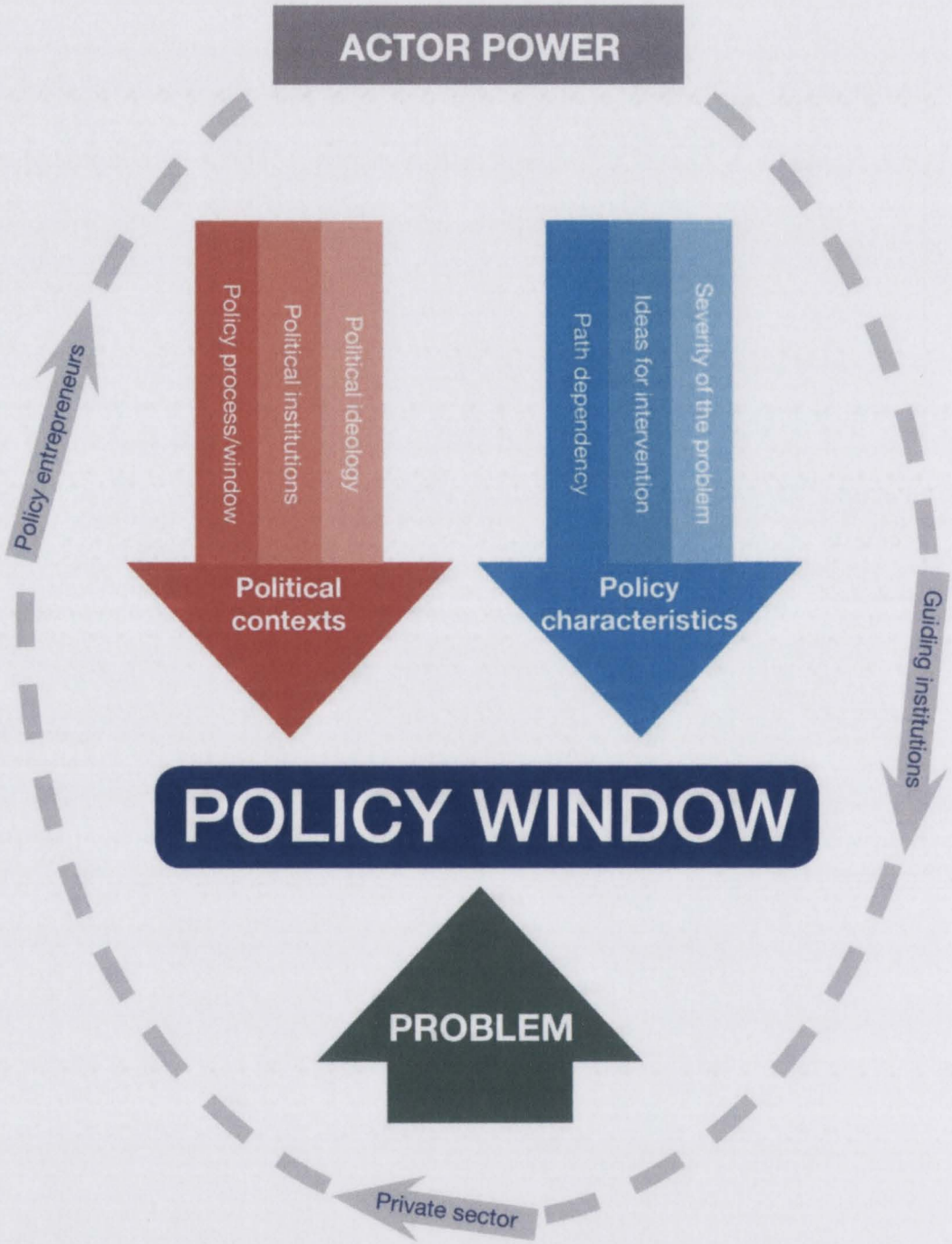
This research reiterates recent calls for rigorous research into and analysis of health policy making (Walt et al, 2008; Gilson, 2012; Mills, 2012). With clear methods and a firm theoretical grounding, there is much scope for further theoretical and empirical work.

Table 10.2 Revised conceptual framework

Category / headline theme	**Variables**	**Description of variable: factors affecting policy choice**
Policy characteristics	***Severity of the problem***	clear measures that show the extent of the problem and level of consensus around it
	Ideas for	the proposed policy 'solution', the degree of agreement on solution, origins of 'solution' including policy transfer, opposition and

	intervention	alternative solutions to problem
	Path dependency	The extent that proposed solution is influenced by previous health system organisation
Actor power	***Guiding institutions***	the degree of priority given to the issue, the role of government departments
	The role of policy entrepreneurs	the role and influence of policy entrepreneurs, particularly strong champions of the policy, in the policy making process
	Private sector interests	the degree and influence of private sector interests and lobbying
Political contexts	***Political ideology***	the degree that contextual historical, economic and political contexts and ideology influences policy choice
	Political institutions	The degree that political institutions influence the policy choice
	Policy process/ window	The process through which the policy was made and the moment when the political, policy and problem streams comes together

Figure 10.1 Revised conceptual framework



10.4 Reflecting on Kingdon multiple stream's model and a proposed 'macro dynamic' Kingdon model

I found Kingdon's model useful in initial analysis of the findings as it allowed the breakdown of the case studies into specific streams of problem, politics and policy; identify the policy window; and explore the when, where and how of the three case studies under examination. According to Kingdon, it is not just the policy idea that is important but why it gains traction, gets on the agenda as opposed to alternatives, and becomes a policy choice and a political priority (Kingdon, 1995). Examining the interaction of the streams, in particular when a policy window got opened, was a constructive way to spell out the policy-making processes from the documents and a very useful element of my conceptual framework.

Kingdon's model allows for the timing and flow of policy making to be taken into account, in particular the convergence between the different streams at significant moments 'the coupling of problems, solutions and politics' which is often 'chaotic and unpredictable' (Thurber in Kingdon, 1995: viii).

