sciendo

Administration, vol. 67, no. 2 (2019), pp. 95–112
doi: 10.2478/admin-2019-0015

Public policy failure in healthcare: The effect of salary reduction for new entrant consultants on recruitment in public hospitals

Fiona Kiernan
School of Economics & Geary Institute, University College Dublin, Ireland

Abstract

Policies fail or succeed for many reasons. These reasons include the decision-making process, which depends on the interplay of interests, as well as ideology and information. While bearing in mind that perception is often all-important in deciding if a policy is a success or failure, this paper examines the policy failure of the 2012 decision to reduce salaries for new entrant consultants in Irish public hospitals. This salary reduction resulted in difficulties recruiting and retaining hospital consultants in the public sector. Firstly, the timeline and context of the decision are explored, taking into account the financial crisis at the time. This leads on to an examination of why this decision was made. It appears likely that self-interest on the part of the Minister for Health was a factor, and that self-interest on the part of the medical unions prevented reasonable discourse. The ideology of austerity was a predominant theme of government budgets in 2012; however, this ideology was also influential in creating an environment that allowed blame for public sector pay to be focused predominantly at public hospital consultants. Finally, I find problems with the information used in decision-making for the policy. This is evident from the irrational beliefs held by policymakers on the likelihood of recruiting consultants with lower salaries.

Keywords: Policy failure, health, workforce, austerity

Introduction

Perception is all-important in examining public policy failures. How a policy is viewed depends to a large extent on the outcome of the decision, but also on who is examining the decision made, and indeed on the duration of time that has elapsed. Indeed, success or failure is likely to depend on more than whether the policy is 'good' or 'bad'. For instance, policies may fail because of exogenous shocks and unforeseen factors, rather than through poor design. Perhaps it is best, then, to start by deciding what constitutes a failure. In their examination of 'policy blunders', which is synonymous with varying degrees of failure, King & Crewe (2013) define policy failure as 'an episode in which a government adopts a specific course of action in order to achieve one or more objectives, and… either fails completely to achieve these objectives or does achieve some or all of them but at a totally disproportionate cost… to cause a significant amount of "collateral damage" in the form of unintended and undesired consequences'. A reasonable explanation is that the decision-making process matters. Therefore, assuming that the process was not affected by unforeseeable and unforeseen events, the success of the policy is likely to depend on this decision-making process. How decisions are made, and which positions are held, depends on the interplay of ideology, interests and information (see FitzGerald et al. in this issue). Using King & Crewe's definition it seems evident that the decision to decrease new entrant hospital consultant pay during the period of austerity following the financial crisis was a policy failure, based on the degree of 'collateral damage' that occurred in the form of recruitment difficulties (King & Crewe, 2013). This relationship between salary reduction and recruitment has been previously described by the Health Service Executive (HSE, 2016). What follows is a description of the timeline of the decision and its impact, with subsequent paragraphs exploring the potential reasons why this path was taken.

In examining the factors leading up to the decision to reduce salaries for new entrant consultants, it is important to start by recognising the political and economic environment at the time of this decision. The global financial crisis, which began in 2008, resulted in acute financial difficulties for the economy. The scale of debt experienced in Ireland was exceptional in the eurozone, with a decrease in overall consumption of the population as a whole by 8.8

per cent between 2008 and 2010 (Gerlach-Kristen, 2014). Successive governments had instituted and continued a programme of fiscal consolidation of 17 per cent of GDP in an attempt to reduce public spending and raise revenue. A focus on reducing public debt was an integral part of the assistance programme agreed with the European Commission, International Monetary Fund (IMF) and European Central Bank (ECB) in December 2010, with government budgets subject to scrutiny by the EU and the IMF. These institutions not only emphasised the need for austerity and a reduction in public debt, but also tied loans to these measures. The Financial Emergency Measures in the Public Interest (FEMPI) legislation was enacted to provide immediate reductions in public expenditure. As well as increases in taxation and social insurance at a population level, attention was particularly paid to the salaries of those in the public sector, with resultant cuts to salary and increases in social insurance (formally named a pension levy, but in reality consistent with an additional tax). In 2012 the government imposed a salary reduction for new entrants to the public sector (with the majority of public sector workers part of either the healthcare or education professions). The reduction in salary was larger for hospital consultants than for other public sector workers, predominantly due to higher base salaries. A substantial pay difference was seen between consultants appointed before and after 1 October 2012. Owing to the numerous consultant contracts in the HSE, it is difficult to determine the percentage reduction compared with the pre-2012 cadre of consultants, but it is estimated to have been around 30 per cent in 2012 (IMO, 2017).[1] Following the implementation of this reduced salary, it became difficult for public hospitals to recruit consultants, with vacant positions seen across all specialties.

