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The National Treatment Purchase Fund – A success for some patients yet a public policy failure?

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Abstract

In 2002 the Irish Government announced the establishment of the National Treatment Purchase Fund (NTPF) as a means of addressing patients' long wait times for public hospital treatment. A new health strategy published in December 2001 promised that 'by the end of 2004 all public patients will be scheduled to commence treatment within a maximum of three months of referral from an outpatient department'. Qualitative methods, including documentary analysis and key informant interviews, were used to gain an understanding of this policy process. The findings were then analysed through the framework proposed for this special issue where ideas, institutions and politics interact. Using McConnell's typology of policy failure, this research finds the NTPF to be an example of a policy failure because, even though tens

of thousands of public patients have been treated under the NTPF, waiting times and numbers have persisted and escalated since the NTPF was established.

Keywords: Health policy analysis, Irish health reform, privatisation, hospital care, policy failure

Introduction

In 2002 the Irish Government announced the establishment of the National Treatment Purchase Fund (NTPF) as a means of addressing patients' long wait times for public hospital treatment (Department of Health and Children, 2002). The aim of the NTPF was to ensure more timely medical care by purchasing treatment for any public patient who had been waiting longer than three months for hospital treatment (Department of Health and Children, 2002). The treatment was to be purchased by the NTPF in Irish public or private hospitals, or abroad if there was not the capacity or expertise in Ireland to carry out the procedure (NTPF, 2005). The NTPF represented a type of privatisation in the provision of specific hospital treatments for long-waiting public patients by the private sector.

The NTPF was established months after the publication of a new national health strategy, *Quality and Fairness: A Health System for You,* in December 2001 and in the run up to the scheduled 2002 general election. Fianna Fáil was the major party in government along with a small liberal party, the Progressive Democrats (PDs) (Murphy, 2008). The Irish economy was performing strongly in the late 1990s; however, Ireland, like most other OECD countries, felt the impact of the dot-com crash (Bergin et al., 2011). The quality of, and poor access to, health services was the major public concern in the run up to the scheduled 2002 election, in particular long waits for public patients to access public hospital care (John et al., 2003). Both Fianna Fáil and the PDs campaigned in the election with promises to improve the health system through the full implementation of the new health strategy, specifically committing to eliminating public hospital waiting times above three months (Wren, 2003). The NTPF was one of the mechanisms to achieve that.

Context of the decision to set up the NTPF

Long waiting times for public patients to access public hospital care was a serious (and ongoing) problem in Ireland's health system

(Department of Health and Children, 2001a; Houses of the Oireachtas Committee on the Future of Healthcare, 2017; Kelly, 2007; Wren, 2003). Despite various initiatives to tackle long waits in the 1990s, large numbers remained waiting for extended periods of time (Department of Health and Children, 2001b; Kelly, 2007). From the late 1990s to 2019, Ireland has had extremely long waiting times to access planned public hospital diagnosis and treatment, way beyond that of most other European and OECD countries (OECD and European Observatory on Health Systems and Policies, 2017).

The two-tier nature of the Irish health system manifests itself in multiple ways but is most profound for patients needing diagnosis and treatment from public hospital specialists (Burke, 2016). There are three main blockages for accessing non-emergency public hospital care in Ireland. The first is when one is referred from a GP to a specialist. Often tests will be required in order to inform the decision of the GP to refer on to a specialist. The wait times for such diagnostic tests in the public hospital system can be weeks, months or years, whereas those who can afford to pay privately, or have private insurance which covers these tests, can be seen in days or weeks (O'Riordan et al., 2013). The second blockage is the wait time from a GP to a first specialist appointment, which can be months or years (NTPF, 2018b). The third blockage is the wait time from seeing a specialist to receiving the necessary treatment, which again can be months or years (NTPF, 2018a). In each of these incidents, people who can afford to pay privately in a public or private hospital will be seen quicker than those on the public waiting lists (Burke, 2016). The privileging of private patients over public patients further exacerbates the long waiting times for public patients (Brick et al., 2010; Houses of the Oireachtas Committee on the Future of Healthcare, 2017).

Previous efforts to reduce waiting lists, including the Waiting List Initiative (WLI), had failed (Comptroller and Auditor General, 2003). The WLI largely bought care in the public hospitals but an assessment of it found over half the money allocated was absorbed into the day-to-day running of the public hospitals (Comptroller and Auditor General, 2003). By the time of the 2002 election, 70 per cent of respondents to an opinion poll cited 'hospitals/health service' as one of the most pressing issues influencing their vote choice and it was the most important issue mentioned (John et al., 2003, p. 126). In response to this, all the parties focused on healthcare in their electoral campaigns. The outgoing government was re-elected, promising to implement the recently published national health strategy and

introduce a range of measures to eliminate public hospital waiting lists, including the rollout of 'a new ear-marked Treatment Purchase Fund', which was to become the NTPF (Wren, 2003).

