



RESEARCH ARTICLE

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 1; referees: awaiting peer review]

Sara A. Burke ¹, Ruairi Brugha², Stephen Thomas ¹

¹Centre for Health Policy and Management, Trinity College Dublin, Dublin 2, Ireland

²Division of Population Health Sciences, RCSI Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland, Dublin 2, Ireland

v1 First published: 28 Feb 2018, 1:1 (doi: [10.12688/hrbopenres.12784.1](https://doi.org/10.12688/hrbopenres.12784.1))
Latest published: 28 Feb 2018, 1:1 (doi: [10.12688/hrbopenres.12784.1](https://doi.org/10.12688/hrbopenres.12784.1))

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.

Results: Despite an Irish health strategy commitment in 2001 to increase the numbers of hospital beds, a majority of which were envisaged in the public sector, two small changes to the Finance Act in 2001 and 2002 resulted in much greater growth in private hospital provision. The result of which was a 34% increase in private hospital beds, whilst public hospital beds grew by 3% between 2002 and 2010.

Conclusion: The use of tax breaks was a core part of national economic policy that strongly contributed to Ireland's boom and bust cycle in the 2000s. The application of tax breaks to health was driven by a small number of people from private hospitals who lobbied the Minister for Finance who championed their introduction, despite opposition from his own department, the Minister and the Department of Health.

Increasing the numbers of private beds, instead of investing in the public health system, exacerbates existing inequalities in access to hospital care in Ireland as the majority of the population do not have access to private hospitals.

The research provides an in-depth analysis of this specific policy making process in order to better understand health and public policy making processes. The research found a highly politicised and personalised policy making process where economic policy goals overrode health policy goals and tax-reliefs were granted to the health facilities, without any public or political scrutiny or consensus.

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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.

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 1; referees: awaiting peer review]** HRB Open Research 2018, 1:1 (doi: [10.12688/hrbopenres.12784.1](https://doi.org/10.12688/hrbopenres.12784.1))

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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.

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

Introduction

For fifteen years up to 2008, Ireland experienced exceptional economic growth and was regarded as a model for economic development (Kirby, 2010). 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). From 1997 to 2007, Fianna Fáil, the dominant Irish political party, was in a coalition government with a small laissez-faire liberal party – the Progressive Democrats (Gallagher & Marsh, 2007).

During this period of economic growth, Ireland’s Department of Health developed a new national health strategy, which had 121 commitments, including an increase in hospital bed provision by 3,000, the majority of which were planned for public hospitals (Department of Health, 2001). Simultaneously, the Department of Finance established tax breaks for developers to build private-for-profit hospitals (Wren, 2003).

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 and their impact on the hospital landscape. It seeks to understand why the changes to the Finance Act were made even though they were contrary to the health strategy commitments.

While there is much written about increased privatisation of hospital care and blurring between public and private providers, there is little research on what influences these policy processes and choices (Maarse & Normand, 2009). This research utilised the Irish context, where the private sector component of the public private mix is unusually strong for Northern Europe, with a view to informing policy making processes and policy analysis research, nationally and internationally.

The aim of this research is to provide an in-depth analysis of this specific policy making process in order to better understand health and public policy making processes.

Irish economic, political and health policy context

Economic context. Throughout the 1990s and the first years of the early twenty first century Ireland experienced exceptional economic growth with annual growth rates of 7.5%, which in some years exceeded 10% (Kirby, 2010). For fifteen years up to 2008, Ireland’s growth rates were over three times the European average (Kirby, 2010).

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 (Kirby, 2010). 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. By 2010, borrowing rates were unsustainable and Ireland entered an EU/IMF/ECB (European Central Bank) bailout (Department of Finance, 2010).

Political context. Two national political parties, Fianna Fáil and the Progressive Democrats (PDs), were in power continually from 1997 to 2007 (Leahy, 2009). Fianna Fáil, which was self-styled as the ‘republican party’, was the largest, oldest, dominant party in Ireland, characterised by a working-class base and conservative policies (Ferriter, 2004).