However, there were some limitations to Kingdon's work discovered during this research. Using the streams in the documentary analysis made me realise the streams were not necessarily a single or a coherent stream. In this research, different people may perceive the problem differently and these perceptions may influence differing policy responses, which in turn may influence the effectiveness or success of the policy. These are tabled and explained below.

Table 10.3 Different identification of different problems for same cases by different interviewees

Case	Main problem	Cause of problem 1	Cause of problem 2
Finance Act	Shortage of public hospital beds	Failure to invest in capital health budget	Too many private patients in public hospital beds
NTPF	Long waits for treatment for public patients	Inefficient use of public hospitals caused by perverse incentives which prioritise private patients	Shortage of public hospital beds Too many private patients in public hospital beds & failure of previous waiting

			list initiatives
Co-location	Shortage of public hospital beds	Failure to implement health strategy	Inefficient public sector, private sector can deliver more quickly and efficiently

Take Case Study 1 (the Finance Act): this may be seen as a response to different problems depending on what interpretation one made. One problem was the shortage of hospital beds – and the Finance Act was deemed a response to encourage developers to build private hospitals which would increase overall numbers of beds and was intended to free up beds for public patients in public hospitals. Another perception of this same 'problem' is the two-tiered health system: that too many public hospital beds were occupied by private patients and subsidised by public money. Another take on the problem was that it was too expensive and slow to build beds in the public system and the Finance Act would encourage private-sector development, which was cheaper, more efficient and less demanding of public money.

In Case Study 2 (the NTPF): the National Treatment Purchase Fund was introduced with the intention of speeding up access to elective treatment in public hospitals by buying private care in private hospitals for the long waiting public patients. Different interviewees had different analyses on what contributed to the long waits, including an inefficient public hospital system, the shortage of public hospital beds, the two-tier mix resulting in the over-use of public beds by private patients. This is important, as diverse understanding of the causes of the problem will create different policy responses. The streams also revealed that some interviewees did not perceive the two tier system as the problem but the solution and core to the Irish health system.

Case Study 3 (co-location) was proposed with the intention of increasing the numbers of private beds in a co-located private hospital, alongside a public hospital, which would free up public beds in the public hospital as private patients would be 'decanted' in to private beds. This was necessary as the 3,000 beds promised in the 2001 health strategy were never delivered. Again, there were differing views on why they were not delivered, ranging from a failure or unwillingness to sufficiently invest in public facilities to a firm political belief that the private sector could provide more beds, more efficiently and more quickly. Having just one problem stream does not allow for such different perceptions of the problem. This quandary was experienced in each of the different cases.

A separate but related difficulty was found with the political streams, while there are three separate cases under research, the politics stream is common to each of the three cases. The Fianna Fáil/PD coalition, and in particular the influence of the PDs and the

'PD wing' of Fianna Fáil, directly drove the three policy responses. The impact of coalition politics and the nature of Irish political institutions and the political economy of the time are also common political streams as they enabled the PDs to have such a high level of influence over government decisions in each of these three policies.

There are also other commonalities in the policy process/window which exposed the personalised and sometimes covert nature of the policy-making processes. In particular the involvement of two ministers, a policy adviser and two private hospital developers who emerged starkly from the policy windows as the policy entrepreneurs. Two of the three political policy entrepreneurs were common across each of the policies. Each of the cases is a separate policy initiative, yet they have in common their intention to increase the provision and delivery of for-profit hospital care as the solution to public-sector problems.

When using Kingdon to outline the documentary findings in chapter five, it emerged that there are strong connections between the policies being researched here and from that I developed a 'macro dynamic version of Kingdon', linking the cases and the common streams across the cases, see figure 10.2 below.

Policy window 1 and 2 – the introduction of tax breaks to build private hospitals in the Finance Act 2001 and 2002

The problem stream is the shortage of public hospital beds. The failure to invest in the public hospital system, the public-private mix within public hospitals, and the excess of private patients in public hospitals each contributed to the shortage of public hospital beds for public patients. The shortage of beds resulted in high numbers on trolleys in the country's Accident & Emergency departments and exceptionally long waits for public patients for elective care and hospital treatment. These were major issues in the 2000 local elections. The government set about developing a new health strategy in response to concerns about the health system.

The political stream is the Fianna Fáil/PD government who were in power from 1997 to 2007. This was an era of immense economic growth and general political stability. The then Minister for Finance, Charlie McCreevy, was lobbied by hospital developers in 2001 and 2002 to introduce the tax relief for private hospital developments.
Despite opposition from the then Minister for Health and the Department of Health, and plans to increase public hospital capacity, McCreevy introduced the changes.

The policy stream is the tax breaks which intended to increase the numbers of private hospital beds, which were meant to free up public beds in public hospitals. The tax breaks resulted in large numbers of new private hospital beds in the decade that followed.

The policy window was opened up by policy entrepreneurs who proposed the idea of tax breaks for developers, which occurred around the time that McCreevy publicly stated that there would not be the public funds to finance the commitments in the health strategy. Also, the policy window was influenced by the broader political economy where tax breaks were a common method of stimulating economic development.

Policy window three – the establishment of the NTPF in 2002

In December 2001 the health strategy was published. It contained 121 recommendations including one to set up the NTPF to buy private care for long-waiting public patients in private hospitals.

The problem stream is the long waits for public patients for elective care in public hospitals, caused by a shortage of public hospital beds and the public-private mix.

The political stream is the Fianna Fáil coalition in government, in particular the powerful role of the PDs, which proposed the idea of the NTPF.

The policy stream is the NTPF which was proposed during the health-strategy development process. It started with a budget of €5 million; within six years its budget was €100 million.

The policy window emerged after politicians rejected the introduction of a common waiting list for all patients in public hospitals as a health strategy proposal and came up with the alternative of a treatment purchase fund, which gained political support despite the initial opposition of the Minister for Health and the Department of Health. The NTPF bought care in private hospitals built with the assistance of the tax breaks (policy windows 1 and 2).

Policy window four – the plan to co-locate private hospitals on the grounds of public hospitals

The problem stream is a shortage of public hospital beds. This was contributed to by failure to invest in public hospitals, the public-private mix and excess private patients in public hospital beds.