Methodology

This research was one of three case studies carried out for PhD research (Burke, 2013). The PhD was an in-depth analysis of the policy process and the adoption of three specific health policy choices, one of which was the NTPF. Qualitative methods of documentary analysis and semi-structured interviews with elites were used to gain a rich understanding of the policy process and to explain the policy process (Gilson et al., 2011; Walt et al., 2008). For this case, sixteen primary documents, including two obtained under Freedom of Information (FOI) requests, and seventeen secondary documents were included in the documentary analysis. FOI requests were made to the Department of Health on internal communication within the Department of Health in relation to the NTPF and between the Department of Health and the Department of Finance between June 2001 and March 2002, when the NTPF was announced. Very few documents were released to the authors – just two relevant to this research. Twenty-one people were interviewed for this research, each of whom was directly involved or had good knowledge of this specific policy process. Of these, seven worked in the private sector, six were or had been senior departmental officials, three were politicians or senior political advisers, and three were representatives of medical bodies. The research was carried out between 2009 and 2012 and the findings reanalysed in 2018[1] with the framework proposed by FitzGerald et al. (in this issue). FitzGerald et al. draw on McConnell's argument:

> that success or failure is multidimensional, suggesting three dimensions: process, programme and politics. Process success is the way in which the decision was made: Did it build a sustainable coalition in favour of the policy? Did the process confer legitimacy on the policy? Did it preserve the goals of the policy throughout? Programmatic success refers to whether the policy met objectives, produced desired outcomes and created benefit for the target group. Political success involves improving

[1] For more detail on the methods, see Burke (2013) and Burke et al. (2018).

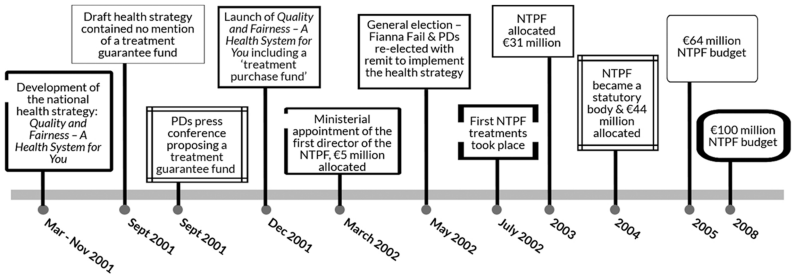
the electoral prospects of the government and enhancing its reputation. It might be consistent with an overall government approach to policy, and allow government to maintain control of the policy agenda.

Failure can presumably be judged on these grounds also: 'a policy fails if it does not achieve the goals that proponents set out to achieve, and opposition is great and/or support is non-existent'. (McConnell, 2010, p. 357)

Findings: The policy process

Drawing on the documents and interviews carried out for this research, the following policy process emerges. The timing of the NTPF's announcement shows that it emerged during the development of the national health strategy *Quality and Fairness*, which was in preparation for most of 2001 (see Figure 1).