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 conservative 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. Together, they had significant influence over Government policy (Collins, 2005; Leahy, 2009).

Health policy context

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. Much of this 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).

While public spending on health increased in the 1990s, there were few attempts to reform the financing or inequitable structure of the Irish health system. 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 with private insurance get preferential (quicker) access to public, as well as private, hospital beds (Burke, 2009).

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).

Throughout the last decade, public hospitals have been under increasing pressure to treat more public patients, to reduce waiting times as well as meet the demand for those with private health insurance (Burke *et al.*, 2014). In 2000, there were limited numbers of private hospital beds with some parts of the country without any private hospitals (Wren, 2003).

Methods

Qualitative research methods were used, combining detailed documentary analysis with topic-guided, semi-structured in-depth interviews with policy elites. The following databases were searched:

- [EU Observatory on Health Systems and Policies](#);
- [Lenus: the Irish health repository](#);
- [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 other reports and grey literature. Freedom of Information requests were used 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. The interviews were conducted in person. Questions asked are in [Supplementary File 1](#).

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. Twenty one in-depth interviews were carried out with policy elites involved in the policy processes. The lead author did the interviews, with 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 were ‘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 representing the interests 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. The participant information leaflet and informed consent form are in [Supplementary File 3](#) and [Supplementary File 4](#).

Two key interviewees turned down the request for interview. In order to mitigate against bias, i.e. 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 check-up points made by interviewees.

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

All interviews were transcribed and coded using NVivo 9 under themes identified in a conceptual framework specifically devised for this research. The conceptual framework was derived from relevant literature in the public policy, health policy and political economy fields. The framework drew on Kingdon’s multiple streams research, policy analysis work of Walt and Gilson, Grindle and Thomas’s empirical work on the political economy of health reform, Reich’s work on political priorities for health policy, as well as Touhy’s and Wilson’s comparative health systems analyses (Grindle & Thomas, 1991; Kingdon, 1995; Reich, 1995; Touhy, 1999; Walt & Gilson, 1994; Wilsford, 1994).

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, which is often opened by a policy entrepreneur (Kingdon, 1995). While this research does not utilise Kingdon’s multiple streams, it draws on Kingdon’s focus on how alternatives to government proposals are generated, as the Finance Act changes emerged as alternatives to original health policy intent. Kingdon’s concepts of policy windows and policy entrepreneurs are explicitly utilised in the framework.

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.

Touhy’s comparative work on how windows of opportunity were more likely to be created by events in the political realm, rather than in healthcare, and Wilsford’s work on path dependency, also influenced the conceptual framework (Touhy, 1999; Wilsford, 1994).

The conceptual framework developed for this research was devised by merging and combining aspects of the work referenced. All material was then analysed using this conceptual framework with the themes and variables outlined in [Table 1](#).

Results

This research sought to explain 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, which was

Table 1. Conceptual framework.

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

inconsistent with and appeared to have undermined the stated health strategy aim of expanding public hospital beds. The results are outlined using the themes and variables identified in the conceptual framework, drawing on findings from the documentary analysis and interviews interspersed.

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). 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). Yet, 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. 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.

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). As a response, a key proposal was 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 public (Department of Health, 2001).

There are arguments for and against whether private hospital capacity assisted in alleviating public hospital capacity. Given that the majority of citizens do not have access to private hospitals and that more complex care takes place in the public system, meeting the needs of the whole population could be best addressed through investment in the public system (Department of Health, 2010).

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. 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. They were a politically acceptable alternative to public sector investment.

Actor power

Guiding institutions. The guiding institutions in these policy developments were the 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.

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 (selected quotes are in Table 2), which show that senior civil servants in both government departments and the Minister for Health’s position was overridden by the Minister for Finance.

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 breaks for hospitals.