The political stream is the Fianna Fáil/PD coalition. The then PD leader and Tánaiste, Mary Harney, had become Minister for Health in September 2004.

The policy stream is the unexpected announcement, in July 2005, of the plan for co-location, in which private developers could use the tax breaks to build private hospitals on the grounds of public hospitals, which in turn are meant to free up beds for public patients in the co-located public hospital.

The policy window was Harney becoming Minister for Health. She and her political adviser developed this project covertly and it was strongly influenced by their political ideology and a belief in the private sector being able to solve the ills of the public sector.

Linking my policies in the Kingdon streams

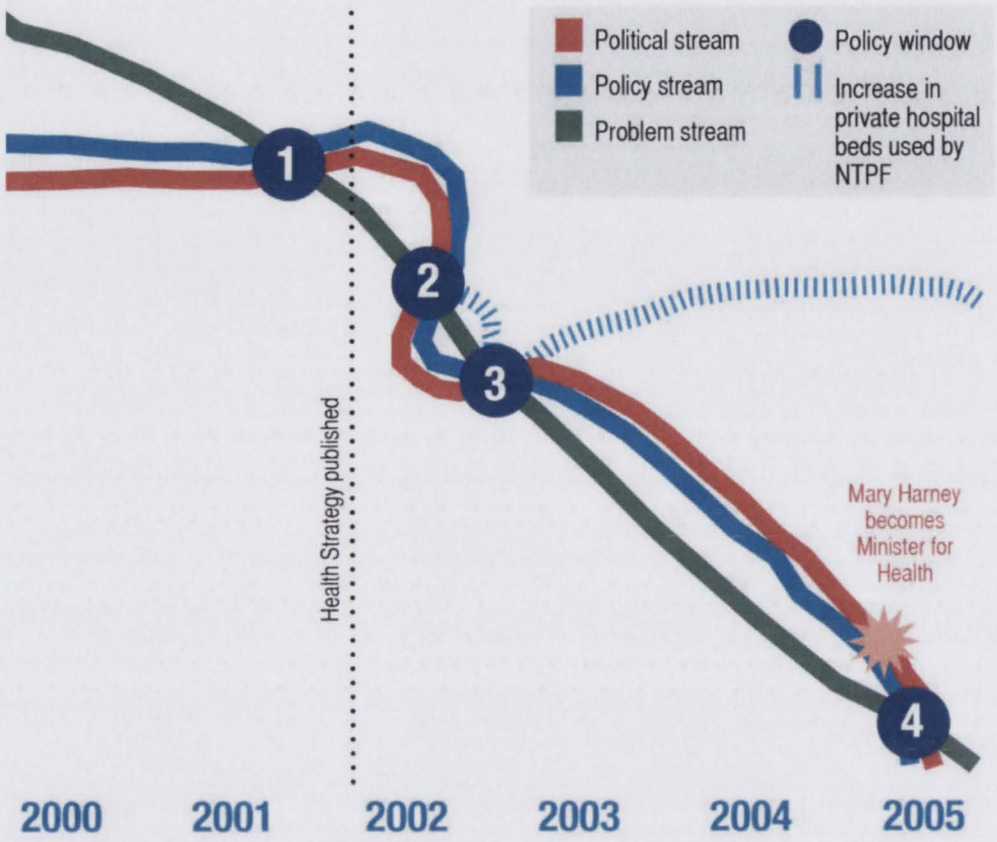
Linking the policies in the Kingdon streams allows for a few different levels of analysis. It shows how the tax breaks given in 2001 and 2002 subsidised the development of private for-profit hospitals which when built, were used by the NTPF to treat public patients in those private hospitals.

The tax breaks also provided a rationale for co-location – they were to be used to build the private co-located hospitals – and co-location was justified as a way of managing the unwieldy nature of the tax reliefs, as the state would have control over their location.

Linking the policies also enabled me to see the common themes among the political and problem streams as outlined above, and the path dependency of health policy in Ireland. For all three policies, the political and problem streams were consistent and they contributed significantly to the policies' development.

This 'macro-dynamic' Kingdon streams evolved as an unexpected finding from this research and provides a basis for future work using Kingdon streams to explore a variety of linked policies.

Figure 10.2 'Macro-dynamic version of Kingdon's multiple streams



Chapter 11

Summary and conclusions

11.1 Introduction

This research set out to explore why three specific policies which aimed at increasing private for-profit hospital care became an accepted method of reform in Ireland between 2000 and 2005. I wanted to explain these three policy-making processes in order to understand more about how policy choices get made, what influenced these specific policy processes, and whether these policies reflected the national health policy or the political economy of the time.

I carried out this research using the three policies as case studies. I utilised qualitative methods of documentary analysis and in-depth interviews to explain and explore my research questions. Large amounts of data were gathered through these methods. The interviews were transcribed and coded in NVivo. All the data were then analysed using a conceptual framework that I developed for this research drawing on leading authors in this field.

11.2 Summary of key findings

The strongest finding emerging from this research is the personalised and political nature of the three policy-making processes under scrutiny. While each policy process was quite different and resulted in different outcomes, the absence of the use of evidence, including the very limited use of learning from other countries, was an associated key finding in this research. Where evidence was used, it was used to justify a political decision, which had already been made. The lack of good, and in some instances any, information was also evident in these policy-making processes.

The role and impact of a few powerful people, politicians, consultants and/or private hospital owners, on the three policy making processes is another of the most robust results from this research. In particular, the role the PDs and what was referred to as the 'Mary Harney/Charlie McCreevy axis' had on these policy-making processes emerges as a central finding. This shows how particular personalities can have a powerful influence on health policy-making processes, even when they are not the Minister for Health. This research also demonstrates the impact of Irish political institutions, in particular coalition governments, can have on policy choices. While the 'Harney/McCreevy axis' played a central role in influencing the changes to the Finance Act and the NTPF, Mary Harney's influence and that of her adviser Oliver O'Connor is also paramount to the co-location

proposal. Every government in Ireland since the 1980s has been a coalition government. The Fianna Fail/PD government in place from 1997 until 2007 was the longest and most stable of them, although it did not have a large majority and required the support of some independents (Gallagher and Marsh, 2008). There are dynamics at work in coalition governments which are not the case when a party has an overall majority. The Programme for Government is a result of often hasty negotiation and bargaining between the parties coming together to form the government and involves compromise (Ansolabehere et al, 2005).