Figure 1: Timeline of NTPF policy process

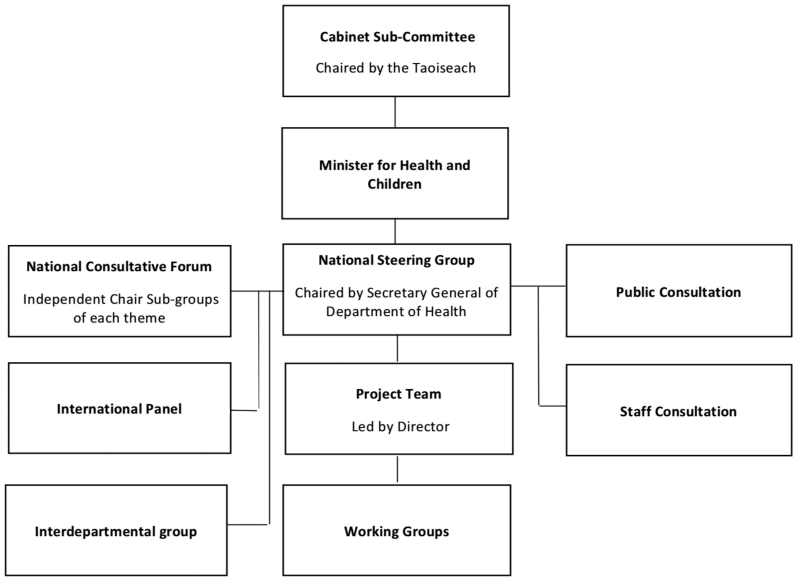


In 2000 the government announced the development of a new national health strategy, the first since 1994 (Kelly, 2007). Extensive consultations were held with the public, patients, workers in the health services and key stakeholders in advance of its publication (Department of Health and Children, 2001b; Kelly, 2007). Waiting times for hospital treatment were one of the main issues raised in the consultations with the public and with stakeholders in the development of the 2001 health strategy:

> Not surprisingly there were many calls for shorter waiting lists for elective procedures and for treatment of various kinds and reduced waiting times for outpatient appointments. (Department of Health and Children, 2001b, p. 27)

Interviewees were asked questions specific to the policy process behind the development of the NTPF; however, what emerged was an unexpected insight into aspects of the health strategy (*Quality and Fairness*) policy process. There was an elaborate process put in place for developing the health strategy with a large public consultation, numerous working groups and engagement with key stakeholders. However, a small number of people held control of the process (Kelly, 2007). See Figure 2 for the structure of the development of the health strategy. There were nine working groups chaired by senior departmental officials, including the areas 'public/private', 'funding' and 'eligibility' (Figure 3).

Figure 2: Structure of health strategy development process, 2001



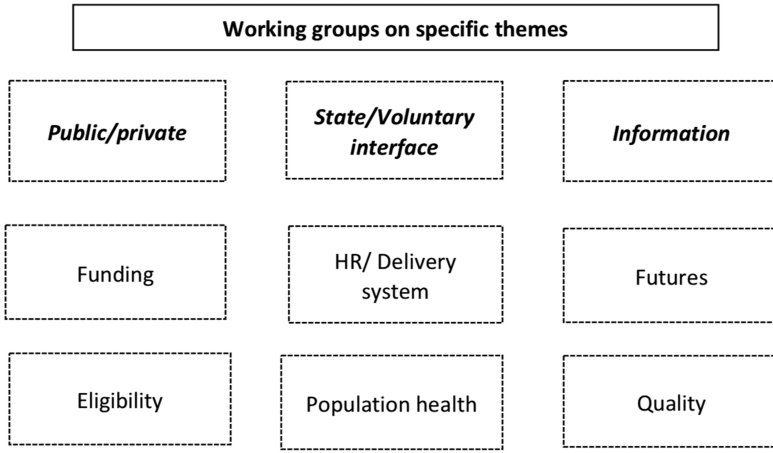
Source: Kelly (2007).

Many interviewed spoke about the public/private working group and how, despite its name, efforts to address the public/private mix were not up for discussion in this working group:

> From my recollection, there was absolutely no discussion of the public/private mix. The public/private mix was never discussed. (IV 8)

> I don't think the people who were busy trying to strategise were ready to try and deal with that big a question – the public/private mix. (IV 10)

Figure 3: Key themes of health strategy working groups, 2001



Source: Kelly (2007).

At the public/private group, however, there was consideration given to introducing a common waiting list for all public patients as a mechanism for addressing the inequality in access experienced by public patients to public hospitals:

> Its genesis [the common waiting list] goes back to the health strategy. We wanted to do one major initiative in the strategy… I mean the health side… was pushing it strongly and it was one we just did not have the political power to pull it through. It was basically that we would to do the waiting lists on clinical, only medical prioritisation [a common waiting list] and a lot of earlier drafts we had that in – that basically irrespective of whether you were a public or private patient, you were to be dealt with on the basis of clinical need. Now there was a lot of opposition from Harney and McCreevy on this. (IV 21)

This was verified by another interviewee, who outlined how the NTPF emerged from the rejection of the common waiting list:

> I remember it being argued very forcefully by some of the political actors, that the idea of a common waiting list in a public hospital was a great idea. But, in terms of the political realities around this, it was absolutely a 'no brainer', you could not do it. At one high-level meeting on the strategy, the adviser to the then Tánaiste at the time said that this common waiting list represented some sort of 'state of nirvana'. How naive could we be to suggest that we would piss off the one single group of people who actually showed some satisfaction with how the health system worked... that approach was going nowhere and it was out of the ashes of that particular discussion that the alternative idea of the NTPF was put on table. (IV 1)

