It's the economy, stupid! When economics and politics override health policy goals – the case of tax reliefs to build private hospitals in Ireland in the early 2000s [version 2; referees: 2 approved]

AUTHOR(S)

Sara A. Burke, Ruairi Brugha, Stephen Thomas

CITATION

Burke, Sara A.; Brugha, Ruairi; Thomas, Stephen (2018): It's the economy, stupid! When economics and politics override health policy goals – the case of tax reliefs to build private hospitals in Ireland in the early 2000s [version 2; referees: 2 approved]. Royal College of Surgeons in Ireland. Journal contribution. https://hdl.handle.net/10779/rcsi.10774763.v2

HANDLE

10779/rcsi.10774763.v2

RESEARCH ARTICLE

REVISED It's the economy, stupid! When economics and politics override health policy goals – the case of tax reliefs to build private hospitals in Ireland in the early 2000s [version 2; referees: 2 approved]

Sara A. Burke [1], Ruairi Brugha[2], Stephen Thomas [1]

[1]Centre for Health Policy and Management, Trinity College Dublin, Dublin 2, Ireland
[2]Division of Population Health Sciences, RCSI Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland, Dublin 2, Ireland

v2 **First published:** 28 Feb 2018, **1**:1 (https://doi.org/10.12688/hrbopenres.12784.1)
Latest published: 03 Aug 2018, **1**:1 (https://doi.org/10.12688/hrbopenres.12784.2)

Abstract

Objectives: To analyse the policy process that led to changes to the Finance Acts in 2001 and 2002 that gave tax-reliefs to build private hospitals in Ireland.
Methods: Qualitative research methods of documentary analysis and in-depth semi-structured interviews with elites involved in the policy processes, were used and examined through a conceptual framework devised for this research.
Results: This research found a highly politicised and personalised policy making process where policy entrepreneurs, namely private sector interests, had significant impact on the policy process. Effective private sector lobbying encouraged the Minister of Finance to introduce the tax-reliefs for building private hospitals despite advice against this policy measure from his own officials, officials in the Department of Health and the health minister. The Finance Acts in 2001 and 2002 introduced tax-reliefs for building private hospitals, without any public or political scrutiny or consensus.
Conclusion: The changes to the Finance Acts to give tax-reliefs to build private hospitals in 2001 and private for-profit hospitals 2002 is an example of a closed, personalised policy making process. It is an example of a politically imposed policy by the finance minister, where economic policy goals overrode health policy goals.
The documentary analysis and elite interviews examined through a conceptual framework enabled an in-depth analysis of this specific policy making process. These methods and the framework may be useful to other policy making analyses.

Keywords

Irish health system, health policy, health reform, national health strategy, hospitals, tax-reliefs, public hospitals, private hospitals, Ireland

Open Peer Review

Referee Status: ✓ ✓

	Invited Referees 1	2
REVISED version 2 published 03 Aug 2018	✓ report	✓ report
version 1 published 28 Feb 2018	? report	? report

1 **Eoin O'Malley**, Dublin City University, Ireland

2 **Mark Exworthy**, University of Birmingham, UK

Discuss this article

Comments (0)

Corresponding author: Sara A. Burke (sarabur@gmail.com)

Author roles: Burke SA: Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Investigation, Methodology, Project Administration, Resources, Software, Validation, Visualization, Writing – Original Draft Preparation, Writing – Review & Editing; **Brugha R**: Conceptualization, Funding Acquisition, Methodology, Supervision, Writing – Review & Editing; **Thomas S**: Conceptualization, Funding Acquisition, Methodology, Supervision, Writing – Review & Editing

Competing interests: No competing interests were disclosed.

Grant information: Health Research Board, Health Services Research PhD Scholarship, 2008-2012, [PHD/2007/16] Health Research Board Ireland [HRA-2014-HSR-499]
The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

How to cite this article: Burke SA, Brugha R and Thomas S. **It's the economy, stupid! When economics and politics override health policy goals – the case of tax reliefs to build private hospitals in Ireland in the early 2000s [version 2; referees: 2 approved]** HRB Open Research 2018, **1**:1 (https://doi.org/10.12688/hrbopenres.12784.2)

First published: 28 Feb 2018, **1**:1 (https://doi.org/10.12688/hrbopenres.12784.1)

REVISED **Amendments from Version 1**

This article has been significantly added to and rewritten to take on board the feedback from the peer reviewers. In particular, the rewrite takes into account the recommendations to focus solely on the policy process, to provide more detail on the methods and the conceptual framework, to solely draw on the data for the findings and discussion sections.

There is now a table which details the literature that informed the variables selected for the conceptual framework and this is incorporated into the text of the article in a new section as well as in the analysis and the discussion.

The methods section has been added to and the findings section has been edited, amended and rewritten drawing conclusions solely from the data gathered. The discussion section has been greatly extended weaving in the literature used for the conceptual framework and other key texts into the analysis. The quotes which were in Table 2 (in version 1, page 7) are now incorporated into the text and they have been supplemented by more material from the original research throughout the text.

This paper emanated from the PhD of the lead author that studied three cases, the changes to the Finance Acts being one of them. When the lead author revisited the PhD, she found that many of the issues highlighted by the reviewers had been dealt with there. The authors have now drawn on this PhD content and included it in the draft manuscript. This rewrite means the overall article is longer but the authors are hopeful that this version addresses the core feedback from the reviewers.

See referee reports

Introduction

For fifteen years up to 2008, Ireland experienced exceptional economic growth and was regarded as a model for economic development (Bergin *et al.*, 2011). By 2010, Ireland was experiencing the worst economic decline of any high income country since the Second World War and was described by the International Monetary Fund (IMF) as 'perhaps the most over-heated of all advanced economies' (Department of Finance, 2010). Prior to 2007, Fianna Fáil, the dominant Irish political party, had been in power for 18 of the previous 20 years (Murphy, 2008). Fianna Fáil is considered 'one of the most successful political organisations in twentieth-century Europe, consistently the largest party in Ireland, usually polling over 40% of the vote and occupying government for 62 of almost 80 years between 1932… and 2011' P1. (O'Malley & McGraw, 2017). In 1992, Fianna Fáil's support dropped below 40% for the first time and they entered coalition with the Labour Party. From 1997 to 2007, Fianna Fáil, was in a coalition government with a small laissez-faire liberal party – the Progressive Democrats (Murphy, 2008).

During this period of economic growth, Ireland's Department of Health developed a new national health strategy, which had 121 commitments, including a commitment to increase hospital bed provision by 3,000, the majority of which were planned for public hospitals (Department of Health, 2001). In the year the strategy was published and the first year of its implementation, the Department of Finance established tax breaks for developers to build private-for-profit hospitals (Department of Finance, 2002).

This research provides an in-depth exploration into the policy processes that led to the introduction of tax breaks to build private hospitals in Ireland during 2001 and 2002. It seeks to understand why and how the changes to the Finance Act were made even though they did not align with the health strategy's commitments and were contrary to advice from officials in the Department of Health, the Department of Finance and the Minister for Health.

While there is much written about increased privatisation of hospital care and blurring between public and private providers, there is little research on the policy processes and the policy choices that increase private provision (Maarse & Normand, 2009).

The aim of this paper is to provide an in-depth analysis of this specific policy making process in order to better understand health and public policy making processes. In particular, it seeks to understand the role of private sector interests in public policy processes.

Irish economic, political and health policy context

Economic and political context. Between 1995 and 2005, Ireland experienced exceptional economic growth with annual growth rates between 5% and 10%% (Whelan, 2009). Between 1995 and 2000, real GDP growth averaged 10% a year, way beyond growth rates in other European countries (Honohan, 2002).

This expansion, which was subsequently found to be unsustainable, was driven by a pro-cyclical economic policy, largely dependent on Foreign Direct Investment; and a property boom fuelled by government tax-reliefs and over-generous, unsound lending practices by banks. These factors, combined with low interest rates, which were predetermined by Ireland's Eurozone membership, fed 'an orgy of borrowing and consumption' (Kirby, 2010 : 4).

Irish economic growth came to a sudden end in 2007/8, at the onset of the global financial crisis (Bergin *et al.*, 2011). By 2010, borrowing rates were unsustainable and Ireland entered an EU/IMF/ECB (European Central Bank) bailout (Department of Finance, 2010).

Two national political parties, Fianna Fáil and the Progressive Democrats (PDs), were in power continually from 1997 to 2007 (Murphy, 2008). Fianna Fáil, which was self-styled as the 'republican party', was the largest, oldest, dominant party in Ireland. 'At its most basic level, Fianna Fáil is nationalist – culturally, politically, and economically P 50 (Puirséil, 2017). However, Fianna Fáil's ideology has always been 'ambiguous' with the party showing itself to have 'chameleon-like qualities in coalition' moving to the left while in coalition with the Labour party in the early 1990s and towards the PD's between the late 1990s and early 2000s P 67 (Puirséil, 2017) (O'Malley & McGraw, 2017).

Popularly known as the PDs, the Progressive Democrats party, which was formed in the late 1980s by a group that split from

Fianna Fáil, pursued economically liberal policies with a strong low-tax, pro-business and pro-market focus (Collins, 2005). Although the minority party in government for ten years from 1997, they had considerable influence over government policy, especially economic policy (Leahy, 2009). Their leader, Mary Harney, was Tánaiste (deputy prime minister) and from 2004 until 2010 she was the Minister for Health. In government, the PDs held considerable influence over health policy even before occupying the health ministry (Wren, 2003).