This research found that the smaller party in coalition had a disproportionate influence on government policy, more influence than its seat numbers (four [1997-2002] and then eight [2002-2007]). It was acknowledged that it had considerable influence in economic matters but this research shows the small party also had considerable influence in the health policy arena ever before it held the health ministry, from 2004 onwards. The fact that the leader of the PDs who was the Tanaiste (deputy prime minister) Mary Harney had previously been a member of the larger party Fianna Fail, meant she had some allies in the larger party and wielded considerable influence.

Where it was possible to show lobbying took place, such as with the changes to the Finance Act, it was very effective and led to policy change. In the other two policies, it is harder to quantify the extent of the lobbying that took place. However the research finds that owners of private hospitals and consultants were to benefit significantly from the policies. The research also finds that these hospital owners and consultants had easy access to and influence on senior politicians. This exemplifies the point made by Gilson, Walt and others about the requirement of assessing the role of power in policy-making processes.

The issue of power also is a key finding. This is most evident in the discovery that the NTPF emerged as a policy proposal after a common waiting list was rejected. The common waiting list was politically discarded on the basis that it would be negatively received by the half the population with private health insurance, who are usually the older and richer half of the population. These are the half the population who are more likely to vote and therefore they have a powerful influence on political, and in this instance policy, choices. This finding suggests that the politicians who made this decision placed a higher value on the people who vote for them and on maintaining the status quo, rather than on addressing fundamental inequalities in access to hospital care. This issue also highlights how a very formal policy-making process in the form of the proposal of a common waiting list in the health strategy was undermined or usurped for an informal political proposal in the form of the NTPF.

The three policies set out to increase access to public patients to either hospital beds or hospital treatment. While each policy was proposed on the basis that they would lead to an increased provision of private for-profit care, they were all promoted on the basis that they were in the interest of the public patients. The documents used in this research show, for the first time, a tenfold increase in private hospital beds when compared to public hospital beds between 2000 and 2010. It also shows that 10 years after the implementation of the policies there remained high numbers of public patients still waiting more than three and six months for treatment. This research quantifies the amount of public money that was diverted to private for-profit hospital care under two out of the three policies that were implemented. This added up to €830 million.

The continued long waits for public patients and the very small increase beds for public patients demonstrate that, apart from the public patients who received care under the NTPF, these policies did not benefit public patients. Instead, the policies benefited private patients, those who owned and worked in private hospitals, such as consultants.

The level of disagreement among the interviewees as to the causes of the problems is evident from the findings. This is apparent across the three cases. Implicit in these findings were ideological differences which influenced different interviewees' differing assessments of the problems. For example, some blamed the long waits for public patients on the failure to invest in public hospitals while others thought it was to do with the inefficient public sector. As detailed in the literature in chapter four, a greater degree of consensus on the problem would assist with finding more effective solutions.

There was a strong degree of consensus among proponents of the three policies: that the private sector could more easily solve the public-policy ills and that this was preferential to reforming the public sector. The failure of previous attempts to reform the public hospital system, and the health system overall, was a common theme among the interview findings. Closely associated with this from proponents of the policies was a firm belief that the private sector was a more efficient and effective provider of care. This viewpoint was without any evidence to back it up. There is little, if any data, in Ireland on the quality of public or private hospital care so it is not possible to say that private care is better or more efficient. There are strong indicators that people who can afford it, have faster access to private care as there are shorter private waiting lists and less demand for such services, however, it is not possible to compare public with private hospital care as the data do not exist. Even if the data did exist, it would not necessarily be comparing like with like, as public hospitals tend to treat more urgent and chronic cases, while private hospitals largely provide elective care (Tussing and Wren, 2005).

Another strong finding that emerges from the research is the failure to reform or invest in the public system, i.e. not building up public hospital bed capacity, not addressing the long waits in the public system for public patients, not getting rid of the perverse incentives that maintained the public-private mix. This inaction created a space from which these private for-profit initiatives could emerge and gain political and public approval.

The question of the competency of officials in the Department of Health and up to 2004 the Minister for Health in relation to the policies under scrutiny for this research is a key finding arising from across the cases. It raises the question of the capacity of the Department of Health to make policy, and in particular to oppose government policy emanating from other government departments or ministries that is contrary to stated health policy. Furthermore, the failure to take responsibility for private healthcare is inherently paradoxical to the Department of Health's simultaneous tolerance and promotion of a public-private mix of hospital care, even within the public hospital system.

The intrinsic contradictions between different arms of government also emerged from this research. For example, with the changes to the Finance Act, the Ministers for Finance and Health were of opposing opinions as to their merits. The aim of the tax breaks was to promote the development of small, private for-profit hospitals, which could be built anywhere, when national health policy was recommending the rationalising of hospitals in line with specialties and regions.

Another finding that emerged from the research is that the three policies considered here were not the priority or main policies being pursued by the Department of Health. Although each of them has been portrayed as addressing a key policy challenge (the shortage of public hospital beds and long waits for public patients), the Department of Health justified their adoption by stating/asking: 'How many ditches do you die ****ing on?' In other words, politicians and senior departmental officials make calls as to which policy issues they pursue and which they object to, take on and fight. This is an important outcome from this research. Shiffman and Kingdon both try to quantify this in their research ie to identify what are the policy/political priorities and then what gets implemented.

Another key finding is the impact that the broader political economy had on the health system. This is most evident in the case of the impact of the Finance Act changes. However the ideology and economic model pursed by the PDs and the Fianna Fáil/PD government is evident as a strong influence in each of the three cases.

An unexpected discovery during this research was the fact that the health strategy never set out to explore the possibility of a one-tiered or a universal system. This is a significant finding that the maintenance of the status quo and the continuation of the two-tier system were decided in advance of the health strategy being developed, demonstrating the power of the status quo and previous policy choices to influence future ones (Wilsford, 1994).