According to the interviewee this discussion took place at a high-level political group made up of cabinet members, including the Taoiseach, the Tánaiste, the finance and health ministers, and their political advisers. Most interviewees were not at this meeting but this series of events was detailed to those interviewed:

> We strongly argued within a number of those [health strategy] groups for a common waiting list and, interestingly, it did not find favour at the political level, as much as anything else, for what they saw as logistical reasons. They asked how can you have a common waiting list and, if you do, how do you distinguish between public and private patients? What's the point in taking out private [insurance] at all… in the end, particularly for the PDs, this idea [a common waiting list] did not travel, they were not happy with it and they pushed these other ideas instead. And in fact, almost the alternative to a common waiting list was the NTPF. (IV 5)

Another senior person involved in this health strategy development process stated that it was consultants who were the breaking point to the common waiting list being acceptable at a political level:

> It was proposed you have a common waiting list… it came to the first meeting of the cabinet, it was not singled out… But the PDs turned up and they went mental about it and started quoting the amount of people with private health insurance, what impact it would have on them. And they had absolutely no answer to the point, and this was the biggest disagreement of the strategy – it

> wasn't the funding. They had absolutely no answers to the question: Why should the state subsidise queue jumping?… There was a very passionate debate – very… It was a policy discussion by political people. The politics, as far as we are concerned, were central to it... Ultimately… they were arguing that the consultants would bring the system to a halt, they would game the system and destroy it in order to maintain their highly subsidised private work. They did not actually have an argument. It was: we cannot afford two to three years of consultants screwing over everybody, that you can't afford the morality of what will happen. In terms of the system, you cannot afford that loss of confidence in ability to bring about change and that this is a fight that is not worth having… Bertie Ahern had been quiet for much of the discussion – in fact he'd been missing for much of it, in Northern Ireland... He said at the end of it: 'If we pick a fight with the consultants, they'll destroy us', and that was the end of it… That was the end of the discussion – basically fear of the consultants... basically he got persuaded … that it was not a big enough or an important fight to take to and that was the end of it… It was probably September/October 2001. The NTPF is the thing which caused fury. (IV 6)

When this series of events was told to departmental officials, they said they could not know about discussions at cabinet. One of these officials then went on to say that although he was not privy to any cabinet discussion, he had heard that the consultants' contract was a point of contention:

> What I heard was a big issue was the consultants' contract – I certainly heard that. I also heard that… access – remember there was a lot of access for the 50 per cent or whatever the figure was at the time who had private health insurance. The consultants' contract was definitely one. (IV 11)

One interviewee said that at the end of this high-level meeting described above, TD Mary Harney's adviser agreed to come back to the group overseeing the health strategy development with a proposal (IV 1).

The next event according to numerous interviewees was a press conference held by the PDs on 25 September 2001 announcing the establishment of a 'treatment guarantee fund'. This came as a

complete surprise to the department and health minister, who were furious that the smaller government party were taking unilateral action during the health strategy development process. One interviewee remembered being at a meeting planning the launch of the health strategy when a call came through about the PD press briefing. The day after the press conference, Mary Harney, TD, the PD leader and Tánaiste, wrote an opinion piece in *The Irish Times* which detailed the new health initiative:

> It is time to put a permanent end to indefinite public waiting lists. That is why the Progressive Democrats are now proposing a radical new initiative that will help to transform the Irish public health system. Under our proposals:
> - every patient currently on a public waiting list would be given a definite appointment date for treatment just as private patients are; ….
> - the current waiting list of over 26,000 public patients would, in practically all cases, be eliminated within six months, and the concept of the public waiting list would be ended permanently, never again to become a feature of the Irish public health system;
> - we will establish a new treatment guarantee fund as an additional line item in the central health budget. (Harney, 2001)

Little information is publicly available documenting the details of the PD's 'treatment guarantee fund', nor was it included in the draft health strategy in September 2001 (Department of Health, FOI, 2001).[2] According to information obtained under FOI, the PD proposal was met with scepticism by the then Minister for Health, Micheál Martin, TD, the Department of Health and the Department of Finance (Department of Health, FOI, 9 November 2011).[3]

Martin pointed out, upon the announcement by the PDs of the 'treatment guarantee fund', that under the WLI, public patients' care was already being contracted out to the private sector and in some instances patients went abroad for treatment (Department of Health, FOI, 9 November 2011). This was the case, but only in a small minority

[2] Draft of the Health Strategy, *Quality and Fairness*, dated in pencil on cover, September 2001, released under FOI.

