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This time is different? Lessons from past reform initiatives in the Irish health system

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Abstract

The publication of the Sláintecare report in May 2017 is a landmark in Irish healthcare policy. For the first time in the history of the state, the Irish political system produced an agreed long-term vision for the health system. The Irish healthcare system has attracted considerable negative comment over a long period and satisfactory healthcare reform had appeared to be impossible to achieve. The history of Irish healthcare reform is replete with policy difficulties. This paper seeks to assess the likelihood that Sláintecare will be implemented given that it is the first long-term, multielectoral cycle healthcare initiative that is agreed by all the main political parties. The paper uses a game theoretic model developed by Dal Bó, Dal Bó, and Di Tella to develop an understanding of the impact of the electoral cycle on politicians and interest groups in negotiating and implementing healthcare reform. It uses a case-study methodology, with previous Irish healthcare reform initiatives as the unit of analysis. Finally, it shows that politicians are at a distinct disadvantage due to the short-term horizon imposed on them due to the electoral cycle and that the adoption of a long-term agreed policy, like Sláintecare, is more likely to be implemented.

Keywords: game theory, healthcare policy, healthcare reform, healthcare system, interest groups, Ireland, Sláintecare, universal healthcare.

Introduction

The publication of the Sláintecare report in May 2017 is a landmark in Irish healthcare policy. For the first time in the history of the state, the Irish political system produced an agreed long-term vision for the health system. Furthermore, it is a reform programme produced by an all-party parliamentary committee with the goal of achieving 'a single long-term vision for healthcare and the direction of health policy in Ireland' (Dáil Éireann, 2016). It was adopted by the Dáil without the need for a vote. The report contains a ten-year plan to reform the health service, recommending the separation of the public and private hospital systems, creating an affordable, universal, and single-tier healthcare system, 'in which patients are treated promptly on the basis of need, rather than ability to pay' (Leahy, 2018). Moreover, it set out a clear path for implementation, with a specialist office to drive reform.

More than seven years on from the publication of the ten-year plan, Sláintecare has been beset by delays, disagreement, and resignations from its implementation body. However, some important reforms have taken place (see Department of Health, 2024). The Health Service Executive is currently implementing the new public-only Sláintecare contract despite the opposition of both medical organisations, significant progress on the Enhanced Community Care Programme has been made, and free general practitioner (GP) care has been extended to an increased amount of the population.

This paper seeks to understand the effect of the electoral cycle and the interaction of government and the medical profession in determining healthcare policy through the lens of policy-process theory. It employs a case-study methodology, with previous Irish healthcare reform initiatives as the unit of analysis (Yin, 2003, p. 24; George & Bennett, 2004, p. 17). As Schlager (2007, p. 293) notes 'Explanations of the policymaking process rest in theories and models, which should be, but typically are not, grounded in a framework'. As the case study examines decision-making in government and the medical profession in 'multiple linked arenas at all three levels of analysis' (Ostrom, 2007. p. 43), it frames the analysis within Ostrom's Institutional Analysis and Development Framework. At a theoretical level, the paper locates the analysis within the linked agenda-setting theories of advocacy coalition theory and punctuated equilibrium theory (see Sabaiter, 2007) and uses the game theoretic model developed by Dal Bó, Dal Bó and Di Tella (2007) as the primary means of analysis.

The model shows how policy reform can be negatively impacted by the short-term time horizons of politicians who face cyclical elections, which means it is difficult to deliver on complex reform. This is in comparison with the interest group with which they need to interact to deliver these reforms, who can develop their position and build influence capacity over a much longer time frame. During their continuous interactions, the interest group can establish a reputation depending on its means. If politicians are amenable to the group's wishes, the interest group may reward them with 'positive incentives' such as election contributions, public support, positive comment in the media, etc. However, if a politician is not amenable to a group, it can impose 'negative incentives' such as strike action, non-cooperation, street demonstrations, blockades, aggressive lobbying, smear campaigns, vexatious legal cases, etc. The model shows that both rewards and punishment can be used in tandem by interest groups to achieve their desired outcomes and that building a 'tough' reputation is an effective strategy for an interest group. This paper further builds on the understanding of Irish healthcare policy reform developed by Weir (2015), Wren and Connolly (2019) and Connolly and Wren (2019).