While opinions may differ about the fairness, or appropriateness, of this decision, particularly given the scale of the recession in the country, the important point for the purpose of this work is that the decision to reduce salaries of consultants resulted in the unintended negative consequences of recruitment and retention difficulties in public hospitals. Therefore, the policy of new entrant consultant salary reductions is an example of a policy failure.

It is interesting to note the timeline of the decision, as it adds to an understanding of 'how' and 'why' this decision was made. This puts the policy into the context of a government aiming to reduce public

[1] This percentage difference between the consultant groups increased in 2018.

expenditure, but it also points out the additional conflicts between the Minster for Health, James Reilly, TD, and the medical unions (the Irish Hospital Consultants Association (IHCA) and the Irish Medical Organisation (IMO)). The timeline of the policy announcement is important because it leads into a later examination of the potential role that stakeholder self-interest played, in particular self-interest on the part of Minister Reilly and the pre-2012 consultant body. It has been recognised that self-interest is frequently involved in political decision-making (Jackson & Kingdon, 1992). I take account of the fact that the economic environment of the time favoured the ideology of austerity. That there were adjustments to public finances because of the financial crisis is without question (Heffernan et al., 2017). However, I am less interested in the pragmatic aspects of austerity and the reductions in public expenditure in sequential government budgets, but instead am interested in the idea that the environment and the culture of austerity allowed public sector workers, and in this case consultants, to be a target for blame (Blyth, 2013). This culture is clear from the language used by the media and politicians at the time. Finally, in the last section I examine the irrational belief that the HSE was, or would remain, a monopoly employer in the face of these changes. This is despite evidence presented to the Joint Committee on Health and Children in 2011 showing evidence of doctors' intentions to emigrate (Joint Committee on Health and Children, 2011).

Context of the decision

With the onset of the financial crisis, government budgets sought to decrease public expenditure by reducing pay and increasing redundancies for public sector workers. As part of the Croke Park Agreement of June 2010 a commitment was made by government not to impose additional cuts to public sector pay in order to avert industrial action. The government at the time was a coalition led by Fianna Fáil. In the 2011 election Fianna Fáil lost power, with a coalition then formed between Fine Gael and Labour. Although the Croke Park Agreement was not revoked by these parties, there was a clear emphasis placed on the need to reduce some public sector salaries in the programme for government agreed by the coalition. This is made clear in the statement agreed by the two parties that 'Under a new consultant's contract, hospital consultants' remuneration will be reduced' (Fine Gael, 2011).

Therefore, the government was constrained by the Croke Park Agreement, preventing it from reducing the salaries of those public sector workers under contract, yet also faced with a need and a commitment to reduce public expenditure. Their approach was to lower salaries for new entrants to the public sector in early 2012, an approach that included public sector workers in healthcare and education. Despite this decision, a new entrant salary reduction was not introduced for consultant clinicians at this point, presumably because consultant clinicians were pre-existing public sector workers, having previously worked at non-consultant grade in public hospitals. Instead, in spring 2012 the government discussed the introduction of a new 'grade' of consultant, who would be appointed alongside specialists, albeit on a lower salary and with a different job description. The introduction of this new 'grade' did not proceed.

At the same time the unions representing hospital consultants, the IMO and the IHCA, were involved in an industrial dispute with the Department of Health regarding a failure by government to adhere to the 2008 contract, which had renegotiated working times and salaries. Following failed attempts to reach an agreement regarding this 2008 contract, the Department of Health, the HSE, the IMO and the IHCA attended the Labour Relations Commission from 13 to 17 September 2012. The discussions at the Labour Relations Commission related only to historic rest days and rostering issues, and salary scales were not due to factor into any agreement. Notwithstanding this fact, a HSE document[2] forwarded by Ambrose McLoughlin, Secretary General, Department of Health, to Minister Reilly on 15 September included a section on consultants' remuneration, which stated:

> It is therefore intended to make future consultant appointments at a lower salary rate than applies at present. There will be no differentiation between future appointees and existing consultants in terms of title, status or scope of practice.