[3] Email entitled 'Internal communication within the department of health outlining queries re the National Treatment Purchase Fund', released under FOI.

of cases, as the vast majority of WLI money was spent on treating patients in the same public hospital in which they originated (Comptroller and Auditor General, 2003).

The Department of Health was concerned with the PD proposal as it felt it would exacerbate the public/private divide, with consultants paid a salary for public work and fee-for-service for private work (Department of Health, FOI, 9 November 2011). The Department of Finance queried how the treatment guarantee fund would prevent consultants from manipulating the system to their own advantage – i.e. it could incentivise consultants to provide more private care in public hospitals (Department of Health, FOI, 9 November 2011).

Quality and Fairness was published in December 2001, containing 121 actions including Action 81, which states:

> a comprehensive set of actions will be taken to reduce waiting times for public patients, including the establishment of a new ear-marked Treatment Purchase Fund…
>
> The target is that by the end of 2004 all public patients will be scheduled to commence treatment within a maximum of three months of referral from an outpatient department. (Department of Health, 2001a)

Intermediate targets were also set, as well as the following actions, so that these targets would be achieved:

- A major expansion in acute bed capacity, as described above, together with reform of primary care, strengthening Accident and Emergency services and the provision of additional non acute places;
- An ear-marked Treatment Purchase Fund which will be used to purchase treatment from private hospitals in Ireland and from international providers. It may also make use of any capacity within public hospitals to arrange treatment of patients. A National Treatment Purchase Team appointed by the Minister for Health and Children will manage the new Treatment Purchase Fund, working closely with the health boards. The team will commence its work immediately, in parallel with other reforms. (Department of Health and Children, 2001a, p. 101)

Other health strategy actions included the provision of 3,000 extra beds designated for public patients by 2011, a planned addition of 25

per cent capacity, 'representing the largest ever concentrated expansion of acute hospital capacity in Ireland' (Department of Health and Children, 2001a, p. 102).

Wren identifies how the original proposal of a 'guarantee' was toned down to a 'target' in the health strategy, *Quality and Fairness*. FOIs show the 'treatment fund' was, like its predecessor, envisaged as a short-term initiative (Department of Health, FOI, 9 November 2011).

There was extensive political support for the NTPF. The Department of Health, under clear political direction, was quick to act on its establishment, appointing its first director in March 2002. The first treatments took place in July 2002. Both the PDs and Fianna Fáil campaigned for the 2002 election on the basis of eliminating waiting lists (Wren, 2003). In 2003 the NTPF was allocated €31 million. In 2004 the NTPF became a statutory body. Its budget increased annually until 2011/2, when Minister James Reilly, TD, announced a policy decision not to treat people through the NTPF. The NTPF budget was cut as Minister Reilly used their money to establish a Special Delivery Unit to address long waiting times in public hospitals (Donnellan, 2013). The Special Delivery Unit was short-lived and, when a new minister was in place in 2015, the NTPF funding increased again as a means of addressing the long waits.

Discussion of findings using the framework

FitzGerald et al. (in this issue) argue 'there is no simple model that can explain good or bad policy choices. How each outcome is explained is unique to factors relevant in each case'. They propose the use of a framework, as outlined in their article in this issue, to assist in understanding 'how these variables interact to produce a policymaking environment that is conducive to good or bad decisions'. What follows is a discussion of the findings utilising this framework.

Ideology

There was unanimity among interviewees that the main driver of the NTPF idea and subsequent establishment was the political priority given to the NTPF by the PDs, who were the smaller party holding the balance of power in government between 1997 and 2002. Their leader Mary Harney was Tánaiste and, even though she was not then health minister (she went on to become the health minister in September 2004), she held considerable influence at the cabinet table. In

particular, the ideology of the PDs was supportive of private-sector involvement:

> The NTPF was destined to succeed: it had huge political commitment behind it, it had a very generous budget when compared with everything else, it was being selected out and fuelled up. (IV 1)

The political priority given to the NTPF also reflected the PD ideology, which believed in challenging state sector monopolies and the possible positive disruption the private sector could have on the public health system:

> According [*sic*] as a problem arose, there was a private-sector solution devised for it, so a problem with waiting lists – a private sector solution was the NTPF. (IV 18)

It was also believed that this relatively small amount of money (compared to the overall health budget) would have much more impact in the private sector:

> If you took the whole of the funding, say €75 million, today and threw it into one hospital, the x hospital for example, that wouldn't improve their efficiency to bring more patients in and operate on them electively. The NTPF did. (IV 13)