Another interesting finding that emerged in relation to co-location, which was not sought as it is beyond the scope of this research, was why co-location was never implemented. There was strong agreement that co-location was sabotaged by those who were given the powers to implement it and that they altered it so much in the public interest, it was no longer viable as a private enterprise. Co-location is a good example of how a politically imposed policy may not succeed, despite high levels of political support for it, if it does not have institutional support for its introduction.

11.3 Generalisability of findings

As outlined in chapter 10, many of the key findings in this research resonate with the literature on this area. The absence of good information on health systems influences the quality of the policy solutions (Shiffman et al, 2007). This is certainly the case here. Each policy lacked fundamental information to inform its development, yet each went ahead as a policy choice. The international literature also shows how information on a problem and a solution can influence the level of consensus and the priority it is given (Shiffman, et al, 2007; John, 2012). The absence of information in an Irish context may have influenced the lack of consensus and the priority the policies gained.

International literature also situates health policy-making processes in the political realm (Grindle and Thomas, 1991; Walt and Gilson, 1994; Kingdon, 1995; Shiffman et al, 2004; Touhy, 1999, John, 2012). This is perhaps the strongest finding from this research: how much politics, and politicians, influenced the policy-making processes in these three case studies. Directly associated with this is the absence – almost entirely – of good practice or evidence to inform their development. In particular, the literature that shows that it is often post-colonial countries that have such personalised, closed policy-making processes (Grindle and Thomas, 1991). This was also a key finding emerging from this research: each of the processes involved a few personalities and the processes were informal, closed and not open to any public scrutiny.

Kingdon's work found politicians were more powerful than any other actors in the policy process. This finding is reiterated in this research. The powerful role played by 'policy entrepreneurs' and policy or political elites who open policy windows features in the

international research on this area (Kingdon, 1995; Shiffman, 2007; Gilson, 2011). Policy entrepreneurs emerge as critical from this research, wielding huge influence over the policy processes and the ultimate section of the three policies. Each of them had power; three of them – two ministers and a political adviser – were very powerful politically; while the other two, as owners of private hospitals, were economically powerful.

The role of the ideology of the government and its influence on policy processes is dealt with theoretically but less empirically in the international literature on health policy making (Walt and Gilson, 1994; Grindle and Thomas, 1991; Harvey, 2005; Reich, 1995). An important finding from this research is that ideology and a preference for private-sector solutions contributed to the rationale for each of the policies development. However, this research does not find that Ireland followed other countries' experiences of 'privatisation' (Harvey, 2005). What happened in Ireland was not a clear 'privatisation' policy agenda as the public sector was being built up and invested in (although critically not reformed) concurrently the government was proposing and adopting some private-sector solutions. This research resonates with Touhy's 'accidental logics' which shows 'that "accidental logics" that drive the dynamics of change… forces in the broader political area have periodically opened windows of opportunity for major policy change in the health care arena in each of these nations. The systems that resulted were largely, if not entirely, "accidents" of their timing of their birth – had windows opened at different times, they might have looked quite different. Between these policy windows the systems were shaped by their own internal logics' (Touhy, 1999: 239).

Examinations of policy-making processes in other counties have also found that economic policy can override health policy (McIntyre et al, 2004). This is clearly the finding for one of the cases and an influence in the other two.

The research drawn on for this work emphasises the key role that government officials play in policy-making processes, often proposing an alternative to the political proposals (Grindle and Thomas, 1991; Kingdon, 1995). While government officials played a central role in these research findings, it is more for what they did not do than what they did. What department officials or ministers did not do – eg reform the public hospital system, deliver on promises for additional public hospital bed capacity, undo the unfair public-private mix – provided fertile ground for the three policies to emerge.

In addition, my research finds to the contrary that the policies were political proposals initially rejected by the permanent civil servants. In particular the rejection of a common waiting list, which would have benefited public patients and the alternative proposal of the NTPF, which became the policy solution to long-waiting public patients, reinforces

other findings that policy makers, in this instance the politicians, acted in the interest of the elite or the privileged instead of redistributing in favour of the poor (Olsen, 1972; Kingdon, 1995).

International research has also found the countries' previous policies are important in determining future policies (Walt and Gilson, 1994; Wilsford, 1994, Gilson et al, 2008). This is also a strong finding emanating from this research: the pubic-private mix in hospital care facilitated the development of these three policies, and it was more politically shrewd to maintain the status quo which privileges private patients over public patients than to come up with more radical solutions. Also the decision to give tax breaks to hospitals and other healthcare institutions was justified as the application of a policy used in every other area to the health arena – the application of past policies to future policy in health (Wilsford, 1994). In addition, co-location was justified on the basis of remedying the problematic nature of the tax breaks.

Empirical research investigating the level of influence of private-sector interests is also well-documented internationally (Walt and Gilson, 1994; Grindle and Thomas, 1991; Touhy, 1999, Shiffman at al 2004; Gilson, 2011; John, 2012). The dominant influence of private-sector interests of both consultants who practise privately and owners of private hospital emerges clearly from this research too.

The role of power in political and policy processes is well-documented theoretically (Lukes, 1995; Walt and Gilson, 1994; Touhy, 1999, John, 2012). As stated above, power played a critical role in each of the studied policy processes.

11.4 Critical assessment of work

The methods of case study, documentary analysis and semi-structured in-depth interviews were suitable for this research. The documents provided a rich description of the cases, while the interviews assisted in teasing out the key research question – the how and why of the policy processes and the policy choices.

The choice of three cases (rather than one or four) was accidental. Three specific policies during the time under consideration met the criteria outlined in chapter three. However, the fact there are three cases, not one or two, strengthens the findings, especially where there is strong commonality in results across the cases, as detailed in chapter nine. Having multiple cases added to the rigour of this research and allows for some general conclusions which provide theoretical insights that can be tested in future research.