There are further interesting points to note here. In the first instance the document circulated on 15 September 2012 contains salary scales in the appendix. The suggested salaries for new entrants are certainly lower than those appointed before October 2012; however, they are substantially higher than the scale ultimately imposed. For instance,

[2] Document titled *Consultants – Implementing the Public Service Agreement,* obtained under freedom of information from Department of Health (25 September 2018).

the figures in the HSE document provide for a starting salary of €166,010 for a Type A contract, €156,258 for a Type B contract and €147,928 for a Type C.[3] This document was finalised at 3.30 pm on 15 September 2012, and emailed later that evening to Minister Reilly by McLoughlin. However, the pay scales announced on 17 September 2012 were €116,207 for Type A, €109,381 for Type B and €95,634 for Type C.

The second point to note is that while the document that was circulated by the HSE/Department of Health contained the appendix with salary scales, the final document issued by the Labour Relations Commission did not include this appendix. Indeed this agreed document states:

> In line with the Government Decision to implement a public service annual pay cap of €200,000, paragraph 1.15 of the PSA [Public Service Agreement] states that 'there will be no further reductions in the pay rates of serving public servants for the lifetime of this agreement'. The parties recognise… that the protections… pertain to the pay rates of medical Consultants as of 1 January 2010. Revised remuneration rates for application to new appointees... which currently attract remuneration rates in excess of the public service pay cap will be published. (HSE, 2012)

The negotiations at the Labour Relations Commission concluded at 8 a.m. on 17 September. Despite the fact that a reduction in salary for new entrant consultants was not part of these discussions, almost immediately after the negotiations concluded Minister Reilly announced a reduction in salaries for new entrant consultants on national media. Of note, Minister Reilly was due to face a motion of no confidence in the Dáil (tabled 3 September) the following day (18 September), although this eventually proceeded on 19 September. Following his announcement, new salary scales were applied from 1 October 2012, with those appointed to consultant positions from this date subject to the salary scale announced by the minister. There was a partial reversal of this reduction in 2015 following negotiations at the

[3] A consultant on a Type A contract can only treat public patients and can only work in public hospitals, whereas those on a Type B contract can only work on public patients but can treat private patients in a public hospital (to a maximum of 20 per cent of their patients). Consultants on a Type C contract can provide care in private hospitals once their public contract has been fulfilled.

Labour Relations Commission, which resulted in an incremental salary scale of nine points being applied (IMO, 2017). However, discrepancies were again emphasised by the planned reversal of the FEMPI Act and the High Court ruling of June 2018 that the HSE was in breach of contract in its failure to adhere to pay and conditions for those in receipt of the 2008 contract.

Evidence of failure

The impact of this policy decision to reduce the salaries of new entrant consultants is broadly considered to be the primary reason for difficulties in recruitment and retention of specialists in Ireland. Objective evidence demonstrates that positions have been left unfilled, with HSE data reporting 349 vacant consultant posts in 2018 (Sinn Féin, 2018). In 2017 the IHCA reported that 15 per cent of consultant posts in public hospitals were unfilled in 2016 (excluding psychiatry, which had an additional sixty-five vacant posts) (Public Service Pay Commission, 2017). While many consultants are choosing to either emigrate or remain abroad after fellowship training, others have chosen private practice in Ireland instead of public hospital employment.

The clearest indication that salary differences between pre- and post-2012 appointees are likely to be responsible for difficulties in recruitment and retention comes from the report of the Public Service Pay Commission on Recruitment and Retention, released in September 2018 (Public Service Pay Commission, 2018). This independent report sought to identify if there were difficulties in recruiting healthcare professionals, and the potential causal factors, by examining the recruitment of nurses, midwives, non-consultant hospital doctors and consultant doctors, using both recent data and pre-recession data to account for general trends. Although there were few quantitative data available, the report is interesting, not just because of its findings for consultants but because it did not have similar results for other healthcare professionals. This difference suggests that the findings may be free from bias. For instance, the report differentiates between the effects of the salary reduction on various professionals within healthcare, and found that this pay differential could not be directly linked to recruitment issues in other subgroups. Therefore, while nurses and midwives were 'aggrieved' at the levels of pay disparity, this had not resulted in difficulties in recruiting or retaining staff (Public Service Pay Commission, 2018). In

contrast, however, it was found that the 'differential in pay between the pre-existing cadre of consultants and new entrants is significantly greater than for other categories of public servant', and that the 'Commission would interpret these data… as indicative of a significant ongoing problem in regard to recruitment of consultants'.