While it is not possible to tell from the documentation whose idea was the NTPF, the political advisor to Mary Harney was repeatedly named as the policy champion. Eleven of the twenty-one interviewees specified this political advisor as the 'main champion', its 'conceiver', 'a strong, strong architect', 'it was his brainchild'. The political advisor was fully supported by Harney, who, as Tánaiste and leader of the PDs, held considerable political weight and influence over political and policy choices at the time:

> [The NTPF] clearly had a sponsor in Harney, in getting itself established as a statutory agency, its own board, funded directly by Health, a growing budget year on year. (IV 14)

> The NTPF. It was political… From my perspective it had PDs written all over it. It was right up their alley: to solve… what was quite a significant political problem at the time. (IV 8)

> They were thinking in terms of a small party in a large government. They had an explicit policy of very selective interventions based on strategic choices which leveraged their influence a lot. Some of them were planned from long range, some of them were opportunistic… I can still recall half bits of conversations that they would have looked at: what is it about the health system that people are most pissed off with? What is most dysfunctional? Waiting lists are scandalous – how can we fix that in a way that is most commensurate with our view of government and people? (IV 10)

There was total consensus among interviewees that the NTPF was a PD-derived and PD-delivered policy, and that the PD ideology influenced the instructional adoption of the NTPF by the Department of Health, even though most of its officials were not supportive of it.

Institutions

The key institution emerging from this research is the Department of Health. A major theme evident in the documents and the interviews was the Department of Health's opposition to the idea of the NTPF:

> There was huge resistance to this [NTPF] in the Department [of Health]… The department was completely opposed to it. If you are trying to understand the genesis of it, the department was opposed to it. (IV 2)

A few interviewees explained this by their failure to take responsibility for the mixed public/private hospital system, and in particular for the private parts of the Irish health system:

> There was a… policymaker's mindset. It was: 'Yes we have a mixed system, but we as policymakers don't engage with the mixed bit, with the other half of that system. Our planning responsibilities don't comprehend the private bit, so we are actually overseeing a mixed system, but we are only concentrating on the publicly owned, publicly delivered bit.' There are endless examples of that. (IV 10)

Many interviewees also commented how the existence of the public/private mix in Irish healthcare allowed policy proposals such as the NTPF to emerge. This is known as path dependency in the policy literature and is very evident in Irish health policy – i.e. the system is

more likely to continue on the path it is on than deviate onto a different path (Wilsford, 1994). As Ireland had never adopted a national health service like many other European countries post World War II, this facilitated the maintenance of a two-tier system and the public/private mix (Burke, 2009; Wren, 2003). Some private hospital-owners or CEOs interviewed explained how the existence of contracting very specific cardiac care to private hospitals also laid the foundations for the NTPF.

Six interviewees specified how the NTPF idea was borrowed or transferred from abroad where the contracting out of elective treatment to the private sector was a common part of the New Public Management and privatisation agendas in England, Scandinavia, South Africa and Australia. Despite requesting documents containing references to a treatment purchase fund or guarantee, no documents were found or released from the department prior to its political announcement in September 2001. When this was put to interviewees, a number of them said that policy transfer was used as post hoc justification for this political proposal.

Most opposition to the NTPF came initially from the Department of Health and some hospital doctors, although quite quickly both groups delivered on the policy; e.g. the NTPF was successfully implemented initially by the department (albeit with strong political direction) and needed doctors' cooperation to roll it out.

Interests

A common issue raised by interviewees was concern in relation to the incentives in the health system which encouraged waiting lists. This manifested itself in a few different ways. One, it was the hospitals with the highest numbers and longest waiting times for public patients that tended to be rewarded by the previous WLI, getting additional money to try to bring lists down:

> There was no accountability; waiting list budgets were routinely going to supplement existing budgets. The higher your waiting list, the more money you got each year, a couple of times a year – a whole system of perverse incentives. (IV 2)

Another issue raised in the interviews was that the introduction of the NTPF would continue already existing perverse incentives which rewarded consultants with the longest waiting lists to profit more by treating the longest waiting privately:

> A lot of consultants'… reputation was measured by the length of their waiting list: the longer your waiting list, the more people who want to see you, the better you were. (IV 9)

> A lot of medics at the time believed that lists were a good thing to have because that's the way you got allocated resources, that's the way you won. The whole allocation of capital, of revenue funding, was haphazard... And there was a sense that the bigger the disaster you were sitting on, the more likely you were to actually get your problem solved, so therefore it was in the interests of hospitals and doctors to have big waiting lists. (IV 16)