A weakness to this study is that three vital personnel refused to be interviewed for this research. However, the fact that so many other senior officials, including a minister, agreed to be interviewed mitigates these effects somewhat, as does the depth of the documentary analysis that for a large part tells the story of the three who did not want to be interviewed. In particular the use of FoIs assisted greatly in understanding what happened, exploring the policy window and in triangulating the findings. The FoIs, especially for the Finance Act, gave a particular insight in to the policy processes that otherwise would not have been gleaned. Fewer relevant documents were obtained for the NTPF or co-location, however seeking them officially and being rejected opened up other doors through which I was able to obtain the documents' informally.

There are problems with recall bias due to the time lag between the time the policies were made and the interviews. There were also problems with people not telling the truth. These were ameliorated by using triangulation and documents used to back up points made, especially if they were unique points.

Power played an important role in these policy-making processes, with five people, all with large amounts of either political or economic power, emerging as the policy entrepreneurs. However, assessing that or quantifying the extent and the role that power played proved difficult. Further exploration of how to quantify and assess power is needed.

The role of the researcher is pertinent to this research especially as I am known as both an 'insider' and an 'outsider' in my roles as a health-policy analyst and a journalist. However, this was dealt with by being reflective throughout, having rigorous methods and a conceptual framework which structured the nature of the work and the analysis. While my position meant that I was refused interviews from three key personnel, it also opened up other doors to people PhD researchers may not always get access to, such as the minister, political advisers and senior government officials, including a secretary general and high-profile private-sector developers. In addition, my journalism experience assisted me in finding key documents, either through the use of FoIs or through personal contacts. A few of the key documents and information I received were refused to me officially, but I obtained through knowing people personally or through contacts in the system who passed the information on to me.

11.5 Contribution to original knowledge

This research is a contribution to original knowledge in the field of health policy making.. This work hopes to contribute to policy making analyses, which explain and explore in

detail what influenced health-policy choices and processes, with a view to developing more effective policy-making processes in the future.

Specifically, it highlights the particular role that politics and politicians play in making health policy and the power that one or an alliance of ministers can have in influencing health-policy decisions, even when they are not the Minister for Health. These findings are specific to health policies that aimed to increase the role of private for-profit hospital care. However, given the strength and consistency of the findings (as detailed in 11.2 and 11.3) and how they resonate with the international literature, there is reason to suggest that they are not unique to these processes and should be investigated for other health policy and public policy making processes. This provides plenty of opportunity for further research in this area.

This research draws on previously unpublished documents, such as the Prospectus document which formed the basis for the co-location policy. It also details previously uncollected figures eg the numbers of public and private hospital beds since 2007. It outlines other figures not in the public domain, for example the numbers of people waiting more than three and six months, as government and the HSE have discontinued publishing such figures. This research collated figures for the first time on the cost of the tax subsidies for private hospitals to the state. This is all new data which contributes to a more informed and rounded picture of the Irish health system.

In particular the large increase in the numbers of hospital beds in private for-profit hospital (34%) compared to the increase in public beds (3%) between 2001 and 2010 shows the dramatic impact of the Finance Acts on the landscape of hospital care in Ireland. This also draws attention to the fact that more than 11 years on from that Act, and despite a huge increase in the numbers of private hospital beds incentivised by the state, the state has failed to introduce or regulate any quality standards in private hospitals.

Another contribution to original knowledge is my development of 'macro dynamic' Kingdon streams. I used Kingdon to link the three policies being researched as they had common problem, policy and political streams. Linking the policies through the Kingdon streams assisted me to make the connection between the policies, as one of the policies enabled the two others. For example, the existence of the tax reliefs introduced under the Finance Act in 2002 meant that there were many more private beds in private hospitals available for use under the NTPF. They also provided one of the rationales for co-location. This 'macro dynamic' Kingdon framework may be useful to other policy analyses.

The original and revised conceptual framework drew on the work of some of the 'giants' of policy analysis. What I used was valuable and greatly facilitated my analysis. However, having utilised it I am now proposing a slightly revised framework with nine rather than seven variables, splitting up political ideology and political institutions into two separate variables and introducing a new variable of 'path dependency' – how future policies are influenced by past policies. I am hopeful that the revised framework will be useful to research in all countries (low-, middle- and high-income), and across all types of policy-making analyses.

11.6 Recommendations for policy making

The most striking finding in this research is the personalised, political and often informal nature of these policy-making processes. Alongside this, comes a clear verdict of the virtual absence of evidence in these policy-making processes. This research is a clarion call for more research and evidence-based policy making in the future. It demonstrates the need for more research 'for policy' as well as 'of policy' processes. It also implies the need for greater scrutiny of policy proposals to assess the extent of their public interest.

This research highlights the hugely political nature of policy making in Ireland. This research finds that this is directly related to our political systems and institutions. Greater attention to the role that our political institutions and ideologies play in policy-making processes could inform more effective policy making in the future. In particular, the relatively new role of political advisers and the transparency of policy decision-making processes deserve further scrutiny.

The absence of information and evidence in the policy-making processes is striking. Improvements have been made since these policies were made in gathering good-quality information to inform decision and policy making. Ensuring this new information and evidence is now used in policy-making processes remains a challenge.

Given the dominant role that a few powerful people played in these policy-making processes, it is essential that such disparities of power be taken into account and rebalanced in future processes. Effective lobbying by powerful vested interests influenced the development of these policies. The current government has committed to the regulation of lobbying with a view to preventing the mistakes of the past, whereby a small number of powerful people held undue influence. This needs to be acted upon and implemented as soon as is possible.

A key finding in this research is the failure of Irish government and health policy makers to reform the public hospital system, to remove the perverse incentives that privilege private patients over public patients. The current government has committed to a universal health-insurance system where access to care is based on medical need not ability to pay. Given our failure to ensure this position in the past, it is essential that current initiatives are closely monitored and analysed for their impact on all patients, especially those most in need of medical care.

Private providers have a role to play in all health systems. However ensuring the subsidy and development of private not-for-profit and for-profit healthcare providers is in the public interest is an essential requirement of government and officials, which was not evident in these policy processes. When public money is diverted to private providers, it must be ensured that this is being done in the public interest, in particular in health policy, in the interest of public patients and the public health system.