Following this introductory section, the next section presents a case study which reviews healthcare reform in Ireland from the early years of the state to the present day and provides in-case analyses using the lens of the Dal Bó, Dal Bó and Di Tella (2007) model. It shows how the electoral cycle and the relationship between the medical profession and politicians has impacted healthcare reform. The final section draws together the evidence presented in the case study and displays the advantages of a long-term agreed policy plan like Sláintecare. Notwithstanding delays and challenges, writing in autumn 2024 in advance of the general election, some progress has been made and the evidence presented in this paper suggests that further reforms, consistent with the vision in Sláintecare, can be achieved.

Case study: Healthcare reform in the Irish political system

For the first time in the history of the state, all the major political parties are agreed on the long-term vision for the health system. This was not the case in the past and allowed the medical profession as an interest group to play a long-term game where it could establish a 'tough' reputation and wait for a Minister for Health that was more amenable to its wishes.

In the first decade of the state, the government, concerned with establishing the state and fiscal credibility, adopted a largely reform and efficiency driven approach to healthcare (Barrington, 1987, p. 100). This changed when Fianna Fáil gained power in 1932. It had a radical reform vision for society and public policy (Barrington, 1987, p. 113). In the area of healthcare, this was given fruition through the Parliamentary Secretary for Health, Dr Conn Ward, who from 1932 to 1946 through his assertive and sometimes abrasive personality, energy, and ambition drove healthcare capacity forward through an ambitious hospital-building programme and an expectation of high standards from those involved in healthcare (Barrington, 1987, p. 115). Dr Ward asserted that it was central government's right to determine health policy for the whole country and the broader health system, something that was not accepted by everyone. He also ensured that if voluntary hospitals received public funds that patients of all classes could receive treatment. The medical profession, which had desired a state-provided healthcare system in the 1920s, revised this position during the 1930s (Barrington, 1987, p. 135).

In the 1940s, influenced by the initiatives to provide national health services in countries like the United Kingdom, Denmark, New Zealand and France, Fianna Fáil and government officials began moves towards a similar system in Ireland (Barrington, 1987, pp. 141–2; Deeny, 1989, p. 104). As part of these reforms, the government proposed to establish a stand-alone Department of Health with Dr Ward as the first Minister of Health and to introduce a controversial Public Health Bill in late 1945. Fearful of these reforms with Dr Ward as minister, 'the profession revealed its muscle' (Wren 2003, p. 31) when a former president of the Irish Medical Association (IMA), Dr Patrick McCarvill made a series of allegations against Dr Ward, only one of which was substantiated. However, it was enough to force Dr Ward's resignation. The IMA, in support of Dr McCarvill, established a fund to defray any legal costs he may incur. This was the first in a series of steps forging the medical profession's 'tough' reputation.

Despite this setback the government pressed on with its reform agenda. Dr James Ryan was appointed as the first Minister for Health in January 1947. In March 1947, he introduced a Health Bill which attracted controversy over the provision of free treatment for mothers pre- and post-partum and for children of school age. The medical profession and Fine Gael vociferously opposed this, with Dr Tom O'Higgins TD stating that private practitioners would lose the 70–80

per cent of the income they earned from attending young children (Dáil Éireann, 1947). Fine Gael also opposed the Bill on the basis that it contravened Catholic social teaching (Barrington, 1987, p. 183). However, Dr Ryan was a more strategic and less combative politician than Dr Ward and under his careful guidance, the Bill passed through the Oireachtas and following consultation with the Council of State on the constitutionality of the 'Mother and Child' sections of the Bill, the President signed the Bill into law in August 1947. Here, the medical profession exhibited patterns of behaviour that are recognisable from the policy-process theory literature (Weible, 2023). It forms an 'advocacy coalition' with Fine Gael and the Catholic church, with elements of the coalition attempting to 'venue shop' by appealing to the President to refer the Bill to the Supreme Court and by taking a separate case to the High Court (Barrington, 1987, p. 185).