The Minister for Finance from 1997 to 2004, Charlie McCreevy, was a senior Fianna Fáil member closely allied with the PDs and their leader. Fianna Fáil adopted the PD's position on many issues in the late 1990s and early 2000s, with 'little obvious difference in ideology between the two. This owed much to the personality of the Minister for Finance, who was a PD in all but name,… increasingly Fianna Fail became associated with the finance industry and developers' (Puirséil, 2017: 67). Together, the PDs and the Charlie McCreevy had significant influence over Government policy (Collins, 2005; Leahy, 2009). (Puirséil, 2017)

Health policy context

In 2001, a new health strategy 'Quality and Fairness' was published, which outlined 121 actions in a seven year reform programme (Department of Health, 2001). The Strategy proposed many measures, of which few were achieved, as most reform efforts went into restructuring the health system from eleven old health boards into one Health Service Executive in 2005 (Burke, 2009; Smith & Normand, 2011).

During the 1990 and early 2000s, public hospitals were under increasing pressure to treat more public patients, to reduce waiting times as well as meet the demand for those with private health insurance (Department of Health, 2001). In 2000, there were limited numbers of beds in standalone, private for-profit hospital beds with some parts of the country without any private hospitals (Wren, 2003). Research published in 2018 found that in the year 2000, there were 6,920 beds in 37 public hospitals, 6,116 beds in 34 private not-for-profit hospitals and 335 beds in four private for-profit hospitals (Mercille, 2018).

As public finances expanded significantly, the Irish public health budget quadrupled between 1997 and 2007, rising from €4 billion to €16 billion (Department of Health, 2010). This rise reflected the economic growth and increased expenditure across spending departments, especially on wages. Analysis on the differences in health expenditure across 30 OCED countries in the early 2000s found that 90% related to GDP per capita (Department of Health, 2010). Analysis of this period of increased spending, undertaken by an Irish government commissioned expert group on resource allocation and financing, stated:

> *In terms of economic sustainability, while Irish healthcare expenditure as a proportion of gross national income (GNI) increased from 7.3 per cent in 2000 to 9.0 per cent in 2007, health expenditure as a proportion of GNI has also risen across the EU and OECD, with the result that in 2007 Ireland still ranked among the low spenders on health in terms of health expenditure as a proportion of GNI (Brick et al., 2010).*

Research on the determinants of health expenditure has shown that there are three main factors which drive increases: 1) national income; 2) population age structure; and 3) institutional features of the health-care system (Propper, 2001). The expert group which reported in 2010 found that these factors were applicable to Ireland at that time. Examination of trends in Irish public health expenditure, national income, population size and composition and prices reveals that the same associations are largely supported by Irish experience over the period 2000–2009 (Department of Health, 2010).

Much of this increased investment was making up for decades of under-spending, when Ireland spent well below the OECD average on health (Wren, 2003). Ireland's average health spending per capita between 1995 and 2008 came seventeenth of 25 OECD countries (McDonnell & McCarthy, 2010).

Capital spending in Ireland between 1997 and 2002 was above the EU per capita average, however this 'should be seen against a backdrop of the twenty-seven preceding years from 1970 to 1996 in which Irish (capital) investment averaged only 66% of the EU average' (Wren, 2004: 2). Between 1990 and 2002, Ireland's spending on its public capital health infrastructure varied between 0.22% and 0.49% of GDP (OECD, 2017).

While public current spending on health increased in the 1990s, there were few attempts to reform the financing or inequitable structure of the Irish health system (Department of Health, 2010). Ireland's inequitable and inefficient public private mix of healthcare is well documented, characterised particularly by the absence of a universal primary care system and inequality in access to the public hospital system, in that those who can afford to pay privately get preferential (quicker) access to public, as well as private, hospital beds (Burke, 2009; Department of Health, 2010; Tussing & Wren, 2005; Wren, 2003).

Methods

As this research is concerned with what influences policy-making processes and the adoption of health policy choices at a national governmental level, the methodologies selected are qualitative. Qualitative methods allow the researcher to garner 'a rich texture' – a deeper understanding of the what, why and how of the policy processes (Walt *et al.*, 2008). They also allow 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. 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).

The qualitative research methods used were detailed documentary analysis with topic-guided, semi-structured in-depth interviews with policy elites. These methods were chosen to allow a deep exploration of the influences on health policy (Marshall & Rossman, 2011). The findings from these were then coded, recoded, distilled and analysed using the variables in the conceptual framework devised for this research and detailed below (see Table 1).

Documentary analysis

The following databases were searched for relevant documents:

- EU Observatory on Health Systems and Policies;
- Lenus: the Irish health repository;

Table 1. Conceptual framework including the sources of variables from the literature.

Category/ theme	Variables	Description of variable: factors affecting policy choice	Sources of variable from policy literature
Policy characteristics	***Severity of the problem***	clear measures that show the extent, and level of consensus, about the problem	Problem identification and issue recognition (Walt & Gilson, 1994) The problem stream, when an issue changes or becomes a political priority (Kingdon, 1995) Problem definition and diagnosing the causes (Shiffman & Smith, 2007)
	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	Policy characteristics (Grindle & Thomas, 1991) Policy content (Walt & Gilson, 1994) The policy primeval soup and technical feasibility (Kingdon, 1995) New ideas/solutions (Shiffman & Smith, 2007)
Actor power	***Guiding institutions***	the role of key institutions and their influence on the degree of priority given to the issue	The role of institutions in in 'politics as usual' situations (Grindle & Thomas, 1991) Actors in key institutions in the policy triangle (Walt & Gilson, 1994) The impact of institutions (Wilsford, 1994) Policy communities (Kingdon, 1995)
	The role of policy entrepreneurs	the role and influence of policy entrepreneurs, particularly strong champions of the policy, in the policy-making process	Policy elites (Grindle & Thomas, 1991) Actors in the policy triangle (Walt & Gilson, 1994) The policy entrepreneur (Kingdon, 1995)
	Private sector interests	the degree and influence of private-sector interests and lobbying	The role of private sector actors (Shiffman & Smith, 2007; Walt *et al.*, 2008; Walt *et al.*, 2008)
Political contexts	***Political ideology/ institutions***	the degree that contextual (historical, economic and political) and political institutions influence the policy choice	Political concerns of decision makers (Grindle & Thomas, 1991) Path-dependent sequence of political changes tied to previous decisions & institutions (Wilsford, 1994) Policy context including political, economic and social context (Walt & Gilson, 1994) The political stream (Kingdon, 1995) Political decision process (Shiffman & Smith, 2007) The importance of political context (Touhy, 1999)
	Policy process/ window	the process through which the policy was made and the moment when the political, policy and problem streams comes together	The process through which issues get on the reform agenda and are pursued (Grindle & Thomas, 1991) The policy process (Walt & Gilson, 1994) How structures and conjuncture can interplay leading to significant policy change (Wilsford, 1994) The policy window and joining the streams (Kingdon, 1995) Windows of opportunity, often opened by political context (Touhy, 1999) Policy development process (Shiffman & Smith, 2007)

- PubMed;
- Social Science Citation Index;
- WHO Global Health Observatory data repository.

However, very few Irish specific documents were found; therefore snowballing methods were used to source relevant documents referenced in government reports and grey literature. A novel feature of this academic research was to use Freedom of Information requests to obtain documents not in the public domain, as well as asking each interviewee for documents relevant to the research. This yielded dozens of documents, so only those directly relevant to the changes to finance acts were included.

Thirty-six primary and secondary documents were analysed in order to trace relevant policy developments. These are listed in Supplementary File 2. The primary documents related directly to the Finance Acts while the secondary documents provided background for political, health and economic policy developments.

Interviews

Twenty one in-depth interviews were carried out with policy elites involved in the policy processes by the lead author during 2010 and 2011. Questions asked are in Supplementary File 1. The lead author had at that time over a decade of experience of interviewing people for health policy/services research.

Elite interviews are with 'individuals considered influential, prominent, and well informed' (Marshall & Rossman, 2011). Everyone interviewed for this research was 'elite', in that they were senior ministers, political advisors, senior departmental and health services officials; owners or chief executives of private hospitals; senior medical personnel or representatives of private hospitals. Snowball and purposive sampling were used to identify and recruit the interviewees (Marshall & Rossman, 2011). The research protocol and instruments were approved by Trinity College Dublin, School of Medicine's Ethics Committee in 2009. The participant information leaflet and informed consent form are in Supplementary File 3 and Supplementary File 4.

Interviewees were guaranteed anonymity and confidentiality. Given the small size of Ireland and the policy making community, interviewees (IVs) are referred to by numbers, as saying they are a departmental official or a minister or an advisor could make them identifiable. One interviewee is identified in the text as he published a memoir subsequent to the interview where he retold what he had told in the interview and it is now in the public domain (Sheehan, 2013).

Two key interviewees turned down the request for interview. In order to mitigate against bias, i.e. there is a probability that those who gave interviews were more favourable to the research, in instances where just one person or a small minority of people made a point, this is made clear in the analysis. Also triangulation of findings from the documents was used to support and verify points made by interviewees. In particular, documents obtained through FOI were used as these often stated the actual position rather than the official public or political position at the time. These were used as prompts in the interviews to validate or challenge points being made.

The strengths of the methods are the in-depth analysis of the policy making process, which allows not only a description of what happened, but also allows for an analysis of what explains what happened. The limitations of the case is that it is just one case that may be atypical of policy making processes.