Alternative hypothesis

Correlation is not causation, and factors other than salary have been recognised as being important in doctors' decisions to migrate. For instance, dissatisfaction with work–life balance, the quality of training provided and the stress of postgraduate training have been shown to be important factors, along with low salaries (Clarke et al., 2017). Indeed, when theories of labour market migration have been examined for healthcare professionals (as opposed to other professions) in an international context, non-wage factors were deemed to be particularly important in the decision to emigrate (Vujicic, 2004). In addition to this, while neoclassical theories of the labour market have focused on wage differentials as a primary motivation for migration, research examining the same theories at a micro level suggests that net income is a more important driver than gross income or wage (Dustmann, 2003). This means that changes to taxation, including the additional taxation/social insurance charges for public sector workers that began during the financial crisis, could also play a role in decisions to emigrate or remain abroad. In fact, this was referred to in the Joint Committee on Future of Mental Health Care debate of 26 September 2018 when Michael Kelly of the Public Service Pay Commission said 'agency staff are not required to pay the pension contribution' (Joint Committee on Future of Mental Health Care, 2018), and this may have contributed to the attraction of agency and locum work instead of permanent public sector roles.

However, despite the fact that potential alternative reasons exist for the difficulty in recruiting and retaining staff, the pay differential remains the most plausible theory. It is important to question studies reporting that work–life balance is a driver of emigration involving those in postgraduate training (Clarke et al., 2017). In reality, issues of work–life balance – in particular, issues related to workplace understaffing and conditions – are not a new phenomenon in Irish healthcare. Furthermore, while there is a culture of emigration for additional training, prior to 2012 the culture of migration included a return to Ireland post fellowship training for a consultant appointment.

The story of the decision

Having established that this was a policy failure, it is then important to examine the reasons why this decision was made. In particular, questions arise as to why Minister Reilly announced the new entrant salary reduction on 17 September 2012 when this issue did not form part of the negotiations in the Labour Relations Commission. Further questions relate to why the salary scales announced were lower than those described in the appendix of the document sent to him on 15 September. Self-interest may explain some of this decision-making. Self-interest is relevant because of the speed and timing of the decision. Self-interest may also explain why the medical unions were not vocal in preventing the introduction of this salary reduction.

Self-interest may have been the reason why Minister Reilly deviated from the negotiated agreement in his announcement on 17 September 2012. Self-interest is not only a rational reason for this behavior; it is also a reasonable one. It is reasonable to assume that even if politicians act frequently in the public interest, they may occasionally act for their own benefit. We know that decision-making by politicians is driven in part by ideology, but also by a desire for re-election, party loyalty, career advancement and pursuit of power (Jackson & Kingdon, 1992). There are two important deviations to note when considering if self-interest was a motivating factor in his decision-making. One is the difference between the announced scales and the proposed scales included in the 15 September document. The other is the fact that new entrant salary reduction was not included in the final negotiated document from the Labour Relations Commission.

The timing of the announcement is also important. Minister Reilly was facing a motion of no confidence from the opposition on 18 September (and subsequently debated on 19 September). Days prior to that, on 28 August, the European Commission released a draft report from the European Commission, the ECB and the IMF examining the Irish economy. This report was critical of the public finances in general; however, there was particular criticism directed at management in the health service. They specifically mention a need for 'permanent' rather than temporary solutions, as well as an emphasis on new working models (European Commission, 2012). The terminology used to describe management of the healthcare sector would have added to political pressure on Minister Reilly, as they reported that:

> the inability to deliver efficiency savings in the decentralised healthcare system points to weaknesses in budget management and accountability. Some of the measures accounting for savings… may need to be replaced with permanent structural measures... The authorities have indicated their intention to consider… maximizing the flexibility under the Croke Park agreement through new working models.

Days later the *Irish Examiner* reported a Labour source on 3 September as saying that Minister Reilly was 'the weakest link in government' and that it would be difficult for him to remain as minister because 'he hasn't touched consultants' (O'Brien, 2012). Subsequently, on 4 September, Ray Butler, Fine Gael TD for Meath West, was quoted on RTÉ as saying that 'Mr Reilly should look at cutting the pay of hospital consultants' ('Fianna Fáil', 2012). The importance of negotiations with consultants for Minister Reilly is further highlighted in the Dáil debates of 19 September, when the consultant contract was used as a defence by the Fine Gael/Labour coalition during the debate on this motion of no confidence (Dáil Éireann, 2012). The words of then Tánaiste Eamon Gilmore, TD, are notable:

> This Government and its Minister for Health has not shied away from tackling vested interest in the health service... and only last week striking a deal to get more flexibility from hospital consultants and reducing pay for new recruits.