Highlighting the fact that politicians have a 'short-term horizon' due to the electoral cycle, Dr Ryan did not oversee the implementation of the Health Act 1947. Following a general election in February 1948, the first 'inter-party' government formed with John A. Costello as Taoiseach and the young and inexperienced Dr Noël Browne as Minister for Health who 'on his first day in Dáil Éireann … inherited the task of unravelling the complex medical and church politics surrounding the 1947 Health Act' (Wren, 2003, p. 33).

In what is recognised as the formative scandal of Irish health policy, a coalition of the medical profession, the Catholic church and Fine Gael ensured that the Mother and Child Scheme did not proceed (Barrington, 1987, p. 218). The Minister for Health, Dr Browne resigned, and the government ultimately fell due to the scandal. As a result of the attempted healthcare reform, a minister resigned, and ultimately a government collapsed. The medical profession, as an interest group, had established its 'tough reputation'.

Fianna Fáil returned to office, with Dr Ryan resuming his role as Minister for Health. Ryan and Eamon De Valera skilfully defused a second significant confrontation with the church and made concessions to the medical profession in order to get the Health Act (1953) through the Oireachtas (Barrington, 1987, p. 239). Free hospital and specialist services were made available to 80 per cent of the population with free pre- and post-partum care made available to some mothers, however, free medical care for children between six months and sixteen years was not provided for. In both GP and hospital consultant care, the medical profession had protected its private-practice income. Consultants, through the fees they could

charge, were incentivised to focus on their private patients, while the vast majority of the population still had to pay for GP services, including for children. Dr Ryan again demonstrated that with skilful political management some reform could be achieved but the providers largely secured the outcome they desired.

Again, highlighting the short-term horizon of politicians due to the electoral cycle, Fianna Fáil lost office just as the government were about to implement the reforms. Dr Ryan rushed through regulations three days before the election, establishing 1 August 1954 as the implementation date of the Act (Barrington, 1987, p. 100). Fine Gael, for the first time, secured the Department of Health portfolio with Mr T. F. O'Higgins appointed as minister. He was the son of Dr T O'Higgins (mentioned above), a former Minister for Defence and member of the IMA Central Council. Reflecting the 'tough' reputation that the profession had established, Costello told Higgins his job was 'to take health out of politics' (Barrington, 1987, p. 245). Given what had happened to his previous government, it is understandable that he wanted to avoid trouble and keep health off the political agenda and corralled within the policy subsystem (Weible, 2023).

Fine Gael, at this time, was considerably sympathetic to the wishes of the profession. O'Higgins, with the help of the medical profession, successfully delayed the implementation of the Act (op. cit.). He further granted much of the profession's policy wish list: he reduced ministerial power over the Medical Registration Council; extended private-practice rights to county surgeons; and legislated for 'the IMA's crowning achievement' (Wren, 2003, p. 42), the introduction of a voluntary health insurance scheme which allowed the higher income group to insure themselves for medical treatment and provided 'in effect insurance for the medical profession that their private income would be secured' (ibid.). The medical profession, with the aid of a sympathetic minister and political party considerably advanced their vision of the health service. An important issue to note here is that major policy changes, once achieved are infrequently reformed. Consequently, when an interest group achieves a policy win from a sympathetic policy-maker, it generally becomes an embedded element of the policy system.

Fianna Fáil returned to power in 1957, and after two decades of radical ambition in healthcare, it too was content to keep 'health out of politics'. Sean MacEntee was appointed as Minister of Health where he remained until the 1965 general election and 'while he had

lost none of his pugnacity or zeal, [he] was opposed to the kind of radical changes in the health services which he had supported'. He believed that the health service, while not ideal 'was as good as any in the world' (Barrington, 1987, pp. 252–3).