In November 2000, Sheehan wrote:

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

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

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). 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).

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 two years running 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 included the following:

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

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.

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).

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). This Harney/McCreevy axis, shared an ideology and belief in tax-reliefs; and the promotion of the private sector as an economic driver emerged as a strong theme in the interviews.

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 undermined the explicit national health strategy with a significant effect on the health landscape, disproportionately increasing the numbers of private hospital beds and exacerbating the inequities in access to hospital care.

Numbers compiled specifically for this research show that between 2002 and 2010, the numbers of public hospital beds increased by 321 (3%), whereas the number of beds in private hospitals increased by 899 (34%). Most of the private beds opened after 2007 which reflects the time it took for the capital allowances to take effect and the planning and building time involved in constructing new hospitals.

Table 2. Quotes from interviews^a with elites.

Category/theme	Variables	Selective, but typical quotes from interviewees in relation to variables
Policy characteristics	Severity of the problem	<p><i>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).</i></p> <p><i>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)</i></p>
	Ideas for intervention	<p><i>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)</i></p> <p><i>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)</i></p> <p><i>I suppose with hindsight that was beginning of the property bubble... there were people seeing these as property plays... in the same way as hotels and golf courses... (IV 21)</i></p>
Actor power	Guiding institutions	<p><i>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)</i></p> <p><i>Tax breaks ... did not impress us [in the Department of Health]... that would never have been discussed in the health department. (IV 11)</i></p> <p><i>I think it's fair to say most if not all of his [McCreevy's] officials were opposed to it but... he [McCreevy] made a virtue of saying, 'I am doing what I believe.' I think that was very much a feature of the man. So [McCreevy] went ahead and did it... We had a complete conflict between the stated policy in the health strategy, the agreed approach by government and the decision by an individual, be it a very strong minister, who decided to go in a different direction (IV 15)</i></p>
	The role of policy entrepreneurs	<p><i>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)</i></p>
	Private sector interests	<p><i>My recollection was the lobbyist on this occasion was Michael Heavey, it was the IHA [Independent Hospitals Association of Ireland] chief executive who objected on the basis that they were not charities (IV 20).</i></p>
Political contexts	Political ideology/institutions	<p><i>The point of all this... is that it was a much more politically saleable way of putting expensive public services in place (IV 1).</i></p> <p><i>Who drove it politically? I think the Minister for Finance would have driven it you know (IV 14)</i></p> <p><i>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)</i></p> <p><i>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).</i></p>
	Policy process/window	<p><i>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).</i></p> <p><i>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 Finance Bill ... (IV 15)</i></p>

^aInterviewees 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 me in the interview and therefore it is now in the public domain.

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.

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 who opposed them had little success in opposing them. Sheehan, when interviewed, confirmed that he drafted the wording that appeared in the legislation (see table for quotes¹). This was corroborated by other interviewees. 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 and quality of hospital care.

Discussion

The documents and interviews clearly show that the changes to the Finance Act 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 different policy commitments, 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 (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.

Recent 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 the government. The smaller coalition party had disproportionate influence over government policy. This was enabled by close alignment of the finance minister to the ideology and policies of the junior partner, which emerged as one of the most robust 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 an 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 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). Here, the path dependency of the long institutionalised public private mix in healthcare, as well as the application of tax-reliefs to the health sector, was the dominant force of change. This is evident in the rapid growth of private hospital beds and low numbers of additional public hospital beds.

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

¹While anonymity and confidentiality was guaranteed to all interviewees, Sheehan subsequently wrote a memoir which included reference to his direct role in drafting the initial changes to the Finance Act (Sheehan, J, Life Close to the Bone, 2013).

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 clearly reveals 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. The result of which was increasing the numbers of private beds, instead of investing in the public health system. As the majority of the population do not have access to private hospitals, this exacerbated existing inequalities in access to hospital care in Ireland.

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.](#)

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