> If you looked at a [public] hospital as a business, the private income they were getting from privately insured patients was helping to pay their bills. There was more private practice going on than there should have been: there was no doubt that there was more than the 20 per cent quota. It was being exceeded regularly… Consultants directly benefited each time a private patient came in. (IV 1)

> The running of public facilities to a private agenda was a cancer on the system. Now, how do you deal with that? That was the big challenge, and one of the core ways was to remove the incentive for the most important decision-makers to run the system to the benefit of the private patient. (IV 6)

The Irish Medical Organisation opposed the NTPF when it was first announced (Wren, 2003). Documents and interviews confirmed this; however, the interviews also brought a more nuanced take on it:

> The docs [doctors] had mixed views about it. Some were very enthusiastic, some were very resistant, but over time the doctors' resistance diminished… and that's what happened: they got used to it. (IV 12)

> There were arguments that money should go in to the public hospitals and that sort of thing, but they got worn down really, and the NTPF was buying large amounts of surgery… The surgical opposition to it was: you are putting public money into private hospitals instead of public ones. And the other big one

> was: you are double-paying surgeons who could be doing this in the public sector; you are paying them to do it in the private sector… I think you'll find very few surgeons now not thinking it matters to the person it benefits, and that's the patient, so the NTPF is now accepted by most surgeons. (IV 13)

> The biggest resistance I got was from [medics]. (IV 16)

Interestingly, the rejection of the common waiting list was made by politicians on the basis that consultants would reject its introduction when in fact what emerged from the rejection of the common waiting list was the NTPF to which they were initially opposed.

All interviewees were asked if lobbying took place to influence the policy's adoption. While department officials said they were not specifically lobbied for such a fund, there was at least one meeting between the most senior official in the Department of Health and a representative of private hospitals, confirmed by an interviewee from a private hospital. There, it was proposed that private hospitals could assist the public system in providing care that the public system was unable to do as it was operating over capacity, if paid accordingly. The establishment of the NTPF resulted in hundreds of millions being spent in private hospitals, which, according to some interviewees, made these hospitals viable and profitable.

Was the NTPF a policy success or failure?

McConnell (2010) delineates three different components of policy success – process, programmatic and political success. Process success is 'the way in which the decision was made: Did it build a sustainable coalition in favour of the policy? Did the process confer legitimacy on the policy? Did it preserve the goals of the policy throughout?' This research finds that the NTPF was a politically imposed policy solution, which did not have much support at the time, evident in the opposition of the Minister for Health and officials from the Department of Health. While its policymaking process did not confer legitimacy on the policy when it was set up, its rapid budget increase indicates that its legitimacy grew after its establishment. The aim of the NTPF remains the same in 2019 as it was in 2002. It can be considered a process success despite its provenance.

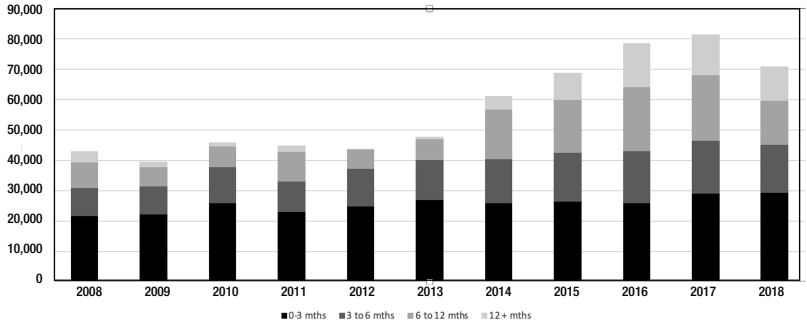
The role of the political advisor to the Tánaiste emerges as central to the policy process and its adoption as a policy. This finding

resonates with international literature on the role of policy entrepreneurs and champions who often drive through a policy reform, using an opening policy window to push through a specific reform they propose (Grindle & Thomas, 1991; Kingdon, 1995; Shiffman & Smith, 2007).

Programmatic success refers to whether the policy met objectives, produced desired outcomes and created benefit for the target group. For any person who received or continues to receive more timely care purchased by the NTPF, its existence and role must be considered a programmatic success for the target group as it did and can ensure them faster access to essential hospital treatment. In its first five years of operation, 100,000 people received treatment under the scheme (NTPF, 2012). The treatment of these people in private hospitals took some pressure off a public hospital system under severe pressure. However, when compared to overall numbers treated, they are just a fraction. For example, between 2002 and 2011, 217,305 patients in total were treated by the NTPF (NTPF, 2012). In 2012 the NTPF treated 18,216 people; however, the HSE treated 603,911 inpatients and 826,825 patients were treated on a day-case basis – i.e. the NTPF treated 1.2 per cent of all public patients treated (HSE, 2012; NTPF, 2012). Numbers waiting increased year on year between 2012 and 2017, reflecting the growing demand for care and a political decision to cut the NTPF budget during this time. Renewed efforts on waiting times and a reinstated NTPF budget in 2017/18 have resulted in some progress on waiting times in 2018. Due to data availability, and changes in the way waiting lists are being counted, it is not possible to provide these figures pre 2008.