Following the 1965 general election, Donogh O'Malley was appointed Minister for Health, publishing a white paper in 1966 (Government of Ireland, 1966) which continued the now conservative thrust of Fianna Fáil policy stating, 'the government did not accept the proposition that the state had a duty to provide unconditionally all … health services free of cost for everyone' (Government of Ireland, 1966, p. 16). Healthcare policy was largely uncontroversial until the early 1970s; however, an illustrative event occurred following a spat between O'Malley and the medical profession over remuneration (Seanad Éireann, 1966). Sean Lemass moved O'Malley out of the Department of Health portfolio and into the Department of Education to avoid a confrontation with the medical profession (Barrington, 1987, p. 269; Wallace, 2008). It is one of the supreme ironies in Irish politics that the minister who is feted for introducing 'free' secondary education in 1967, opposed the same principle in healthcare.

The next two Ministers for Health, Sean Flanagan and Erskine Childers were both late in their careers and generally favourable towards the medical profession. The Health Act 1970, initiated by Flanagan and completed by Childers, was the next significant policy change, and as Maev-Ann Wren (2003, p. 48) concludes 'on terms that suited the profession'. The new Act replaced the 'poor law' dispensary service with a 'choice of doctor' General Medical Services (GMS) Scheme; it established the regional health boards to manage the health system in place of the local authorities; and set up Comhairle na nOspidéal to manage consultant posts with a majority of consultant membership (Barrington, 1987, p. 274). The 1966 white paper (Government of Ireland, 1966, p. 32) stated that government preferred GPs to be paid a capitation fee for each eligible patient, however, the profession lobbied for and obtained the more lucrative 'fee per service' payment. There was little sentimentality about the loss of the 'poor law' dispensary system, but its replacement effectively left the provision of primary care to private entrepreneurs. This major change in policy dismantled a framework that could have been used as a foundation to establish a properly resourced, multidisciplinary primary care network. Again, the needs of the profession were the significant driving force of the policy outcome. The profession, as a

group, could now achieve significant reform from those inside and attuned to the policy subsystem with little opposition as the Dal Bó, Dal Bó and Di Tella model (2007) predicts.

Fianna Fáil lost power in 1973. The new Tánaiste and leader of the Labour Party, Brendan Corish, as Minister for Health, attempted to extend free hospital care to the entire population. Labour Party policy, since 1969, had been to introduce 'a free comprehensive health service' and this was supported and promoted by the trade unions. The profession opposed the scheme and by threatening industrial action, it had to publicly 'reveal its muscle'. Corish was forced to withdraw the scheme just before its implementation date of 1 April 1974. Corish, in the Dáil, stated that he believed that the medical profession, in stymying the scheme, had usurped his role as minister and that of the government in deciding policy (Dáil Éireann, 1974). He stated that his intention was not to abolish private practice but to offer everyone the option of free treatment. Corish, like Browne before him, received little support from his Fine Gael government colleagues or from Fianna Fáil on the opposition benches. However, Fianna Fáil did suggest that Corish could have extended eligibility to the GMS scheme rather than extending hospital care to the wealthy (Wren, 2003, p. 52). It is interesting to note that the medical profession was confident to take on the government without the support of the Catholic church who in the intervening period had lost its appetite to object to 'socialised' healthcare. Indeed, Corish could claim in the Dáil that the bishops' Advisory Council for Social Welfare had approved of the scheme (McInerney, 1973).

Fianna Fáil returned to office in June 1977. Charles Haughey, the new Minister for Health, oversaw a rapid and unplanned expansion of health services (Wren, 2003, p. 57). Following campaigning by the Irish Congress of Trade Unions, he extended free hospital accommodation (but crucially not consultant care) to the whole population in 1979. The medical profession accepted the change only after it was pointed out that it still had control of hospital beds and could not be seen to go against the provision of free hospital accommodation for the Irish people (Wren, 2003, p. 58). When Haughey became Taoiseach, he appointed Michael Woods as Minister for Health.