Added to this was the defence from the Minster for Finance, Michael Noonan, TD, that:

> The Minister's most notable achievement is the new arrangements agreed in negotiations last week with hospital consultants.

Minister Reilly's decision to introduce lower salaries appears to have been helpful in defeating this motion of no confidence.

There is also evidence of potential self-interest on the part of those consultants appointed to public hospitals before October 2012. Rational choice theory tells us that the self-interested employee would seek to improve or maintain their personal welfare instead of improving collective welfare. This has been shown regardless of

whether or not the country exhibits a predominantly socialist or capitalist belief system, since individual self-interest related to changes in disposable income has been seen with left-leaning governments (Elinder et al., 2015; Healy et al., 2017) as well as those with more right-wing policies (Erikson, 1989). It is plausible that a potential reduction in salaries would induce self-interested employees to protect their own welfare. The role of the union is to control these short-run rewards by focusing on group welfare. However, this does not appear to have been a priority of the medical unions in 2012, with a notable lack of evidence of communication between the unions and the Department of Health following the reduction in salary for new entrants. It would seem that the focus remained on the welfare of those appointed before 1 October 2012, rather than the welfare of potential future consultants. There is little evidence that the unions were vocal in their disagreement with the new entrant salary reduction. Indeed, a letter sent on 28 September 2012 from the Director of Industrial Relations in the IMO to the Department of Human Resources in the HSE questioned four technical points regarding the implementation of the reduction, and not the principle of the contract as a whole. This questioning of the technical points almost implies that the union was not preparing for a rejection of the new salary scales.

A subsequent letter sent on 26 October 2012 from the IMO to the HSE discussed concerns regarding the Labour Relations Commission decision, and potential pay cuts to consultants appointed pre 1 October 2012, but did not mention the announced pay reductions for new entrant consultants. Following this, it appears that the next communication from the IMO was on 18 December 2012. Since identical copies of these letters have been received separately from both the Department of Health and the IMO, it would seem that there was no other communication or negotiation between the unions regarding this matter until at least May 2013 prior to Haddington Road discussions (or at least the IMO has not provided any further communication on this matter). A review of communications from the IHCA has similar findings. In a statement from the IHCA to its members on 6 October 2012, which was also publicly released, it was clear that the IHCA was not eager to engage in discussions about contracts: ‘Consultants will individually decide if they can accept proposed changes... The IHCA will not be entering into a collective agreement on the proposals.’

The dearth of formal communication from the unions in the weeks to months after the announcement of reduced salaries could realistically have been perceived by the Department of Health as suggestive of apathy on the part of the unions and their membership regarding this issue. The decision was therefore relatively uncontested, meaning that the reductions were introduced before adequate examination of the potential negative impact took place.

Ideology

However, the economic environment at the time of the financial crisis may have been a factor in this decision-making, as a focus on ideology rather than economic analysis has been shown to be related to policy failures (Grossman, 2013). The ideology of austerity, a voluntary deflation in which an economy reduces wages and public spending in order to restore competitiveness and inspire confidence, was predominant in Ireland in 2012. Successive government budgets during the financial crisis had emphasised a need for reductions in public expenditure, and indeed loans from the IMF, the EU and the European Financial Stability Facility fund were tied to these measures.

Austerity is a potentially harmful ideology for two reasons: firstly because it reduces consumption and demand, but secondly because it apportions blame, usually to those who were not responsible for the financial crisis. It is more than just a reduction of public spending, but is also the idea that someone must take 'responsibility', and that reductions are a necessary payback for excessive public spending (Blyth, 2013). The language used by proponents of austerity indicates an attempt to vilify and apportion blame – notably the term 'PIIGS' to describe affected European countries during the Great Recession (Blyth, 2013).

When this is examined in the Irish context, parallels can be seen in both the decisions taken and the language used to assign responsibility and blame. It is clear that the focus of both the Fianna Fáil/Green Party and Fine Gael/Labour governments was on reducing public expenditure. Austerity measures between 2012 and 2013 resulted in the removal of €28 billion from the economy due to taxation increases and public expenditure decreases ('The eighth austerity budget', 2013).