Private nursing homes in Ireland now have quality standards and are regulated (only after an investigative television programme exposed institutional abuse in a private nursing home). However, despite increasing the provision and use of private hospital care, government has failed to set standards or regulate private hospitals. This needs to be acted upon immediately.

11.7 Recommendations for further research

My revised conceptual framework requires further testing. There are opportunities to test this framework on other polices in other countries or in Ireland. This revised framework could be used to test any policies but it would be particularly interesting to use it in similar research on policies which seek to increase the role of for-profit providers and/or those that had a high level of political involvement.

There are strong suggestions in the literature that the personalised, often informal and closed nature of policy making found in this research is more prevalent in post-colonial countries. It is therefore worth exploring this proposition in other policy processes in other comparable countries. The finding that informal policy processes may have been more important than formal processes also provides a fascinating area for policy research in any country.

Two findings were stumbled upon during this research. Firstly, how the health-strategy development process never considered a different form of financing or a universal system. Secondly, how and why co-location was never implemented – and possibly how

it was sabotaged by the public servants who were given responsibility to implement it. These provide interesting areas for further research and could contribute to understanding how health policy gets made (or not made), and, crucially, how policy does not get implemented.

Another unexpected methodological finding was how the introduction of Freedom of Information means civil servants are less likely to write things down in official documents. Research in this area, exploring the habits of public servants and testing if FoI has changed their practices would be very interesting.

The nature of coalition governments and their impact on policy formulation is a key finding from this research. This raises the question as to why there is not more research on this area, in particular the role that political institutions play on policy formulation. Political science is brimming with studies on election results, voting patterns and political parties. Yet, there seems to be a dearth of research on the impact of politics on policy making. There is huge scope in Ireland, and in other countries, for more research on how coalition politics influenced policies and how the nature of the Irish political system and political institutions impact on policy development. There is some work in the area of clientelism and its impact on local provision, but to my knowledge there is little empirical research in an Irish context on how our political institutions influence policy-making processes. This provides a ripe area for further research.

There is also plenty of scope for research how the ideological make up of a government influences policy process and policy choices. It would be particularly interesting to discover which plays a more important role and in what circumstances – political institutions or political ideology – on policy-making processes.

Kingdon and Shiffman's work was concerned with which issues get on the policy agenda, which gain political priority and which get implemented. In other words, which policies get made and which do not – and why. Carrying out such research in an Irish context could greatly enhance the understanding and effectiveness of Irish policy making in the future.

Appendix I

Semi-structured interview guide for elite interviews

Contextualising the role of the interviewee:

1. What was your position between 2001 and 2006?
2. What role did you have in the policy making process?
3. Which policy/ies were you involved with: the Finance Act in 2001 and 2002; the establishment of the National Treatment Purchase Fund; and the plan to co-locate private hospitals on the grounds of public hospitals?
4. What was your role in this particular policy development?

Role and assessment of primary influence on policy making process:

5. In your opinion, what was the primary influence on this policy's development?
6. Why was this the primary influence?
7. Who led its development? Was there a policy champion? Did the Dept of Health lead this policy reform? If not, who did?
8. Did this policy reflect health policy goals (Or other broader political/economic goals) at the time?
9. Was there previous efforts to address this issue in the public system? Was the private sector seen as an alternative to the failure to public sector reform?
10. What were the main arguments for the adoption of this policy?

Assessment of other factors in policy development process:

11. What other factors influenced its development?
12. Did people/sectors actively lobby for its introduction?
13. Was this a policy transfer in line with international developments (eg increased privatisation/contracting out of healthcare)? If so from where? And can you give examples?
14. Was there evidence of what impact this policy choice would have? If so what and where could I find it?

Assessment of opposition to policy development:

15. Were there people opposed to its development?
16. Who were they?
17. Were there arguments against this policy's development? What were they?

Other places and people I should go to for information:

18. Who else should I talk to about who and what influenced this policy's development?
19. What are the relevant internal or external documents I should read in relation to this policy's development?
20. Any other thoughts?

Appendix II

Participant Information leaflet

1. Title of study: An analysis of policy choices which aimed at increasing the use of for-profit hospital care in Ireland 2001-2005.

2. Introduction: This research is a detailed policy making analysis, using three policy initiatives between 2001 and 2006, to understand what influences policy choices.

The three policies are: the changes to the Finance Act in 2001 and 2002; the establishment of the National Treatment Purchase Fund; and the plan to co-locate private hospitals on the grounds of public hospitals.

The research will be based on in-depth documentary analysis and a series of one to one semi structured interviews. Interviewees will be asked to give 45 minutes of their time.

3. Procedures: People have been invited to participate in the study due to their involvement in or proximity to one or more of the policy making processes. Participants will be asked to participate, if they agree, they will be asked to sign an informed consent form. All interviews will be transcribed. Interviewees will be given the option of seeing a transcript of the interview and to agree that it is an accurate record of the interview. Interviewees anonymity will be guaranteed and only the principal researcher (Sara Burke) and her supervisors (Steve Thomas, Trinity and Ruairi Brugha, RCSI) will know the identity of the interviewees.

A computerised package will be used to analyse the findings and a unique interviewer number will be used. All interviews will be transcribed and anonymised using a unique interviewee identifier number. The transcriptions will be kept in a locked cabinet with access strictly restricted to the researcher. Where soft copy transcriptions are loaded on to the computer they will be anonymised and stored under password protection.

All computerised data/information collected will be anonymised by using identity numbers for the participants and will be pass word protected. The data/information will be stored for the duration of the study, i.e. until the work is fully reported and disseminated. It will then be kept in a locked cabinet for five years. Data Protection Act guidelines will be followed. The findings will be written up in a way to assure anonymity. Final copies of the research will be given to all participants in the study. The research write up will take the form of a PhD thesis and other publications.

4. Benefits: It is hoped that the research will inform policy making processes and will be of use and interest to the study participants as well as a broader policy making audience.