A 'common' consultant contract was offered in April 1981 which 'gave them the best of all worlds – state salaried, pensionable posts, with the right to unlimited private practice in or outside public hospitals' (Wren, 2003, p. 60). The contract failed in the first instance

to specify the duties expected of hospital consultant staff. Consequently, it became impossible for health system management to organise the hospital system in an efficient and equitable fashion. Furthermore, the remuneration allowed under the contract created perverse incentives. Consultants received a salary for their public work and were allowed to earn unlimited private-practice fee income in both public and private hospitals. Consequently, some consultant staff were incentivised to concentrate on their private role, and public waiting lists increased. Some consultants could engage in 'second degree' price discrimination whereby the patient had to choose from a 'menu' of paying in 'waiting time' for public treatment or paying cash either through private insurance or directly to the to the consultant for timely and often better treatment privately.

The contract inflicted huge damage to the health system and on the ability of the government to reform health policy. The contract, like the introduction of the Voluntary Health Insurance Board (VHI), was a significant policy change that became structurally embedded in the system and ensured that subsequent reform in the public hospital system became extremely difficult to implement. Again, in a short window, with politicians favourable to the interest group, significant advantageous policy change was achieved.

The 1980s were a difficult decade for the Irish economy and society. A series of short-lived governments in the early 1980s and an economy rapidly deteriorating to prolonged stagnation brought health cuts. The period of political instability ended with the election of a Fine Gael/Labour coalition in late 1982 with Barry Desmond as Minister for Health. Desmond announced his support for a 'full comprehensive health service for all, with priorities based on people's medical needs rather than their ability to pay for services' funded by national health insurance which would subsume the VHI (Wren, 2003, p. 64). However, he never really pursued it, and officials counselled that the policy could end the same way as the previous Labour Party Health Minister's attempted reform.

While the economy, the public finances, and consequently, the public health system were all enduring a significant period of difficulty, private healthcare expanded. Membership of the VHI grew considerably from 20.7 per cent of the population in 1979, to 25 per cent in 1980, to 29 per cent by 1986. The Blackrock and Mater Private hospitals opened in 1986 (Wren, 2003, p. 66), Desmond tried to curtail private medicine: by insisting the VHI offer separate policies for the private clinics; stopping the construction of a private clinic on the

grounds of the public Beaumont Hospital; and by charging consultants for the costs of their private work in public hospitals. Desmond engaged in guerilla warfare rather than a frontal assault against the profession. Dáil debates at this time show cross-party concern at the increased level of private work consultants were now conducting in public hospitals due to the new contract and the consequent emergence of public-patient waiting lists (Dáil Éireann, 1987).

Fianna Fáil returned to power in March 1987, with Monaghan GP Dr Rory O'Hanlon appointed as Minister for Health. While the government continued to cut public health expenditure, private medicine continued to expand with 36 per cent of the population in the VHI by 1993 and 46 per cent by 1991 (Wren, 2003, p. 78). The government, in an attempt to control costs, negotiated a capitation scheme with GPs for GMS patients, while private patients continued to pay on a fee-for-service basis (Wren, 2003, p. 79). This effectively incentivised GPs to refer GMS patients to more expensive hospital and consultant services to free up their appointment schedule for paying patients.

Following an opportunistic general election, called by Haughey in an attempt to achieve the overall majority that eluded him, a Progressive Democrats/Fianna Fáil coalition was formed in June 1989, with O'Hanlon remaining in the Department of Health. Free hospital consultant care for all was introduced from 1 June 1991, with a system to limit private practice in public hospitals to 20 per cent of bed capacity, and a revised consultants' contract to reflect these changes. The disinterest with which the consultants now showed to the introduction of free consultant services for the whole population is in stark contrast to their reaction to the similar proposal by Corish in 1973–4.

Why was the consultants' reaction so different this time? In 1974, hospital and consultant care were free at the point of use for 90 per cent of the population. The remaining 10 per cent could either pay directly or insure themselves with the VHI. Hospital management largely had the capacity to restrict private practice to ensure the public patient was treated in a timely fashion. This system, from a public patient's point of view appeared to work reasonably well, although an IMA report from 1975 showed that they were aware that public patients received inferior care (Mulcahy et al., 1975).