Furthermore, the maintenance of a low corporate tax rate and tax reductions for the financial sector during this period is also consistent

with a pro-austerity policy (Hardiman & Regan, 2013). Alongside the reduction in public expenditure, there was also evidence of austerity policies in the language that assigned blame and responsibility to the public sector. This was presumably necessary in order to ensure that the public would accept these reductions. That it worked is also clear. While the 'prime cause' for the financial crisis was related to both the banking industry and exposure to a global financial crisis (O'Sullivan & Kennedy, 2010), the message that the public sector was to blame for the financial crisis appears to have become fact in the eyes of the media. This can be seen from an editorial in *The Irish Times* in 2018: 'It seems as if almost everybody has forgotten that the unsustainable rise in public service pay in the first decade of the 21st century was the prime cause of the crisis in the public finances that led to austerity' ('Public sector pay', 2018). The culture of austerity (as opposed to the methods) can also be seen in the phrases used to describe the skill set of consultants. Bhattacharyya (2015) tells us that austerity aims to convince us that we are 'expendable, replaceable, and always in need of retraining and upgrading'. This is mirrored in the phrases used to describe those consultants who were likely to be appointed after 2012 – 'baby' consultants, 'less qualified', 'provide an inferior service', and incremental pay would be given based on 'experience' (Lynch, 2012). The message that consultant pay was the biggest driver of health sector financial difficulties also played out in the media – 'consultant pay is to healthcare what Anglo Irish is to the banking sector' (O'Shea, 2011). Linking consultants to Anglo Irish Bank meant that blame and responsibility for excessive public spending would lie primarily with public hospital consultants, making it easier for salary reductions to be instituted.

Irrationality

There appeared to be an irrational belief that despite reductions in salary, the HSE and public hospitals were, and would remain, a monopoly employer. This belief was irrational and did not include available evidence on doctor migration that occurred prior to the recession. For instance, there was an overemphasis on reports from the OECD comparing specialist pay across OECD countries. While OECD findings were used by politicians to report that Irish consultants were in receipt of the second-highest salaries in the EU, the nuances of these results were not considered. While mean consultant salary was included in Ireland, mean salaries in other

European countries included salaries of trainees and general practitioners, as well as specialists. Perhaps these nuances were missed by those involved in health workforce planning; although, if correct, the exclusion of these data would suggest a degree of confirmation bias. That politicians and policymakers were irrational in believing that Irish positions were attractive is also clear. In January 2012 the Minister of State for Health, Róisín Shortall, TD, stated her intention to bring 'payment for hospital doctors into line with the rest of Europe, so that Ireland can… employ the talented medical graduates who emigrate to countries where they achieve professional satisfaction for much lower remuneration' (Shortall, 2012). This assumption that EU doctors would fill Irish positions was not based on prior evidence, nor does it appear to have been examined in the months before the salary reduction. While Irish trainees have historically left the country for fellowship training and returned to take up consultant positions, a similar pattern was not seen for EU doctors, even in the years prior to the financial crisis and ensuing reductions in salary.

In the first instance there has always been substantially different work practices between Ireland and the remainder of the EU (excluding the UK). The shorter training schemes and more specialised care in mainland Europe meant that European training would not necessarily fit with the work requirements in Ireland, with the result that migration to Ireland would not be an attractive choice. Indeed, the Department of Health should have been aware of available data from 2007 on doctor migration in Europe. From these data it can be seen that while the UK consistently attracted most doctors, Ireland had the highest number of emigrants at 47.5 per cent, and little inward migration. The second-highest rate of doctor emigration was seen in Malta, at 23.1 per cent (Garcia-Perez et al., 2007). This evidence tells us that Ireland has negative net migration for health professionals, and therefore it is logical to consider that emigration would increase during times of increased financial strain. Furthermore, doctors from anglophone countries find it easier to migrate. Therefore, when examining likelihood of migration, it would have been more appropriate for the Department of Health to consider the healthcare labour markets of anglophone countries rather than an EU labour market. The relative comparators were in fact the UK, Australia, Canada and the US – anglophone countries with a history of net immigration in healthcare, and a strong Irish expatriate community. Salary comparisons using appropriately selected data would have shown that Australia, the US and Canada have higher

salaries for specialists, and that the UK has potentially higher salaries than those recorded by the OECD (when merit awards are taken into account). Not only was evidence on the opportunities for emigration for Irish doctors available to the Department of Health, the evidence on the attractiveness of these positions was also clear, along with data examining the intention to emigrate. A survey conducted by the IMO in 2011, and presented to the Oireachtas Joint Committee on Health and Children, discussed these intentions to emigrate (Joint Committee on Health and Children, 2011). A letter sent to the Department of Health by the IMO in the months after the September 2012 decision mentioned that many Irish doctors would emigrate rather than take up employment in the public sector – '25 per cent of Irish trained doctors will leave the country' (Tweed, 2012). The idea that European doctors would be available to fill those positions was not borne out by evidence as there was no history of migration to Ireland from other European countries, and no evidence that the Department of Health had surveyed European doctors' intentions and opportunities to migrate.