Conceptual framework

A conceptual framework allows the researchers to analyse what influenced the policy process in a systematic way, to identify elements of the public policy process and the relationship between them (Sabatier, 2007). 'Conceptual models can provide tools to describe, understand and explain policy processes' (Exworthy, 2008). The absence of explicit conceptual frameworks and shortage of detail on research design and methodology were highlighted by Gilson and Raphealy in their review of empirical analyses of health policy change processes in low and middle income countries between 1994–2007 (Gilson & Raphaely, 2008). The review notes the majority of articles are largely descriptive in nature, analytically weak and the absence of conceptual frameworks weakens their analytical capabilities and ability to explain the processes being researched (Gilson & Raphaely, 2008), Walt *et al.* called for more explicit conceptual frameworks in health policy analysis paying particular attention to the role of politics, policy processes and power (Walt *et al.*, 2008). According to Walt *et al.*, Gilson *et al.* and John, policy making is not just about a decision but a process of the continued interaction of institutions, ideas and interests and these need to be taken into account in the conceptual framework (Gilson *et al.*, 2011; John, 2012; Walt *et al.*, 2008).

In the absence of finding a specific conceptual framework suitable for this research, the authors devised their own from a very broad and deep search of the relevant literature in the public policy, health policy and political economy fields in order to help describe, understand and explain this particular policy process. It is hoped the framework will be useful to other policy analyses in the future.

Three main or overriding themes of 1) policy characteristics; 2) actor power and; 3) political contexts and the seven variables were derived from the following literature:

- Merilee Grindle and John Thomas – Public Choices and Policy Change – the political economy of reform in developing countries, 1991; (Grindle & Thomas, 1991)
- Gill Walt and Lucy Gilson – Reforming the health sector in Developing Countries: The Central Role of Policy Analysis, 1994; (Walt & Gilson, 1994)
- David Wilsford – Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way, 1994; (Wilsford, 2008)

- John Kingdon – Agendas, Alternatives and Public Policies, 1995; (Kingdon, 1995)
- Caroline Touhy – Accidental Logistics, The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada, 1999. (Touhy, 1999)
- Jernmy Shiffman and Stephanie Smith – Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality, 2007; (Shiffman & Smith, 2007)
- Gill Walt, Jeremy Shiffman, Helen Schneider, Susan F Murray, Ruairi Brugha & Lucy Gilson – Doing' health policy analysis: methodological and conceptual reflections and challenges, 2008; (Walt *et al.*, 2008).

The seven variables are:

Policy characteristics

Variable 1 – the severity of the problem. Public policy literature details the importance of clarity on the extent and the nature of the policy 'problem' and the extent of consensus on it in relation to the policy process and in particular agenda setting. Specifically, Kingdon, Walt and Gilson and Shiffman *et al.* highlight how this variable plays a crucial role in a 'problem' moving up the political agenda becoming a policy choice or decision.

Variable 2 – ideas for intervention. There is a large body of policy literature identifying where the 'solution' comes from, the idea for intervention, its origin and if and when potential alternatives emerge. The selection of this variable was influenced by Kingdon's notion of the primeval soup from where policy ideas emerge, the importance of policy content and characteristics as identified by Grindle and Thomas, Walt *et al.* and Shiffman & Smith This literature draws attention to the importance of available alternatives during the policy process where new solutions can emerge as the alternative and become the policy choice.

Actor power

Variable 3 – guiding institutions. The key role played by institutions and actors in particular gained greater precedence through Walt and Gilson's policy triangle. David Wilsford's work on path dependency specifies how institutions can be central to maintain the status quo rather than bringing about change. Kingdon notes the need to pay attention to policy communities who have a key role to play in influencing the policy process. Grindle and Thomas identify how institutions play a key role during non-crisis, 'politics as usual' situations of policy change. 'Institutions' have a key influence on the extent to which an issue gains traction, becomes a priority and is actually addressed in public policy measures.

Variable 4 – the role of policy entrepreneurs. Kingdon's classic work on why policy issues rise onto and fall off governments' agendas, identified the problem, policy and political streams that come together at a certain moment in time to form a policy window, and this window is often opened by a policy entrepreneur (Kingdon, 1995). Kingdon defines 'policy entrepreneurs' as 'advocates who are willing to invest their resources – time, energy, reputation, money – to promote a position, in return for future gain' (Kingdon, 1995: 179). Kingdon identifies how policy entrepreneurs are 'not only responsible for prompting important people to pay attention, but also for coupling both problems and solutions to politics' (Kingdon, 1995: 18). Kingdon also points out how there is no single formal or informal position for policy entrepreneurs, they can be a cabinet secretary, lobbyist, civil servant or academic.

While Walt and Gilson did not use the specific term policy entrepreneur, by putting actors at the centre of the policy triangle they are drawing attention to the role of individuals and the organisations in which they work, play in the policy process. Grindle and Thomas outlined the importance of the perception and behaviour of policy elites and 'how their actions can be understood as manoeuvring within constraints and opportunities created by context, circumstance and policy characteristics' (Grindle & Thomas, 1991: 188).

Variable 5 – private sector interests. While there has always been a focus on the role of government and public institutions in what and how policy gets made, Shiffman & Smith, Grindle and Thomas and Walt *et al.* each highlight the need to pay equal attention to the role of private sector interests in the formulation of health and public policy.

Political contexts

Variable 6 – political ideology. This variable encompasses the importance of historical, economic and political context as well as the political institutions that influence the policy choice. Touhy highlighted the importance of political context in policy change. Kingdon devised a specific political stream to represent the importance of politics in the policy process. Walt and Gilson included the political and economic context as key to 'context' as one of the variables in their policy triangle. Grindle and Thomas and Shiffman & Smith each specify the need to take into account the political concerns and 'interests' of decision makers, the political ideology and the political decision process, while David Wilsford links path dependency to existing institutions as detailed below:

> *A path-dependent sequence of political changes is one that is tied to previous decisions and existing institutions. In path dependency, structural forces dominate, therefore policy movement is most likely to be incremental. Strong conjunctural forces will likely be required to move policy further away from the existing path onto a new trajectory. It is the combination of path-dependent limits along with occasional windows of exceptional opportunity, or conjunctures, that determine the ways small or big that a political system responds to policy imperatives*. (Wilsford, 1994: 252).

Variable 7 – policy process/window of opportunity. Policy literature is as much concerned with the policy process that led to a particular policy's development and or its implementation as much or more than the actual policy content (Grindle and Thomas, Walt and Gilson). When Kingdon's three streams (problem, policy and political) come together, he describes this as the window of opportunity which creates a possibility for change. These do not come along too often as much policy

change is incremental, but occasionally, often due to the political context as identified by Touhy and Wilsford, critical change can occur in 'windows of opportunity' or 'exceptional opportunity'. Grindle and Thomas focus on windows which occur often after a significant crisis or seismic event which often open these 'exceptional windows'.

Interdependency of the variables. While the three themes and seven variable emerging from the policy literature are independent in the conceptual framework, there is an explicit recognition that they are interrelated and often overlap. For example, actors and policy entrepreneurs are influenced by what policy is deemed a political priority and the economic, social and political context that they are operating within.

The conceptual framework developed for this research was devised by merging and combining aspects of the work referenced. All interviews were transcribed, coded, recoded and distilled using NVivo 9 under themes and variables identified in a conceptual framework specifically. NVivo allows the researcher to organise and classify data, to work through the data systematically so as to ensure a rigorous justification for the findings and an audit trial of analysis and findings (Bazeley, 2011). All material was then analysed using this conceptual framework as outlined in Table 1. Table 1 includes the original literature from where the variables were derived.

Results

This research sought to understand the policy making process behind the changes to the Finance Act in 2001 and 2002 that gave tax-reliefs to developers to build private hospitals. The results are outlined under the themes and variables identified in the conceptual framework, drawing on findings from the documentary analysis and interviews. However, often it is the interrelationships between the variables that are more interesting than the variables themselves. These issues are drawn out in the findings and discussion sections.

Policy characteristic

Severity of problem. By 2000, there was widespread agreement inside and outside the health system that the shortage of public hospital beds and the associated long waits for public patients in emergency departments and for hospital admission for elective treatment was one of the major challenges facing the Irish health system (Department of Health, 2001).

> *There would have been simply on the basis of supply and demand, a shortage of beds. That was just caused by the failure to provide beds in the public system over the years. And a rundown of the quality of what was available in the public system (IV 1).*

Simultaneously, there were increasing numbers with private health insurance without much choice in private hospital options. By 2001, over 47% of the population had private health insurance, which facilitated faster access to care in public as well as private hospitals (HIA, 2013). Private health insurance contributed towards less than 7% of overall health expenditure in the early 2000s (OECD, 2004).

While there was agreement about the shortage of public beds and long waiting times experienced by public patients, there was significant disagreement as to the causes. Government decisions had closed large numbers of public hospital beds in Ireland during the 1980s economic crisis (Wren, 2003). By 2000, in line with international trends, there was an expectation of a falling need for hospital beds facilitated by advances in medical technology, shorter lengths of hospital stays and increased numbers of day cases.

Since the 1990s, government policy stipulated that a maximum of 20% of patients treated in public hospitals can be private patients (Wren, 2003). In 2002, after this policy was restated in Quality and Fairness, 25% of public hospital discharges were found to be private and in some hospitals up to 40–50% of patients were private (Comptroller and Auditor General, 2003). This high demand for private treatment in public hospitals, combined with incentives, encouraged doctors and hospitals to prioritise private patients over public patients and exacerbated two-tier access to hospital care (Burke, 2009).

The main explanation given by interviewees for the shortage of public hospital beds was the failure to invest in the capital public health budget.

As specified earlier, Ireland's capital spending was higher than EU average between 1997 and 2002 but that was making up for 25 years of underspending on capital health infrastructure (Wren, 2004). Interview data revealed the perception that if the public system was not going to invest sufficiently in building public hospital beds then tax breaks were a good way to incentives the private sector to do so.