The existence of the NTPF resulted in fewer people waiting longer periods for hospital treatment. However, this reduction in the numbers waiting was not sustained (see Figure 4) and long waiting times persisted a decade after it was established. Internationally, waiting up to three months for non-urgent treatment is considered the norm but waits of over six or twelve months are very unusual in an international context. The longer a patient is waiting for treatment, the greater the deterioration in the condition and the more complex the intervention, often resulting in poorer outcomes and more costly medical care. If the programmatic success of the NTPF is to be judged on achieving its aim, which was that no one would wait more than three months for treatment, NTPF figures show this clearly has not been achieved.

Figure 4: Waiting times for adults and children for inpatient and day-case public hospital treatment



Applying a systems thinking approach to the NTPF is useful to explain why a specific initiative such as the NTPF was unsuccessful. According to the World Health Organization, 'systems thinking works to reveal the underlying characteristics and relationships of systems' (World Health Organization, 2010). The premise being that complex systems such as health systems that are constantly changing are also tightly connected and very sensitive to change elsewhere in the system. Systems thinking can help explain why 'seemingly obvious solutions sometimes worsen a problem', and that in order to address a specific problem – in this instance long waits for public patients – a whole range of interrelated components need to be addressed.

During the development of the health strategy, a range of policy solutions were proposed, including significantly increased capacity in the public hospital system and primary care, as well as the introduction of a common waiting list, whereby all patients in public hospitals would be treated according to medical need, thus eliminating the two-tier access.

The health strategy commitment to increase hospital bed capacity by 3,000 beds by 2011 was not acted upon. Figures show there was an increase of 1,257 more day beds in public hospitals in 2011 when compared with 2001; however, there were 1,490 fewer inpatient public hospital beds, an overall decline despite the promised increase (Mercille, 2018).

McConnell defines 'political success' as 'improving the electoral prospects of the government, and enhancing its reputation. It might be consistent with an overall government approach to policy, and allow government maintain control of the policy agenda' (McConnell, 2010).

While the NTPF can be seen to be a short-term political success – the government were re-elected in 2002 – in the long-term, long waits for public patients in public hospitals are still one of the main issues of concern of the electorate (House of the Oireachtas Committee on the Future of Healthcare, 2017). It can be argued that the existence of the NTPF allowed those in positions of responsibility (politicians, senior officials in the Department of Health, health service and hospital managers) to provide short-term responses while failing to tackle the health system causes of the long waits for public patients.

This proposal of a common waiting list for all public hospital care was rejected politically, with particularly strong opposition from the PDs in 2001. This rejection opened up the policy window for the introduction of the NTPF, which accentuated the perverse incentives of the two-tier system. In this respect, the NTPF may be considered a political policy failure.

Interestingly, the 2017 Oireachtas report on the future of healthcare takes a different approach, outlining a systems thinking approach to addressing the long waits, including many of the measures cited in the 2001 health strategy and additional measures such as significant increased capacity in primary care, diagnostics and public hospitals, as well as the removal of private practice from public hospitals (Houses of the Oireachtas Committee on the Future of Healthcare, 2017).

Conclusion

The NTPF policy process tells an interesting story in Irish health policy. The documents and interviews show that the NTPF emerged as an alternative when a much bigger health policy proposal – a common waiting list – was rejected during the national health strategy's development, and other key measures such as increased public hospital capacity were not delivered. From this rejection of a common waiting list, a policy window was opened and an alternative idea of the NTPF emerged 'out of the ashes'. The NTPF idea was worked up solely by the PDs, specifically by the political advisor of Mary Harney, the then Tánaiste.

The NTPF was set up as a short-term measure to eliminate the problem of public patients waiting more than three months by buying private care for long-waiting public patients. While it has been a success for anybody who receives treatment in a more timely manner, it clearly has not eliminated lists of public patients waiting over three

months. Using McConnell's typology of policy success and failure, while there have been some short-term policy, programmatic and political successes associated with the NTPF, the fact that waiting lists for public patients persist and have escalated seventeen years on from its establishment means it has been a policy failure.

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