Conclusion

Notwithstanding the fact that perception is paramount in deciding if a policy is a success or failure, the decision to introduce a significant salary reduction for new entrant consultants in October 2012 can certainly be considered a failure if we consider resultant 'unintended and undesired consequences' (King & Crewe, 2013) as indicative of a policy failure. While there may be many reasons why this decision was made, three possible reasons were examined here. The first was self-interest on the part of two major actors – Minister for Health James Reilly and the unions representing consultants appointed prior to 1 October 2012. Certainly Minister Reilly's announcement on 17 September is likely to have been related to political pressures, both from the European Commission and within the Dáil. His deviation from the planned salary scales documented on 15 September (which were not part of the negotiated document on 17 September), in the face of a motion of no confidence, points to self-interest as being a factor. The evidence for self-interest on the part of those appointed prior to 1 October 2012 is weaker because it is based on the absence, rather than presence, of documents and communication. In addition, the interests of consultants are demonstrated through the actions of

the unions, rather than directly. The second reason for the decision is the ideology of austerity. The government was constrained by the terms of the financial bailout, and was certainly required to reduce public expenditure. This included, albeit incorrectly, a focus on reducing public salaries. However, austerity is more than just the act of reducing public expenditure. Austerity also created an environment that allowed blame for excessive public sector pay to be focused at public hospital consultants. The final reason for the decision was due to irrational beliefs about the strength of the public healthcare system as an employer. There was sufficient prior evidence available to policymakers to suggest that this would result in emigration of doctors to anglophone countries, and no evidence to suggest that inward migration would occur.

The result of these factors was a decision influenced by bias, and potentially exacerbated by emotional undercurrents related to security on the part of the main actors. The implication of this policy failure must certainly be that labour market decisions, likely to have significant long-term effects, should require extensive economic analysis prior to their institution.

References

Bhattacharyya, G. (2015). *Crisis, austerity and everyday life: Living in a time of diminishing expectations*. London: Palgrave Macmillan.

Blyth, M. (2013). *Austerity: The history of a dangerous idea.* Oxford: Oxford University Press.

Clarke, N., Crowe, S., Humphries, N., Conroy, R., O'Hare, S., Kavanagh, P., & Brugha, R. (2017). Factors influencing trainee doctor emigration in a high income country: A mixed methods study. *Human Resources for Health, 15*, 66.

Dáil Éireann. (2012). Confidence in the Minister for Health: Motion (resumed) [private members]. *Dáil Debates*.

Dustmann, C. (2003). Return migration, wage differentials, and the optimal migration duration. *European Economic Review, 47* (2), 353–69.

Elinder, M., Jordahl, H., & Poutvaara, P. (2015). Promises, policies and pocketbook voting. *European Economic Review 75* (C), 177–94.

Erikson, R. S. (1989). Economic conditions and the presidential vote. *The American Political Science Review, 83* (2), 567–73.

European Commission. (2012). *Economic adjustment programme for Ireland summer 2012 review.* Retrieved from http://ec.europa.eu/economy_finance/publications/occasional_paper/2012/pdf/ocp115_en.pdf [8 November 2018].

Fianna Fáil and Sinn Féin to table no-confidence motion in Health Minister James Reilly. (2012, September 4). Retrieved from https://www.rte.ie/news/2012/0903/336034-health-cuts/ [15 April 2019].

Fine Gael. (2011). *Programme for government.* Retrieved from https://www.socialjustice.ie/sites/default/files/attach/policy-issue-article/3292/2011-03-06-programmeforgovernment2011-2016.pdf [15 April 2019].

Garcia-Perez, M. A., Amaya, C., & Otero, A. (2007). Physicians' migration in Europe: An overview of the current situation. *BMC Health Services Research 7*, 201.

Gerlach-Kristen, P. (2014). Testing the permanent income hypothesis for Irish households, 1994–2005. *The Economic and Social Review, 45* (4), 511–35.