> *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? (IV 16)*

> *no one had built a hospital, we needed capacity, we still need capacity, the debate was we needed extra capacity… we are not going to build it all ourselves publicly and therefore… (IV 19).*

As detailed earlier in this article, there were very few private for-profit hospitals and beds in 2000 when compared to the proportion of the population with private health insurance (Mercille, 2018).

Ideas for intervention. The long waits for public patients needing admission to public hospitals emerged as a central issue in the 2001 national health strategy (Department of Health, 2001). Arguments for and against whether private hospital capacity would assist in alleviating public hospital capacity was evident in both the documents analysed and the interviews. What emerged were two totally separate policy processes – one in the Department of Health where the majority of expansion was envisaged through investment in and expansion of the public

system (Department of Health, 2010). The other in the Department of Finance, where the idea of incentivising private sector capacity through tax reliefs for developers was facilitated by the Minister of Finance.

'Quality and Fairness', which was published in 2001, included a key proposal to increase the numbers of hospital beds by 3,000, 650 of which were due to come on stream in year one, 450 of which would be publicly provided (Department of Health, 2001). The strategy specifically stated under action 78 –

> ***Additional acute hospital beds will be provided for public patients:***
>
> - *Over the next ten years a total of 3,000 acute beds will be added to the system. This represents the largest ever concentrated expansion of acute hospital capacity in Ireland... The Government has decided to provide for a total of 3,000 beds, taking account of investment in non-acute facilities and community support services, increased use of day beds and a number of other factors.*
> - *650 of the extra beds will be provided by the end of 2002, of which 450 will be in the public sector, thus providing extra capacity for the treatment of public patients on waiting lists. The private hospital sector will be contracted to provide 200 beds, all for treatment of public patients on waiting lists. (Department of Health and Children, 2001: 102).*

Quality and Fairness was published in December 2001 but was developed during 2000 and 2001. While there was a large public consultation process and parallel policy development process involving national and international stakeholders for Quality and Fairness, many of the key decisions were made in meetings not in the public domain (Department of Health and Children, 2001; Wren, 2003).

In parallel, in 2000, the Department of Finance was developing the annual Finance Act, which is the primary legislation that brings the provision for the national budget into effect. The development of the Finance Act takes place behind closed doors. In the national budgets in the years up to 2001, there had been a proliferation of tax-reliefs, which gave tax breaks to developers to build hotels, houses, apartments, car parks, and shopping centres (Commission on Taxation, 2009).

Tax-reliefs were a central instrument of government policy, which fuelled the economy and a construction industry boom, which in turn generated huge tax revenues for successive governments. Tax-reliefs allow individuals or companies to pay less tax due to 'reliefs' (Department of Finance, 2011). Ireland had 245 tax-reliefs in the 2000s, a far higher number than any other OECD country (Commission on Taxation, 2009). There was unanimity among interviewees in this study that the changes to the Finance Act in 2001 and 2002 that gave tax-reliefs to build private hospitals were an extension to healthcare of the model used in other sectors. While there was consensus on the problem of the shortage of public hospital beds, there was little consensus on the solution. Some interviewees spoke about how tax reliefs to incentivise private hospital development were seen as a politically acceptable alternative to public sector investment.

> *The point of all this… is that it was a much more politically saleable way of putting expensive public services in place (IV 1).*
>
> *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 (IV 16)*
>
> *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… (IV 18)*

The tax breaks when proposed were seen as a potential solution amongst the interviewees with hindsight but at the time were vehemently opposed by officials in the Departments of Health and Finance evident in the section below.

Actor power

Guiding institutions. The guiding institutions in this policy's development were the government departments of finance and health. Documents obtained show that officials from both departments opposed the changes to the Finance Acts in 2001 and 2002, which gave tax breaks to build private hospitals. Differences between the ministers of Finance and Health are also detailed, showing the health ministers opposition to the proposal.

In one communication 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* (Department of Finance, 2000a).

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* (Department of Health, 2000).

These findings were reinforced by the interview data

> *I think there would have been an anxiety about plonking what would seem to [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… the changes to the Finance Acts… there was simply no health involvement at all (IV 1)*

> *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).*

> *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).*

> *I am not aware of anyone on record [in the Department of Health] saying this was a good idea, 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).*

> *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).*

These show that senior civil servants in both government departments and the Minister for Health's were opposed to the introduction of tax reliefs.

The role of policy entrepreneurs. Two policy entrepreneurs emerge clearly from the documents. In the first year that health institutions were included for tax-reliefs, James Sheehan, a surgeon and co-owner of Ireland's first stand-alone private hospital, lobbied finance minister McCreevy seeking tax reliefs for 'charitable' i.e. not-for-profit hospitals. Sheehan was at the time in the process of looking for investors in a private hospital he wanted to build in Galway. This was originally planned as not for profit but became a for-profit hospital in order to secure investment to get the Galway Clinic up and running (Sheehan, 2013).

In November 2000, Sheehan wrote to the Finance Minister:

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

Communication between the finance and health departments at the time reflect this.

> The Minister is under pressure from Jimmy Sheehan to concede tax incentives for his project (Department of Finance, 2000a).

This finding was verified by interview data:

A response from the Department of Finance specified 'the Minister is inclined to extend the tax-relief sought by Sheehan' (Department of Finance, 2000).

> *It was a very personal act. It was a very personal act... Charlie McCreevy and I [Sheehan] were the only two involved in it. (IV 15)*

The 2001 Finance Act included stipulations that gave tax breaks to developers to build private hospitals with stipulations that hospitals would have more than 100 beds and be of charitable status (Department of Finance, 2001).

In 2002, a representative of private hospitals, Michael Heavey, lobbied the government for the tax-reliefs to be extended to for-profit hospitals.

Some of the interviewees spoke about how this was a direct result of lobbying the Minister of Finance by private sector interests, specifying Michael Heavey who them represented the private hospitals.

> *My recollection was the lobbyist on this occasion was Michael Heavey, it was the IHAI [Independent Hospitals Association of Ireland] chief executive who objected on the basis that they were not charities (IV 20).*

The Finance Act 2002 was amended to include the provision of tax free finance for the development of for-profit hospitals and the number of beds required was reduced to 70 (Department of Finance, 2002).

> *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).

This is verified by FOI material which includes a letter from Michael Heavey, who was representing private hospitals to the health minister Michael Martin, making the case for smaller hospitals and those which were not charities to be included (Heavey, 2000).

'Why should these hospital [for- profit and under 100-bed hospitals] not qualify for relief?' (Heavey, 2000).

Private sector interests. The extent of private sector influence is evident from the fact that the two policy entrepreneurs that directly influenced the changes to the Finance Act over the

two years were from private hospitals. In one communication between the Departments of Finance and Health during this time, a hand-written note from a senior finance official stating that the Minister was under pressure from private sector interests - Jimmy Sheehan – the owner of a private hospital to introduce tax reliefs (Department of Finance, 2000a).

One interviewee stated:

> *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 James Sheehan, Sheehan was pushing for it, 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... (IV 17)*

Every interviewee was asked about the extent of lobbying. All of the public sector interviewees acknowledged that lobbying took place at a political level. Politicians and/or political advisors interviewed concurred and in two instances specified times and dates that they lobbied which were verifiable through the documents obtained under Freedom of Information,

Political contexts

Political ideology/institutions. The senior partner in successive coalition governments, Fianna Fáil, was in power continuously from 1997 to 2011. Fianna Fáil, traditionally had a strong working class base; however, during its time in office, it shifted to the right as government economic policy was driven by the PDs (Leahy, 2009; Puirséil, 2017). Recent political science analysis has found that Fianna Fáil were ideologically ambiguous, more pragmatic than ideological,

> *at the heart of Fianna Fáil's overall success is its utter pragmatism, its ambiguous ideology, and ability to adapt consistently to changes within the party, party system, and broader society to maintain its levels of support.*
>
> *Ultimately… the highly pragmatic nature of the party as it eschews doctrinaire politics or obviously ideological positions to maintain its ability to attract voters from across Irish society* (O'Malley & McGraw, 2017: 2–3).

Although the Minister for Finance, McCreevy, was a long standing Fianna Fáil member, his political ideology and economic policy was considered closer to the PDs' policies (Leahy, 2009). McCreevy was a close ally of PD leader Mary Harney, and their influence was referred to, both in the media and in interviews for this study, as the 'McCreevy/Harney' axis (Leahy, 2009) (Puirséil, 2017). This Harney/McCreevy axis shared an ideology and belief in tax-reliefs as an efficient tool for capital investment and the achievement of public policy goals.

> *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 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 very top and it was led at a particular level, ie the minister (IV 1)*
>
> *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… (IV 4)*
>
> *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 how things are to be done – he was highly regarded; he had no difficulties carrying his colleagues with him (IV 5)*
>
> *It goes back to that, to McCreevy (IV 9)*
>
> *Who drove it politically? I think the Minister for Finance would have driven it… I think he'd [McCreevy] justify it as an economic driver and just another area for development (IV 14)*
>
> *The rumour that was out of there, that…Charlie McCreevy, very pro-enterprise guy, pro-business, and that he readily drove in the [changes] (IV 17)*
>
> *It was very much driven by McCreevy, as I see it you have to look back and assume that the Harney/McCreevy axis had a lot of influence at that time … I think they were socially very close and ideologically very close, both very dominant players at the cabinet table… (IV 18)*

The role of the private sector emerged as a strong theme in the interviews.

> *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)*
>
> *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 argument that people have and that might have been a backdrop to it… (IV21).*

Another finding emerging from the interviews was that the existing mix of public and private healthcare allowed for increasing private provision without any real public or political scrutiny of the development.