In the intervening years, due to the Haughey/Woods contract, hospital management lost the capacity to manage consultant staff in public hospitals. Following the introduction of the common contract,

waiting times for public patients increased. Since consultants were now paid a salary for their public work but could earn extra income for their private work, they naturally favoured private patients. Consultants had an incentive to treat private patients, in person and faster than public patients. The longer the public waiting list, the greater the incentive for patients to take out private health insurance. When free consultant care was offered to everyone in 1991, it did not impact on the consultants' private income because many of those who were eligible for free care took out private insurance so that they could receive prompt care and a personal consultant service rather than the services of a less qualified doctor that the consultant had delegated to the public patient. Patients were now being charged for timely access to superior quality care with the medical profession as sole gatekeepers. Private consultant income was now significantly dependent on public patients receiving inferior delayed care.

Following short stints in 1991 and 1992 in the Department of Health by Fianna Fáil TDs, Mary O'Rourke and Dr John O'Connell, the Labour Party returned to the Department of Health portfolio, with Brendan Howlin as minister in the Fianna Fáil/Labour coalition that was elected in 1992. In a reflection of how all parties' ambitions (except the minor Democratic Left party) in health policy had collapsed, Wren (2003, p. 97) reflects 'Labour's approach was as anodyne as the other parties'. When the Labour/Fianna Fáil coalition collapsed in 1994, it was replaced by the 'Rainbow coalition' of Fine Gael, Labour and Democratic Left. The new Fine Gael Minister for Health, Michael Noonan had no radical ambitions for reform and 'like, Howlin, believed that the primary problem of the public health system was under-resourcing' (ibid.). A significant portion of Noonan's time in the Department of Health was taken up by the hepatitis C scandal (Wren, 2003, pp. 109–23).

The economic growth of the 1990s increased the population and consequently the pressure on the health service. Due to the boom in public finances, each government's easy political solution was to increase funding. Brian Cowen had been appointed Minister for Health after Fianna Fáil returned to power with the Progressive Democrats as partners in 1997. Cowen famously described the health portfolio as 'Angola' due to the number land mines (scandals) on which a minister might step. A further revision of the consultants' contract was negotiated in 1997, with little change. Indicating the lack of ambition prevailing, the 'public only' consultant was removed as an option. The inability of the political system to deal with the issue

became so embedded and resistant to change that Wren (2003, p. 96) notes 'between 1991 and 2002, every Minister for Health accepted the two-tier system of hospital bed designation'. It is a measure of the medical profession's 'tough reputation' that no minister during this period seriously challenged the medical profession's preferred policy position.

However, the seeds of reform were laid in the 1990s as the failure of each attempted reform kept the issue on the agenda (Weir, 2015, pp. 306–8). With a booming economy, each government, as short-term players, took the easier solution of increased funding rather than the difficult problem of reform. An indication of the increased attention and dissatisfaction in the health service (Weir, 2015) was the commissioning of a series of reports. In the last years of the 1990s and the first of the 2000s, no fewer than eight major documents were commissioned to examine various aspects of the health service (Department of Health, 1993, 2003; Department of Health and Children, 2001a,b, 2003; Department of Health and Children & Deloitte & Touche, 2001; Comhairle na nOspidéal, 2002; Watson Wyatt Worldwide & Prospectus Consultants, 2003). The significant conclusions of the reports were that the problems of the health service were fundamentally structural, with too many hospitals and an underdeveloped primary healthcare service. The management of hospital consultant staff was ineffective, and their work patterns did not meet the needs of patients, with excessive delegation to junior doctors. Furthermore, restrictions on private work were ineffective and a better balance needed to be achieved in consultant practice between emergency, elective, teaching, research and management. With little to no apparent improvement, attention increasingly focused on hospital consultants' work practices as the root of the problem. They lost credibility as headlines appeared in newspapers stating, 'Consultants fight to maintain their fruitful monopoly' (2000), 'Consultants are on the pig's back' (Browne, 2003) and '…Vested interests come in for a battering' (Houston, 2003).