5. Confidentiality: Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group.

6. Compensation: This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

7. Voluntary Participation: If you decide to volunteer to participate in this study, you may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study.

8. Stopping the study: You understand that the investigators may withdraw your participation in the study at any time without your consent.

9. Permission: This research has the approval of the Trinity College Dublin's School of Medicine Research Ethics Committee.

10. Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Sara Burke who can be telephoned at 087xxxxxxx. If the study team learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Further information contact Sara Burke, sarabur@gmail.com, 087xxxxxxx

Appendix III

Informed consent form

PROJECT TITLE: An analysis of policy choices, which increased the use of for-profit hospital care, in Ireland 2001-2006.

PRINCIPAL INVESTIGATORS: Sara Burke, PhD student. Supervisors: Steve Thomas - Trinity College Dublin and Ruairi Brugha, RCSI.

BACKGROUND: This is a detailed policy making analysis, using three Irish health policy initiatives between 2001 and 2006, to understand what influences policy choices.

The three policies are: the changes to the Finance Act in 2001 and 2002; the establishment of the National Treatment Purchase Fund; and the plan to co-locate private hospitals on the grounds of public hospitals.

The research will be based on in-depth documentary analysis and a series of one to one semi structured interviews. Interviews will be asked to give an hour of their time. Anonymity of participants is assured.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: .....

CONTACT DETAILS: .....

PARTICIPANT'S SIGNATURE: .....

Date:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:..... Date:.....

Please return to Sara Burke, PhD scholar, Centre for Health Policy and Management, Trinity College Dublin, 3-4 Foster Place, Trinity College, Dublin 2

(Keep the original of this form in the investigator's file, give one copy to the participant, and send one copy to the sponsor (if there is a sponsor).

Appendix IV

FOI documents used in this research

Finance Act 2001 and 2002

1. Letter to Minister for Finance, Charlie McCreevy, dated 25 February 2000, seeking the 'total write offs of all income' for 13 investors in a '100 bed hospital and 100 convalescent homes'. Much of the letter is redacted including who it is from.

2. Letter from Fred Foster, Department of Finance to Dermot Smyth, Department of Health, dated 5 October 2000, stating that the Minister for Finance is intent on introducing tax reliefs for 100 bed hospital and 100 convalescent homes. The letter states 'there are strong arguments against introducing tax-based scheme to support the creation of hospitals'.

3. Letter from Dermot Smyth, Department of Health to Fred Foster, Department of Finance, dated 1 November 2000, 'agreeing with arguments against introducing a tax based scheme to support the creation of hospitals'.

4. Letter from James Sheehan, dated 21 November 2000, to Minister for Finance, Charlie McCreevy seeking 'tax incentives' for 'a new medical facility in the West of Ireland' which will be structured as a charitable foundation'.

5. Fax from Fred Foster, Department of Finance to Dermot Smyth, Department of Health which had a letter from Jimmy Sheehan to Charlie McCreevy seeking tax breaks for not-for-profit private hospital development, 5 February 2001, including hand written note from Dermot Smyth on cover of fax saying 'his minister [Charlie McCreevy] is under pressure from James Sheehan to concede tax incentives for the project'.

6. Email to Paul Barron, Department of Health from Fred Foster, Department of Finance, dated 13 February 2001, stating that 'the minister is included to extend the tax relief sought by Mr Sheehan' seeking advice on whether private hospitals 'could be regulated in some way'.

7. Internal memo, dated 28 February 2001, between officials within the Department of Health, seeking comments on request for tax reliefs for private hospitals stating the Department of Health had no function 'in relation to the regulation, co-ordination or assessment of the services provided by private hospitals'.

8. Multiple correspondences (emails and faxes during February and March) between Department of Health and Department of Finance officials re exact wording of the stipulation set out in the Finance Act, including briefing notes for a Seanad debate on the Finance Act.

9. An internal correspondence, unclear from where and undated, although it has hand written on it 22 February 2001, referring to a meeting with James Sheehan re his proposals for a private hospitals in Galway. It also refers to 'further discussion with Dr Madden who sent in more details regarding his proposed health park for Carlow'. This could be the development referred to in document one above.

10. Letter from Minister for Finance Charlie McCreevy to Minister for Health, dated 2 March 2011 stating that 'the Government have agreed that a provision be included in the Finance Bill under which capital allowances will be available to promoters of certain private hospitals'. He specifies that the Minister for Health 'will designate as public beds a similar number of beds in public hospital system which, prior to the provision of the new beds has been designated as private'.

11. Letter from Michael Martin to Charlie McCreevy, which was never sent and has no specific date on it, its dated 'March 2001'. In this letter Minister Martin explains why private beds in public hospitals could not be redesignated as public when private hospitals are built.

12. Letter from Michael Heavey, Independent Hospital Association of Ireland to Minister for Health, Micheál Martin, dated 9 April 2001, seeking the extension of tax reliefs to for-profit hospitals , also querying who hospitals had to be 100 beds and over.

13. Letter from Vera McManamon, private secretary to Minister Micheál Martin, to Michael Heavey, Chief Executive of the Independent Hospital Association of Ireland, 17 May 2001, responding to a request from Heavey to extend the tax reliefs to for-profit hospitals, explaining that the legislation was the remit of the Minister for Finance and the 'Minister for Health and Children has no function in the matter'.

14. Multiple correspondences between the Department of Health and European Commission notifying them of the introduction of Capital allowances for independent Hospitals, October 2001.

15. Correspondence between Department of Finance and Department of Health, much of which is redacted in February/March 2002 stating the Minister for Finance's intention to extend tax reliefs to for-profit hospitals and reducing the beds number requirement to 70 beds.

NTPF FOI documents

16. Draft of health strategy *Quality and Fairness*, dated in pencil on cover, September 2001.

17. Email dated 9 November 2001, internal communication within the Department of Health outlining queries re National Treatment Purchase Team including concerns from Minister Martin re same.

Co-location FOI documents

18. Final copy of techncial work carried out by Prospectus for the Department of Health in 2005 called *Development of private facilities on public hosptial sites - memorandum on related policy issues*.

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