> *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).*

One of the clearest findings of this research is the political nature of the policy making process. In the case of the introduction of tax-reliefs to health, it was policy making outside of the health domain, which led to a large increase in the numbers of beds in private, for-profit hospitals.

> *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.* (IV 1)

> *The Finance Act was primarily Finance driven (IV 21)*

These changes to the finance Acts in 2001 and 2002 resulted in a disproportionate increase in the numbers of private hospital beds. Figures published in 2018 show a threefold increase in the numbers of inpatient beds in private for-profit hospitals between 2002 and 2010, while the numbers of beds in public and voluntary hospitals declined during this time (Mercille, 2018).

Policy process/window. Two separate policy processes were in train while tax-reliefs to build private hospitals were introduced. The first was the public process of developing a new national health strategy, which started in autumn 2000 (Department of Health, 2001). The other was the annual budget development process, which ran throughout the autumn in the run up to the December 2000 budget and culminated with the publication of the Finance Act in March 2001.

> *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 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. (IV 5).*

Interviewees confirm what the documents show: that the tax breaks were driven by the Minister of Finance, McCreevy, and that health officials and the health minister had little success in their opposition.

Some of the interviewees explained how the development of the Finance Act worked to the exclusion of other government departments, even if it related to them.

> *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).*

> *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, that was done by the Department of Finance behind closed doors, largely without the knowledge or involvement of health (IV 18).*

Sheehan, when interviewed, claimed that he drafted the wording that appeared in the legislation.

> *So I approached Charlie McCreevy on that basis … and I said, 'Look is there any chance you could extend it [tax reliefs] to the health situation?' He said, he'd look at it, he'd put me in touch with his officials in the department. I went with a submission, he met me and he was very helpful. They asked me for my views and we drafted it together…. And I sat down with them and we wrote the [relevant sections of] the Finance Bill … (IV 15).*

This is verified in two FOI document used in this research. One health official stated 'the Minister is under pressure from Jimmy Sheehan to concede tax incentives for his project' (Department of Finance, 2000a). Days later a finance official in the Department of Finance wrote to the Department of Health stating 'The Minister is inclined to extend the tax relief sought by Sheehan' (Department of Finance, 2000). Sheehan has subsequently written publicly about this matter ((Sheehan, 2013)). This scenario was put to and corroborated by other interviewees.

The subsequent changes made the next year were directly influenced by the representative of the private hospitals lobbying the finance minister. This too was corroborated by the

documents and interviews. The 2001 and 2002 tax breaks for private hospitals resulted from lobbying, behind closed doors, with no public or political debate about their possible impact on access to public hospital care and the quality of care. In 2018, private hospitals are not regulated and are not included under the remit for quality appraisal by state regulator HIQA (the Health Information and Quality Authority).

Discussion

The documents and interviews clearly show that the changes to the Finance Act in 2001 and 2002 which gave tax reliefs to build private hospitals were political decisions, made by the finance minister who was effectively lobbied by private hospital interests, who persuaded him to apply tax-reliefs to the health arena.

Even though there was an extensive national health policy developed at this time, with policy aims to increase hospital beds for public patients, mainly in the public hospital system, the wishes of the finance minister over rode the opposition of finance and health officials as well as the health minister.

This reflects findings in international health policy literature where economic policy goals usually over ride health policy aims (Kingdon, 1995; McIntyre *et al*., 2004). The power struggle between the Departments of Health and Finance emerges clearly from this case-study. This is probably true for most elected governments, in that ultimately it is the Department of Finance that holds the purse strings and therefore the power.

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. In 2018, the first comprehensive set of figures on the numbers and types of hospital beds was published (Mercille, 2018). This absence of good, or, in some circumstances, any information, is likely to have contributed to the lack of consensus on the causes of the problems and appropriate solutions.

Another key finding from this research is the absence of evidence used to develop the policy solution. Grindle and Thomas, Kingdon, and Shiffman & Smith 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 & Thomas, 1991; Kingdon, 1995; Shiffman & Smith, 2007). The findings are contrary to this: there is no evidence of any costings of the proposal in advance of the changes to the 2001 and 2002 Finance Acts. In fact, documents obtained through FOI for this research show that use of tax reliefs was contrary to the advice of both officials in the finance and health departments. This indicates little technical policy-making or analysis took place in advance of the political decision being made to adopt these changes to the Finance Acts. This is contrary to what is considered good practice in policy-making processes (Walt *et al*., 2008). Analysis carried out for this research found that €150 million was given in tax reliefs to build private hospitals between 2002 and 2010 when these tax reliefs were discontinued following the recommendations of the Commission on Taxation.

Kingdon's research found that alternatives proposed by permanent civil servants were often selected over political proposals (Kingdon, 1995). Again, this research finds to the contrary, that it was policies proposed by private sector interests and adopted by the finance minister which resulted in this policy change. The 'solution' that emerged was an alternative to public investment in public hospitals as proposed in the health strategy, a process largely driven by public servants. In turn, this failure to sufficiently invest in the public system provided the justification and adoption of private-sector solutions.

The Departments of Health and Finance emerge as central institutions in this policy-making process more for what they did not do, than what they did. Grindle and Thomas's work found well-intended officials who were capable of effective policy making (Grindle & Thomas, 1991). These 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.

Contrary to some of Grindle and Thomas's findings, this research finds a disempowered Department of Health. It is impossible to generalise from this case but its examination draws attention to the non-implementation of the health strategy, which was the key policy document determining policy priorities for the Department of Health during the this time.

When it was put to an interviewees about how these two small changes to the Finance altered the landscape of hospital provisions, one response was as follows:

> *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… big flashing lights, like… cancer was a big one, heart was a big one, the health strategy, primary care plus other issues… There was a million things going on. Then you have a scandal… SARS, emergency stuff… [we] probably did not see it coming [the private sector development]… If you are fighting other battles and they say we want to go ahead with this… they [the minister and Department of Finance] are saying tax reliefs are in. We are not delighted with it but we live with it… you can't win them all (IV 21).*

This demonstrates the juggling of priorities that health departments have to continually deal with and helps explain how some policy changes, even though they are not priorities get through without the support of the Minsiter or Department of Health.

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

This research reinforces the emphasis Walt and Gilson put on the importance of the role of actors (Walt & Gilson, 1994 and Walt *et al.*, 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). One of the policy entrepreneurs identified was a medical consultant and co-owner of a private hospital, the other the owner of a private hospital and representative of private hospitals, many of which have significant investment from medical consultants.

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 & Smith use a similar concept, albeit with different titles (Shiffman & Smith, 2007). They describe the powerful role that 'political entrepreneurs' can play in influencing an issue becoming a political priority. The policy entrepreneurs identified in this research were strategic and opportunistic in the moments they choose to 'ride the wave'. Each was successful in that they secured two small changes to the Finance Acts, which significantly altered the hospital landscape evident in the large increase in private for-profit hospital beds (Mercille, 2018).

Grindle and Thomas's research found that policy elites were good at getting their issue on the policy agenda (Grindle & Thomas, 1991). This was the experience in this case. They and Kingdon identify that policy entrepreneurs often come from positions of power; this too was a finding in this research.

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 consultants and private hospital owners have easy access to senior politicians; in countries which 'generally have structural roots in the colonial past' (Grindle & Thomas, 1991: 51).

This was also found in this research and suggests that further research is needed on this matter in an Irish context. Is this privileged access just typical of young, post-colonial countries or is it true of other countries too?

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 *et al.*, 2012). The continuity of the government in power from 1997 to 2007 was the factor in this case rather than government change.

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, the years 2000–2002 in Ireland was not a time of crisis. Ireland was experiencing unparalleled 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 in crisis and that the failure to effectively reform the public system created the opportunities for private for-profit health sector. They also found that political pressures can alter policies (Grindle & Thomas, 1991). This was confirmed by the findings in this research.

Research trying to explain the policy decisions that led to the Irish 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).

Political ideology emerges, generally and in this study, as one of the strongest influences on the policy processes, in health as in other policy arenas. In this case, political ideology was served by the political institutions, in pursuit of a particular economic policy pursued by finance minister, McCreevy, and actively supported by the Deputy Prime Minister, Harney. The Deputy Prime Minister was the leader of the smaller coalition party which had disproportionate influence over government policy. This was enabled by close relationship between McCreevy and Harney whose ideology and policies were in line with the junior coalition partner. This emerged as one of the stronger findings in this research.

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). Touhy concluded that it was these 'accidental logics that drive the dynamics of change' (Touhy, 1999: 239). This resonates strongly with the findings in this research, in that these policies were born out of the political ideology of the time, which drove a specific economic policy agenda that included tax breaks, not out of any analysis of their potential effects on health policy.

Touhy 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 sow the seeds of future policy failures (1999). This emerged as a finding from the interviews, in that the existence of Ireland's unique public-private mix of healthcare allowed the justification of adding more layers to it with the introduction of tax-reliefs to build private hospitals.

This finding bears out the work of David Wilsford and others on 'path dependency' (Wilsford, 1994). '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 explain a path-dependent model where 'actors 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 (Wilsford, 1994). The vast majority of change in Ireland's health policy occurred in an incremental manner (Burke, 2009; Wren, 2003). Wilsford's work and others that draw on his work, is very relevant to this research as Ireland's historical public private mix in healthcare combined with the broad use of tax reliefs in other sectors laid the ground work and influenced the application of tax-reliefs to the health sector.

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).

Reflections on the conceptual framework and methods

The conceptual framework devised for this research drew on key health and public policy texts. While three themes and seven separate variables were identified, central to the framework was the interrelatedness of the variables. The findings from the documents and the interviews were then coded, recoded, distilled and analysed through the framework.