Micheál Martin became Minister for Health in January 2000. Within days of his appointment, the Labour Party tabled a motion on the 'crisis' in the hospital system (Wren, 2003, p. 107). Martin sought to renegotiate the consultants' contract, but they were dogged by delays over disagreements about medical indemnity. Reflecting the delays, the Taoiseach Bertie Ahern in September 2004 'took the unusual step of devoting his entire opening address of the Fianna Fáil Árd Fheis to the health issue' where 'he retained his strongest words

for hospital consultants who he said should immediately return to negotiations over a new consultants' contract' (Brennock, 2004). Fianna Fáil, for the first time since the 1950s, appeared to be willing to challenge the profession. He reshuffled his cabinet the same month and the Tánaiste and leader of the Progressive Democrats, Mary Harney TD, fed up with what she saw as Fianna Fáil ineffectiveness and provider posturing, sought the health portfolio. There was comment in the media that Martin was happy to be relieved of the Department of Health (Drapier, 2004). Furthermore, Harney's seeking of the department was seen as a considerable risk. Pat Rabbitte TD pointed out when congratulating Harney:

> It is brave to take on the Department of Health and Children given seven and a half years of failed reform … I think all the Fianna Fáil backbenchers will join with this side of the House and say: It is the PDs, sure we would have a great health service only the PDs are in charge.
>
> (Dáil Éireann, 2004).

Health policy had become so problematic and dysfunctional that it is described as Angola (by Cowen above), effectively a graveyard for political careers, and that any politician seeking the post was foolish. This level of dysfunction obviously did not serve the public, politicians or providers.

Harney saw the renegotiation of the contract as the key element of the reform of health services. She also proposed the introduction of colocation of public and private hospitals as a means of ensuring consultants met their public duty obligations. The negotiations dragged on for a further four years, with the consultant side doing everything in its power to delay the negotiation in the hope that Harney would move on. The general election in April 2007, saw Harney return to the Department of Health even though her party had been decimated. The *Sunday Business Post* (O'Meara, 2008) acknowledged, 'The general election saw the surprise return of Harney to Health, and the realization for consultants that nothing had changed at Hawkins House'. A new contract was finally agreed in January 2008. Again, we see the short-term horizon of a politician being of importance to the interest group from a tactical perspective. Harney was viewed as a tough minister by the profession, and it was happy to delay agreement of the contract until after the election in the hope of a more favourable minister in the portfolio.

Significantly, at the Fine Gael Árd Fheis in 2006, the party's spokesperson on health, Dr Liam Twomey pledged to support 'the Tánaiste in her efforts to confront the power of hospital consultants' (Collins, 2006). The newspaper report continued, 'There is a clear issue of public interest at the heart of the row over her desire to introduce a new contract for public hospital consultants, given the appalling value for money provided by the existing common contract'. From the discussion above, it is evident that Fine Gael had traditionally been aligned with the medical profession. The party had been significant to the success of the profession in designing a health system to meet the medical profession's needs since the 1950s with Fianna Fáil rowing in after their initial period of radicalism in the 1930s–40s. Things had changed by 2006, when both parties were willing to publicly challenge the profession. However, in the teeth of opposition from the two main political parties, the medical profession was still able to negotiate a favourable contract largely protecting its private-practice rights in public hospitals.

The agreement of the contract in 2008 coincided with the financial crisis in Ireland and worldwide. Mary Harney attempted to implement the agreed contract in the remaining time of the government. The government introduced pay cuts, moratoriums on hiring new staff, general health spending cutbacks, etc. With the public finances in crisis, the Irish Hospital Consultants Association, for the first time in its existence, agreed to sign up to a national wage agreement in 2010. Under the terms of the Croke Park Agreement, the government agreed not to further reduce pay until 2014. This meant that any future salary cap on high earners, like the medical consultants, could not be lower than existing rates.