Grossman, R. S. (2013). *Wrong: Nine economic policy disasters and what we can learn from them.* New York: Oxford University Press.

Hardiman, N., & Regan, A. (2013). The politics of austerity in Ireland. *Intereconomics, 48* (1), 4–32.

Healy, A. J., Persson, M., & Snowberg, E. (2017). Digging into the pocketbook: Evidence on economic voting from income registry data matched to a voter survey. *American Political Science Review, 111* (4), 771–85.

Heffernan, E., McHale, J., & Moore-Cherry, N. (2017*). Debating austerity in Ireland: Crisis, experience and recovery.* Dublin: Royal Irish Academy.

HSE. (2012). *Consultants – Implementing the Public Service Agreement.* Retrieved from https://www.hse.ie/eng/staff/resources/terms-conditions-of-employment/ccontract/psa2012.pdf [15 April 2019].

HSE. (2016). *Towards successful consultant recruitment, appointment and retention.* Retrieved from https://www.hse.ie/eng/staff/resources/hr-publications/consultantrecruitment-dec16.pdf [10 January 2019].

IMO. (2017). *IMO submission to the Public Service Pay Commission.* Retrieved from https://www.imo.ie/news-media/news-press-releases/2017/imo-submissions-tot-the-p/Published-Submission-Consultants.pdf [4 January 2019].

Jackson, J. E., & Kingdon, J.W. (1992). Ideology, interest group scores and legislative votes. *American Journal of Political Science, 36* (3), 805–23.

Joint Committee on Future of Mental Health Care. (2018, September 26). *Health sector pay report: Public Service Pay Commission.* Retrieved from https://www.oireachtas.ie/en/debates/debate/joint_committee_on_future_of_mental_health_care/2018-09-26/2/ [4 January 2019].

Joint Committee on Health and Children. (2011, October 20). *Non-consultant hospital doctors: Discussion (resumed).* Retrieved from https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health_and_children/2011-10-20/3/ [22 April 2019].

King, A., & Crewe, I. (2013). *The blunders of our governments.* London: Oneworld.

Lynch, P. (2012). *Profession's unease at the new consultant 'down' grade*. Retrieved from https://www.imt.ie/features-opinion/professions-unease-at-the-new-consultant-down-grade-01-09-2012/ [15 April 2019].

O'Brien, P. (2012). *Labour: Reilly is weakest link in cabinet.* Retrieved from https://www.irishexaminer.com/ireland/labour-reilly-is-weakest-link-in-cabinet-206278.html [15 April 2019].

O'Shea, B. (2011). *GP slams 'immoral' consultant pay.* Retrieved from http://www.irishhealth.com/article.html?id=18768 [15 April 2019].

O'Sullivan, K. P. V., & Kennedy, T. (2010). What caused the Irish banking crisis? *Journal of Financial Regulation and Compliance, 18* (3), 224–42.

Public sector pay: A defining test for Paschal Donohoe. (2018, April 25). *The Irish Times.*

Public Service Pay Commission. (2017). *Re: requested supplementary information and reply on public service pension matters.* Retrieved from https://paycommission.gov.ie/wp-content/uploads/IHCA-supplemental-submission.pdf [8 November 2018].

Public Service Pay Commission. (2018). *Report of the Public Service Pay Commission: Recruitment and retention module 1.* Retrieved from https://paycommission.gov.ie/wp-content/uploads/pspc-report-2018-body_web.pdf [10 January 2019].

Shortall, R. (2012). *Moves afoot for reform of chaotic healthcare model.* Retrieved from https://www.irishtimes.com/opinion/moves-afoot-for-reform-of-chaotic-healthcare-model-1.439118 [8 November 2018].

Sinn Féin. (2018). *Unmatched posts.* Retrieved from http://www.sinnfein.ie/files/2018/Consultant_Vacant_Post_Locations_submitted_v1_+.pdf [15 April 2019].

The eighth austerity budget. (2013, October 19). Retrieved from https://www.economist.com/europe/2013/10/19/the-eighth-austerity-budget [15 April 2019].

Tweed, S. (2012). *New salary – Consultants* [Letter]. Retrieved from https://www.imo.ie/i-am-a/consultant/live-issues/proposed-reduction-in-sal/Ltr-to-BOB-re-Consultant-salary-reduction-181212.pdf [15 April 2019].

Vujicic, M. (2004). The role of wages in the migration of health care professionals from developing countries. *Human Resources for Health, 2*, 3.