In some places, data were double or treble coded e.g. the justification for using the private sector to address the long waiting times for public patients was coded in 'ideas for intervention', 'political ideology' and 'private sector interests'. If unsure where best to code/recode/distil them, this was discussed by the lead author with the co-authors and a judgement was made as to where best to use the data. The coding, recoding and distilling of the rich data gathered allowed not just for a description of the policy process but an in-depth analysis as to why this policy choice was made and who and what influenced the policy process under the seven variables.

The inclusion of the 'policy window' in my conceptual framework allowed the authors to gain more insight and to utilise the interview content to explore the policy process. Examination of the policy window revealed unknown or unreported aspects of this policy making process. It found that the Minister for Finance, who was lobbied by a private hospital developer, then invited him into the department to assist with drafting the relevant sections of the act, which gave tax reliefs to build private not for-profit hospitals. The following year, after more lobbying the Act was changed to reduce the hospital size and include for-profit hospitals.

The 'policy windows/process' variable reinforces the importance of examination of the interaction of interests, ideas and institutions, an analytical paradigm that integrates political, processes and power as originally proposed by Walt & Gilson (1994) and later developed (Gilson & Raphaely, 2008). The findings also support the literature which advocates the study of policy should be as much about what was not done as much as what is done (Gilson *et al.*, 2011; John, 2012; Walt *et al.*, 2008), as well as identifying the perverse and unintended consequences of policy decisions.

The conceptual framework devised for this research provided a useful tool through which to organise and analyse the material garnered from the interviews and the documents. This research reiterates recent calls for rigorous research into and analysis of health policy making (Gilson *et al.*, 2011; Walt *et al.*, 2008). With clear methods and a firm theoretical grounding, there is much scope for further theoretical and empirical work.

The use of documentary analysis and key informant elite interviews was appropriate for this type of research, producing large volumes of rich data. The use of Freedom of Information requests added greatly to the data gathered as they revealed what was going on behind the scenes in the Department of Health and the Department of Finance, which was not evident in the publicly available documentation. This documentation allowed the researcher to verify or challenge findings in the interviews.

Conclusions

The introduction of tax-reliefs in Ireland for private hospitals in 2001 and 2002 is a clear example of a politically driven economic policy, which came from outside of the health arena and had a significant impact on healthcare provision. Even though there was a much larger, health policy development process, the zeal of the finance minister for tax-reliefs for health over-rode the opposition of his own officials, the health minister and department officials.

The research finds that a small number of people involved in private hospitals lobbied the Minister for Finance for the changes to be introduced. This demonstrates politicised and personalised nature of these policy-making processes, in particular the power of the private sector in influencing the policy choice.

Data availability

There were two main sources of data for this research article – documents and interviews. The documents are listed in Supplementary File 2. It is not possible to provide the transcripts of interviews, given the nature of the interviews – interviewees were given guarantee of complete confidentiality and anonymity in their informed consent forms, it is not possible to provide them as source data. Their availability, even if anonymised, would break the agreements with interviewees and the approval

received from the research ethics committee in the School of Medicine in Trinity College Dublin. Any breach of it would be detrimental to the trust built with this research team. Given the small size of the policy community in Ireland, then and now, the interviewees would be recognisable to people working in health policy in Ireland.

Competing interests
No competing interests were disclosed.

Grant information
Health Research Board, Health Services Research PhD Scholarship, 2008–2012, [PHD/2007/16]

Health Research Board Ireland [HRA-2014-HSR-499].

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Acknowledgements
This research was carried out as part of Sara Burke's PhD, which was funded by the Irish Health Research Board.

Supplementary material
Supplementary File 1: Interview template.

Click here to access the data.

Supplementary File 2: Documents used in the analysis.

Click here to access the data.

Supplementary File 3: Participant Information leaflet.

Click here to access the data.

Supplementary File 4: Informed consent form.

Click here to access the data.

References

Bazeley P: **Qualitative Data Analysis with NVivo**. Thousand Oaks/London, Sage. 2011.

Bergin A, FitzGerald J, Kearney I, *et al.*: **The Irish Fiscal Crisis.** *National Institute Economic Review.* 2011; **217**(1): R47–R59.
Publisher Full Text

Brick A, Nolan A, O'Reilly J, *et al.*: **Resource Allocation, Financing and Sustainability in Health Care Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector (Volume II).** Dublin: ESRI, 2010.
Reference Source

Burke S: **Irish Apartheid. Healthcare Inequality in Ireland.** 1st edition ed. Dublin: New Island. 2009.
Reference Source

Collins S: **Breaking the Mould How the PDs Changed Irish Politics.** Dublin: Gill and MacMillan. 2005.
Reference Source

Commission on Taxation: **Commission on Taxation Report 2009.** Dublin: Stationary Office. 2009.
Reference Source

Comptroller and Auditor General: **Report on Value for Money Examination, Department of Health and Children, The Waiting List Initiative.** Dublin: Comptroller and Auditor General. 2003.
Reference Source

Department of Finance: **Letter from Fred Foster, Department of Finance to Dermot Smyth, Department of Health dated 5 October 2000.** Dublin, Released under FOI. 2000.

Department of Finance: **Fax from Fred Foster, Department of Finance to Dermot Smyth, Department of Health Including Hand Written Note from Dermot Smyth**. Dublin: Released under FOI 2000. 2000a.

Department of Finance: **Email from Fred Foster, Department of Finance to Paul Barron, Department of Health, 13 February 2000. FOI**.

Department of Finance: **Finance Act 2001.** Dublin: Department of Finance. 2001.
Reference Source

Department of Finance: **Finance Act, 2002.** Dublin: Department of Finance. 2002.
Reference Source

Department of Finance: **EU/IMF Programme of Financial Support for Ireland**. Dublin: Department of Finance. 2010.
Reference Source

Department of Finance: **Impact Assessment of Legacy Property Reliefs. Department of Finance Consultation Paper.** Dublin: Department of Finance. 2011.
Reference Source

Department of Health: **Letter from Dermot Smyth, Department of Health to Fred Foster, Department of Finance Dated 1 November 2000.** Dublin: Released under FOI 2000. 2000.

Department of Health: **Quality and Fairness.** Dublin: Department of Health. 2001.
Reference Source

Department of Health: **Report of the Expert Group on Resource Allocation and Financing in the Health Sector.** Dublin: Department of Health. 2010.
Reference Source

Department of Health and Children: **Your Views about Health. Report on Consultation. Quality and Fairness - A Health System for You.** Dublin, Department of Health and Children. 2001.
Reference Source

Exworthy M: **Policy to tackle the social determinants of health: using conceptual models to understand the policy process.** *Health Policy Plan.* 2008; **23**(5): 318–327.
PubMed Abstract | Publisher Full Text

Gilson L, Hanson K, Sheikh K, *et al.*: **Building the field of health policy and systems research: social science matters.** *PLoS Med.* 2011; **8**(8): e1001079.
PubMed Abstract | Publisher Full Text | Free Full Text

Gilson L, Raphaely N: **The terrain of health policy analysis in low and middle income countries: a review of published literature 1994-2007.** *Health Policy Plan.* 2008; **23**(5): 294–307.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Grindle M, Thomas J: **Public Choices and Policy Change. The Political Economy of Reform in Developing Countries.** Baltimore: John Hopkins University Press. 1991.
Reference Source

Heavey M: **letter to Michael Martin, 9 April 2001, FOI.**

HIA (Health Insurance Authority of Ireland): **HIA Annual Report and Accounts 2012.** Dublin: HIA. 2013.
Reference Source

Honohan PWB: **Catching up with the Leaders: The Irish Hare.** B. P. o. E. Activity, The Brookings Institute: 2002; (1): 1–57.
Reference Source

John P: **Analysing Public Policy.** London Routledge. 2012.
Reference Source

Kingdon JW: **Agendas, Alternatives, and Public Policies.** Boston: Little, Brown. 1995.
Reference Source

Kirby P: **Celtic Tiger in Collapse. Explaining the Weaknesses of the Irish Model.** 2nd ed. London: Palgrave Macmillan. 2010.
Reference Source

Kitchin R, Callaghan J, Gleeson K, *et al.*: **Placing Neoliberalism: The Rise and Fall of Ireland's Celtic Tiger**. *Environ Plan A.* 2012; **44**(6): 1302–26.
Publisher Full Text

Leahy P: **Showtime. The Inside Story of Fianna Fail.** Dublin: Penguin Ireland, 2009.
Reference Source

Maarse J, Normand CH: **Market competition in European hospital care.** In: B Rechel, S Wright, N Edwards, B Dowesdill, M McKee (eds), *Investing in hospitals of the future*: WHO: Copenhagen. 2009; 105–124.
Reference Source

Marshall G, Rossman C: **Designing Qualitative Research.** Fifth ed. Thousand Oaks: California Sage. 2011.
Reference Source

McDonnell T, McCarthy D: **Public Expenditure Discussion Paper: The Composition of Spending, Income Equality and Economic Growth.** Dublin: tasc. 2010.
Reference Source

McIntyre D, Thomas S, Cleary S: **Globalization and Health Policy in South Africa.** *Perspectives on Global Development and Technology.* 2004; **3**(1): 131–52.
Publisher Full Text

Mercille J: **Privatization in the Irish hospital sector since 1980.** *J Public Health (Oxf).* 2018.
PubMed Abstract | **Publisher Full Text**

Murphy G: **The Background to the Election.** How Ireland Voted in 2007. The Full Story of Ireland's General Election. M Gallagher & M Marsh. New York, Palgrave MacMillan: 2008; 1–19.
Publisher Full Text

OECD: **Private Health Insurance in OECD countries: The Benefits and Costs for Individuals and Health Systems.** *The OECD Health project.* Paris: OECD. 2004.
Reference Source

OECD: **Health At A Glance.** *OCED Indicators.* 2017.
Publisher Full Text

O'Malley E, McGraw S: **Fianna Fáil: the glue of ambiguity.** *Irish Political Studies.* 2017; **32**(1): 1–29.
Publisher Full Text

Propper C: **Expenditure on Healthcare in the UK. A Review of the Issues.** *Fisc Stud.* 2001; **22**(2): 151–183.
Reference Source

Puirséil N: **Fianna Fáil and the evolution of an ambiguous ideology.** *Irish Political Studies.* 2017; **32**(1): 49–71.
Publisher Full Text

Sabatier P: **Theories of the Policy Process.** Oxford, Westview Press. 2007.
Reference Source

Sheehan J: **Letter from James Sheehan to Minister for Finance, Charlie McCreevy Dated 21 November 2000**. Dublin: Released under FOI. 2000.