Following a general election in late February 2011, Fine Gael and the Labour Party formed a coalition government. Dr James Reilly served as Minister for Health, whose policy was to move the Irish healthcare towards a Dutch style universal health system with free GP care by 2016. The Labour TD, Roisin Shortall, served as Minister for State for Primary Care. As Wren and Connolly (2019, p. 12) note, it was the first Irish Government since the Mother and Child Scheme of 1951 that sought to remove fees for GP care for children. 'It is hard to overstate the historic nature of the 2011–2016 Programme for Government' that sought to end two-tier access to hospital care and primary care, free at the point of use financed by universal health insurance. However, due to the economic crisis, Reilly's pressing task

was to agree financial savings and cost-saving changes in work practices with the consultants. The talks dragged on for so long that the government introduced a contract at lower pay for new consultants entering the system. Leo Varadkar was appointed as Minister for Health in July 2014. He spent considerable time negotiating with the consultants over their pay and the now two-tier nature of consultant pay introduced by Reilly. The government abandoned Reilly's core promise of a universal health system based on the Dutch model in late November 2015 citing concerns around costs (see Wren, Connolly & Cunningham, 2015).

Prior to the general election of February 2016, Fine Gael, Labour and Sinn Féin campaigned on a policy of universal healthcare. Even though Fine Gael lost a significant number of seats, it returned to power as a minority government with the support of independent TDs and a formal 'confidence and supply' agreement with Fianna Fáil, with Simon Harris being appointed Minister of Health. The relatively precarious nature of the government support in the Dáil increased the power of the legislature relative to the executive. Early in the term of the new Dáil, former junior health minister Roisin Shortall introduced a proposal to establish the all-party Committee on the Future of Healthcare with 'the aim of achieving cross-party consensus on the long-term vision for health care and health policy, and to make recommendations to the Dáil in that regard' (Committee on the Future of Healthcare (32nd Dáil), 2017). The outcome, the Sláintecare report, was agreed in May 2017 and approved by the Dáil without the need for a vote. The government published the Sláintecare Implementation Strategy in August 2018, establishing the Sláintecare Programme Office, an advisory council, and a three-year implementation strategy.

Conclusion: Is this time different?

Having analysed the history of Irish healthcare reform using Dal Bó, Dal Bó and Di Tella's game theoretic model (2017), there is evidence to show that providers as long-term players, have, in the past, largely been able to design the healthcare system to meet their needs at the expense of an equitable and efficient system. While governments were able to achieve some reforms, they were partial, protected private practice and left gaps in provision and inefficiencies. The medical profession established its 'tough' reputation in the 1940s and 1950s

and has largely maintained it since, although there is some evidence of a more cooperative approach since 2008. The historical case study presented in this paper shows that the medical profession achieved significant policy wins when Ministers for Health, were favourable to them, particularly, the establishment of the VHI in 1958, the setting up of the GMS scheme in 1971, and the 'common' consultants' contract in 1981.

The intractability of healthcare reform, particularly since the 1990s, attracted various policy entrepreneurs in journalism, politics, the medical profession, and academic researchers to examine the field. A cohort of politicians, academics and journalists continued to ask questions, seek election, and conduct research. In addition, the separation of the Health Service Executive out of the Department of Health in 2003 allowed the department the time and focus to build up expertise in the necessary areas. These elements formed the backdrop to the establishment of the all-party committee on healthcare and its subsequent publication of the Sláintecare report.

The Sláintecare plan effectively allows politicians to operate as long-term players nullifying considerably the advantage of the interest group. The realisation that the electoral cycle stymied healthcare reform was crucial to this change. In the past, ministers brought to the portfolio their own ideas for the health system, for example, Mary Harney wanted to introduce the colocation of public and private hospitals, while James Reilly sought a Dutch style, universal health insurance system. Policies, like these were generally not taken seriously by the medical profession as it rightly believed, they would not be implemented. This left the profession unwilling to engage in a reform programme that was unlikely to be implemented. Consequently, the health system remained hamstrung as politicians were often unwilling to allocate more resources to health as they believed the profession would not engage in reform.

The agreement of a long-term policy path among the major political parties gives credibility and certainty to government policy. The long-term plan charts a definite path of change for the foreseeable future that both sides can engage in with some confidence. From the theory and evidence presented in the case study, writing in the autumn of 2024, before the forthcoming general election, it is reasonable to be cautiously optimistic that the Sláintecare plan will be implemented, patients in the future will be treated on the basis of need rather than ability to pay and that 'this time is different'.

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