Sheehan JM: **Life Close to the Bone.** Dublin, Self-published. 2013.
Reference Source

Shiffman J, Smith S: **Generation of political priority for global health initiatives: a framework and case study of maternal mortality.** *Lancet.* 2007; **370**(9595): 1370–1379.
PubMed Abstract | **Publisher Full Text**

Smith S, Normand C: **Equity in health care: the Irish perspective.** *Health Econ Policy Law.* 2011; **6**(2): 205–17.
PubMed Abstract | **Publisher Full Text**

Touhy CH: **Accidental Logics. The Dynamics of Change in the Healthcare Arena in the United States, Britain and Canada.** Oxford: Oxford University Press. 1999.
Reference Source

Tussing DA, Wren MA: **How Ireland Cares. The case for healthcare reform.** Dublin, New Island. 2005.
Reference Source

Walt G, Gilson L: **Reforming the health sector in developing countries: the central role of policy analysis.** *Health Policy Plan.* 1994; **9**(4): 353–70.
PubMed Abstract | **Publisher Full Text**

Walt G, Shiffman J, Schneider H, *et al.*: **'Doing' health policy analysis: methodological and conceptual reflections and challenges.** *Health Policy Plan.* 2008; **23**(5): 308–317.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Whelan K: **Policy Lessons from Ireland's Latest Depression.** UCD CENTRE FOR ECONOMIC RESEARCH WORKING PAPER SERIES 2009 U. C. F. E. RESEARCH. Dublin, UCD. 2009.
Reference Source

Wilsford D: **Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way.** *J Public Policy.* 1994; **14**(3): 251–83.
Publisher Full Text

Wilsford D: **Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way.** *J Public Policy.* 2008; **14**(3): 251–283.
Publisher Full Text

Wren MA: **Unhealthy State. Anatomy of a Sick Society.** Dublin: New Island. 2003.
Reference Source

Wren MA: **Health spending and the black hole.** Quarterly Economic Commentary, The Economic and Social Research Institute. 2004.
Reference Source

Version 2

Referee Report 12 November 2018

https://doi.org/10.21956/hrbopenres.13923.r26335

Mark Exworthy
Health Services Management Centre, School of Social Policy, University of Birmingham, Birmingham, UK

There has been a significant engagement with both of the reviewers' comments. The authors' responses are appropriate to the importance and scope of the comments – robust defense at times, acknowledging limitations at other points. I welcome these responses. I also agree with the revisions that have been made. The transparency of these revisions is clear in the sections `Amendments from version 1' (page 3) and Authors' responses (page 20 and 23). The paper now reads very well.

Competing Interests: No competing interests were disclosed.

Referee Expertise: Health policy: policy implementation

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Referee Report 03 September 2018

https://doi.org/10.21956/hrbopenres.13923.r26336

Eoin O'Malley
School of Law and Government, Dublin City University, Dublin, Ireland

I'm happy that the changes made address some of the issues I had with the original version, and have improved the piece.

Competing Interests: No competing interests were disclosed.

I have read this submission. I believe that I have an appropriate level of expertise to confirm tha it is of an acceptable scientific standard.

Version 1

Referee Report 23 March 2018

https://doi.org/10.21956/hrbopenres.13844.r26085

Mark Exworthy
Health Services Management Centre, School of Social Policy, University of Birmingham, Birmingham, UK

This is an interesting article which seeks to examine the ways in which health policy is `made' at a national level. The case-study is relevant to a wider understanding of health policy reform, irrespective of the specific Irish or policy context.

The length of the article militates against a fuller exploration of the conceptual framework, the empirical data and the discussion. That said, I think there are several areas which the authors might wish to elaborate or develop.

Introduction
The significance of the quadrupling of the heath budget in a decade is hugely significant. The expansion opens up new actors and policy options; taken-for-granted assumptions about finance and service delivery may no longer apply as strongly. The authors could delve into this further, drawing on documentary and/or interview data more clearly.

Methods
The issue of anonymity is described well although this does present some uncertainty in terms of corroboration. The authors do offer some data triangulation. Given the elapsed time between the period in question and this publication, it is important that the authors add the year/date of interviews to provide temporal context. There is a danger of recall bias and post-hoc rationalisation.

Conceptual framework
The authors draw on a reasonably wide selection of concepts for an article of this length. It shows that the article is drawn from a broader study. A narrower focus would provide greater conceptual clarity. It is hard to trace how the framework (used by the authors) was devised since Kingdon's model is one of two outlined on page 4, and yet the authors state "this research does not utilise Kingdon's multiple streams" but "Kingdon's concepts of policy windows and policy entrepreneurs are explicitly utilised in the framework." In my opinion, Kingdon's (entire) model would indeed be suitable for this study. In any case, citation of other studies (which used Kingdon's or Touhy's approaches) would be merited.

Findings
• *Severity:* more evidence from interviews/documents could have been provided to substantiate the claims being made. In particular, evidence from sources outside political/policy networks (eg. media reports, public opinion) would be highly relevant (given Touhy's argument). The percentage of population with PHI appears significant given growth of hospital beds in this sector seems to have been seen as a viable option.

• *Intervention:* the feasibility of increasing bed numbers by 3,000 (including 650 in one year) does not seem to have been addressed. Although the implications of the proliferation of tax breaks in other areas of the economy/society (including health care) were apparent, it was not clear how a consensus about application of tax breaks to health care was achieved. More detailed would be required, for example (eg. para.1, page 6 "They were a politically acceptable alternative to public sector investment"). This would include a comparison of how alternatives (drawn from Kingdon's `primeval soup') were considered and apparently rejected.

• *Actor power:* this section provides a good sense of the policy process and change over time. The authors note the potential imbalance between anonymised and named sources. Although this gives a somewhat tendentious perspective, it is transparent. I have an equivocal view of the table on page 7 regarding the role of policy entrepreneur; it is overly simplistic but it does address the elements of the framework. The article does point towards the inter-connections between elements but needs to be elaborated better (ideally in a longer assessment) to gain a thorough assessment of the data and the application of the conceptual framework to the data.

Discussion
This section does cover new and intriguing perspectives on `Accidental logics' and `Path dependency.' These could have been described better at the outset and then a more nuanced assessment offered in the Discussion section. Equally, the Discussion does not address Kingdon's multiple streams.

Overall, the article attempts to trace the process relating to a significant change in policy (between espoused policy and actual implementation). Whilst the conceptual and empirical sections offer interesting and relevant material, I feel that the article is under-developed in the sense of substantial contributions to theoretical perspectives. Some of the empirical data are cursory and more depth could have been provided. The interpretation of the data in relation theoretical framework needs further development. Much of this comment might be due to the nature/structure of the article (eg. Word length); in which case, I would suggest a more focused remit of the article, drawing on one aspect of the conceptual framework and exploring the relevant data associated with it.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Not applicable

Are all the source data underlying the results available to ensure full reproducibility?
No

Are the conclusions drawn adequately supported by the results?
Partly

Competing Interests: No competing interests were disclosed.

Referee Expertise: Health policy: policy implementation

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 23 Jul 2018

Sara Burke , Dr, Ireland

The article now includes a more detailed outline of the origins of the conceptual framework, it elaborates on it and we have strengthened and lengthened the findings and the discussion of the empirical findings.

Introduction

This issue is now dealt with more extensively in a section on the health policy context. This draws on the broader health policy and relevant Irish literature, which was not a specific focus of the interviews. For example, in order to explain the increase in health budget, we have added the following text:

Analysis on the differences in health expenditure across 30 OCED countries in the early 2000s found that 90% related to GDP per capita (Department of Health, 2010). Analysis of this period of increased spending, undertaken by an Irish government commissioned expert group on resource allocation and financing, stated:
'In terms of economic sustainability, while Irish healthcare expenditure as a proportion of gross national income (GNI) increased from 7.3 per cent in 2000 to 9.0 per cent in 2007, health expenditure as a proportion of GNI has also risen across the EU and OECD, with the result that in 2007 Ireland still ranked among the low spenders on health in terms of health expenditure as a proportion of GN'I (P 65, (Brick A 2010)).
Research on the determinants of health expenditure has shown that there are three main factors which drive increases: 1) national income; 2) population age structure; and 3) institutional features of the healthcare system (Propper 2001). The expert group which reported in 2010 found that these factors were applicable to Ireland at that time. Examination of trends in Irish public health expenditure, national income, population size and composition and prices reveals that the same associations are largely supported by Irish experience over the period 20002009 (Department of Health and Children 2010)….
Capital spending in Ireland between 1997 and 2002 was above the EU per capita average, however this 'should be seen against a backdrop of the twenty-seven preceding years from 1970 to 1996 in which Irish (capital) investment averaged only 66% of the EU average (P2 (Wren MA 2004). Between 1990 and 2002, Ireland's spending on its public capital health infrastructure varied between 0.22% and 0.49% of GDP (OECD 2017).

Methods

The year/dates of the interviews and greater clarification on how material was verified are now provided.

Conceptual framework

As the reviewer has correctly identified, this paper came from a broader study – the PhD of the lead author. As detailed in the overall response to reviewers, there is now much more detail on the literature drawn on, including a new text in the conceptual framework section explaining the rationale and literature from where each of the variables was derived. This is specified in a more developed table and in the text in longer methods, findings and discussion sections.

Findings

More quotes are added as suggested to substantiate points made. Other sources not originally analysed in the research are not used.
Intervention:
The points made here have been clarified in the body of the text. The research found that while there was political support for tax breaks in general, there was no consensus on their introduction into Health. In fact, it was the result of private sector lobbying, together with the positive response by the Minister for Finance to the lobbying at the time that brought about the policy change.
Actor Power:
The table of quotes has been discarded as a table and these and other quotes are now provided throughout the text. The interconnections between the elements are dealt with in the discussion section where they are now weaved into the relevant literature and in a new section entitled 'Reflections on the conceptual framework and methods'.
Discussion:
These issues are now addressed in a longer text in particular in the new section on conceptual framework Page ? , an extended findings (Page ? - ?) and discussion sections (Page ? - ?) with some sections largely rewritten.

Competing Interests: No competing interests were disclosed.

Referee Report 13 March 2018

https://doi.org/10.21956/hrbopenres.13844.r26091

? Eoin O'Malley
School of Law and Government, Dublin City University, Dublin, Ireland

This is an interesting paper, that could be much more convincing if it were revised to take account of what I see as a number of problems.

1. This could be set up better. It is not clear, except for the innuendo, that the policy was necessarily bad. I think the paper would be improved if it didn't try to assess the policy, and instead looked at how the policy was made, and what explains the policy choice. It is asserted that the chosen policy went against the Department of Health strategy - this is the key to the framing of the paper - but I think it would be more convincing if we could see that strategy, and show this more clearly.

   There are also some problems with the argument. There had been the quadrupling of the budget when the 'neo-liberal' agenda was in place, this hardly suggests libertarian ideology at the centre of the government. It might be more interesting to look at why this was concentrated on current spending and not capital spending.

2. There is not a strong basis for the analysis in the literature cited. The empirical evidence appears to point to interest-based politics, and or ideology. The multiple streams framework doesn't really add anything. There is a literature, I'm working on, that looks at policy failures as a result of institutions (which can incorportate path dependency), interests and ideology. It seeks to explain how these interact to reduce/ target the flow of information to policy makers. I can see how this would add to the explanation here. As it is written, there are assertions made in the Discussion that don't really stand up to scrutiny, or at least aren't well supported in the text, f.i. there's nothing here that

suggests that path depdendency is important. That doesn't mean it is not, just that the case hasn't been made.

3. There was no discussion of how Finance Bills are produced and negotiated. This would be useful.

4. The empirical evidence is dealt with in a somewhat patchy manner. The most damning bit of evidence evidence seems to be the claim that James Sheehan wrote the relevant section of the Finance Bill. Is this true? I'd be disinclined to believe everyone's claims. I'd prefer if the authors used process tracing techniques - it would make the paper much longer, but more convincing.

5. Other small stuff. There are no page numbers for references that are clearly page specific. Some references are to edited books, not the individual chapter that claim is drawn from, e.g. Gallagher and Marsh 2007. There is a reliance on the analysis of Kirby (2010) that is highly contestable, and hardly mainstream. he for instance does not recognise the genuine (and verifiable) increase in wealth, welfare and well-being associated with the Celtic Tiger years. On p.3 there is a misuse of the word conservative.. the authors mean liberal. Typo on top of p. 4, public patients? The methods section read a bit like an MA thesis. Claim on p. 5 that public patients do not have access to private hospitals is not strictly true, and they did through the national treatment Purchase Fund.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
No

If applicable, is the statistical analysis and its interpretation appropriate?
Not applicable

Are all the source data underlying the results available to ensure full reproducibility?
Partly

Are the conclusions drawn adequately supported by the results?
Partly

Competing Interests: No competing interests were disclosed.

I have read this submission. I believe that I have an appropriate level of expertise to confirm tha it is of an acceptable scientific standard however I have significant reservations as outlined above.

Author Response 23 Jul 2018

Sara Burke , Dr, Ireland

1. The article is now solely focussed on the policy making process for example in the abstract, which is nearly entirely rewritten, it now states

Objectives: *To analyse the policy process that led to changes to the Finance Acts in 2001 and 2002 that gave tax-reliefs to build private hospitals in Ireland.*
Methods: *Qualitative research methods of documentary analysis and in-depth semi-structured interviews with elites involved in the policy processes, were used and examined through a conceptual framework devised for this research.*
Results: *This research found a highly politicised and personalised policy making process where policy entrepreneurs, namely private sector interests, had significant impact on the policy making process. Effective private sector lobbying encouraged the Minister of Finance to introduce the tax-reliefs for building private hospitals despite advice against this policy measure from his own officials, officials in the Department of Health and the health minister. The Finance Acts in 2001 and 2002 introduced tax-reliefs for building private hospitals, without any public or political scrutiny or consensus.*
Conclusion: *The changes to the Finance Acts to give tax-reliefs to build private hospitals in 2001 and 2002 is an example of a closed, personalised policy making. It is an example of a politically imposed policy by the finance minister, where economic policy goals overrode health policy goals. The documentary analysis and elite interviews examined through a conceptual framework enabled an in-depth analysis of this specific policy making process. These methods and the framework may be useful to other policy making analyses.*

The relevant sections of the health strategy are now quoted in the findings, 'ideas for intervention' section:

strategy specifically stated under action 78 –
Additional acute hospital beds will be provided for public patients:
• Over the next ten years a total of 3,000 acute beds will be added to the system. This represents the largest ever concentrated expansion of acute hospital capacity in Ireland... The Government has decided to provide for a total of 3,000 beds, taking account of investment in non-acute facilities and community support services, increased use of day beds and a number of other factors.
• 650 of the extra beds will be provided by the end of 2002, of which 450 will be in the public sector, thus providing extra capacity for the treatment of public patients on waiting lists. The private hospital sector will be contracted to provide 200 beds, all for treatment of public patients on waiting lists. (P 102, (Department of Health and Children 2001).

We have taken on-board the reviewer's observation and addressed these points, as much as the data gathered and other relevant sources allowed. In particular, the issue of capital under spending is addressed, along with new text on the context, in the health policy context section. However, while we could have speculated, the empirical data (interview data and documents gathered for this research) did not allow us draw any conclusions or explanations for the focus on current spending over capital spending.

2. These points have been addressed in the extended, revised text. Much more space is given to outlining how the conceptual framework was devised in the text and a significantly amended table details the literature from which they emanated. A whole new section on the conceptual framework is included.
Much more empirical evidence is provided in the form of quotes from the interviews to back up the points made in the text. The authors believe that Kingdon's work is relevant especially in terms of policy entrepreneurs, policy alternatives emerging in the policy stream and examination of the policy window. These are made more explicit in the findings and the discussion.
This reviewer has shared the literature that he and colleagues are working on in relation to

'institutions, interests and ideology' with the lead author. This has not been utilised here as the authors were keen to present the conceptual framework they devised and used in this research. Interestingly each of these - institutions, interests and ideology, as proposed by the reviewer – are close to the 'interests, ideas and institutions' as proposed by Walt and Gilson (1994) and cited in the text. This Walt and Gilson paper greatly influenced the conceptual framework utilised here, albeit used differently with more variables but three of the variables are 'guiding institutions, private sector interests and political ideology' are similar to those proposed by this reviewer.
The rewrite has been careful to make sure that the discussion stands up to scrutiny and is directly drawn from the data and literature we presented, in particular drawing on more empirical data from the original research.

3. Where possible, the interview data and documentary analysis were drawn on to shed some light on the Finance Act development process.

4. More empirical data has been included in the revised text, including citing two FOI documents which verify the Sheehan 'claim'. However, the authors do not see that is as 'damning evidence' or even the strongest finding. What this reveals is a personalised, politicised policy making process that took place behind closed doors, where private sector interests lobbied the Finance Minister which led to a significant policy change. This happened alongside more open, health driven policy process was taking place. This is now the focus of the entire draft.

This is a case study completed as part of a PhD, the authors believe the methods and analysis presented stand up and are the better for this review process. To start now on process tracing would require a complete reworking of the data, or even new data collection.

5. These issues have been addressed, page numbers and specific chapters are now included in the references.
The word conservative was replaced with liberal.
More 'mainstream' literature other than Kirby has been cited expect when Kirby's analysis was deemed useful to include.
The methods section is now longer. During this time, most public patients did not have access to private hospitals, in 2002, 1,920 public patients were given care in private hospitals, 961,237 patients received care in public hospitals in 2002, so the vast majority of public patients did not have access to private hospitals in 2002. The text is amended to reflect this.
Sources:
P1/3 NTPF Annual report, 2006. http://www.lenus.ie/hse/bitstream/10147/46017/1/9839.pdf
P 5 Department of Health Annual Report, 2003.
https://health.gov.ie/wp-content/uploads/2014/03/annual_report_2003.pdf

Competing Interests: No competing interests were disclosed.