"How can it be possible that, despite such unbelievable wealth, we have a health service that is now worse than it was in the 1980s when the country was in the depths of recession and threatened by bankruptcy?"

"Out of nearly 13,000 hospital beds only 8,000 are public beds. 2,500 beds are in private hospitals and almost 2,500 are private beds in public hospitals."

"Drug companies are now the most profitable of all companies in the world! Even banks and oil companies are less profitable."

WHY IS THE IRISH HEALTH SERVICE IN CRISIS?

By Dr. Peadar O Grady

A *Socialist Worker* pamphlet

Contents

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Dedication:
For Molly and Jessica.

Preface

After more than a decade of the Celtic Tiger economy, an economy characterised by spectacular profit rates, we have a health service which plummets daily to new depths of depravity.

The situation in the Accident & Emergency Departments has reached such calamitous proportions that patient's relatives, in their distress, frustration and anger, spontaneously set up 'Patients Together' and came on to the streets of Dublin to try and get something done to alleviate the horror in our A&E Departments.

And the problem is not confined to just the Dublin hospitals, or to particular times of the year. It is now affecting every A&E Dept in the country all the year round, causing patients and their relatives to take to the streets in protest, from Letterkenny to Wexford and from Naas to Galway.

As nurses, under the slogan 'Enough is Enough' we are threatening action against what are not only intolerable conditions for our patients, but also for ourselves as workers. On top of this, we too are potential patients. Our friends and families also have to endure this barbarity when we are at our most vulnerable and require health care.

But what is wrong with the health service in Ireland, a country which, according to the latest economic reports, is now the 4th richest country on the planet?

How can it be possible that, despite such unbelievable wealth, we have a health service that is now worse than it was in the 1980s when the country was in the depths of recession and threatened by bankruptcy?

In answer to these questions and to a population desperate for solutions, the Government has pushed the 'bottomless pit theory'. Creaking with bureaucratic chains and choked by trade union powers, the health service, the theory goes, is a bottomless pit of wasted billions. Essentially, it insists that a state-run public health service is inherently inefficient. What is required, it argues, is the tying down of the trade unions even further by deals like 'Sustaining Progress' and the tendering out of as much of the health services as is possible to the Private Sector.

This pamphlet cuts straight across this argument. Far from 'the bottomless pit', Peadar O'Grady demonstrates that the Irish Health Service was stripped of its resources from the mid 1980s into the 1990s and continued, for the greater period of the Celtic Tiger, to receive well below average EU funding as a proportion of GDP.

He further argues that there is a global plan for health care. But it is a plan that is not concerned with the delivery of health care to those who need it. It is concerned only with the profits that can be creamed out of the provision of health care to those who can afford to pay for it.

Since the 1980s and the emergence of neo-liberalism, pioneered by Margaret Thatcher in the UK and Ronald Reagan in the US, health care has become a business making billions for financial speculators and unaccountable shareholders.

We are at a turning point in Ireland. These vested interests are gathering:

Larry Goodman, Dermot Desmond and the AIB bank, all famous for their involvement in the recent corruption scandals, are now looking to health care as a business opportunity.

Nobody should be fool enough to believe that they are investing their millions for the good of our health.

Both as patients and workers we face a stark choice -

either we fight for a health service delivered on the basis of need by a work force properly paid for the work we do

or

we have imposed on us a US model of health service delivered only to those who can pay and returning vast profits to the vested interests

This pamphlet makes the case for a real fight to end the crisis and to stop the drive towards privatisation. It is an important contribution to the debate about defending health care as a public service that needs to be had, both in our unions and society as a whole.

Jo Tully

Irish Nurses Organisation (INO) Executive
Personal capacity

INTRODUCTION

"No society can legitimately call itself civilised if a sick person is denied medical aid because of a lack of means."

- Aneurin Bevan, founder of the NHS, quoted in Unhealthy State by Maev-Ann Wren.

"Inequality in Ireland is higher than in any other western country apart from the US."

- Irish Times 16/7/04

We live in one of the wealthiest countries in the world and have some of the best-trained and most dedicated health workers. Despite this many people live in fear of ill health and we are often overwhelmed by the tasks of caring for ourselves and our network of friends and family.

In the boom years of the Celtic Tiger, average income rose, unemployment fell and the population rose by 10 percent. There was a widespread expectation of major improvements in health and quality of life. The reality has been very different. For many, low pay, rising prices, indirect taxes, long working hours, long commuting times and increased work pressures have resulted in increased levels of personal stress and a poor quality of life.

The incidence of depression and the use of antidepressants is increasing, and the number of teenagers committing suicide has tripled in this period. Alcohol consumption, now amounting to €6 billion a year in sales, increased by more than a third in the nineties - by far the highest increase in the EU. Obesity rates have tripled and adult-onset diabetes is now being seen in children.

The richest 10 percent in Ireland are 9.7 times wealthier than the poorest 10 percent. In his book: The Health of Nations, Why Inequality is Harmful to your Health, Ichiro Kawachi states: "The degree of income inequality in society explains about three quarters of the variation in life expectancy across countries whereas by itself, the absolute size of the economic pie (measured by per capita GNP) accounts for less than 10%." In other words, how we share the wealth in so reland is a classic example of how inequality impacts on health. We have the lowest life expectancy in the EU and some of the worst death rates for heart disease and cancer.

Levels of relative poverty tripled in Ireland during the 1990s and grew at even greater rates among the elderly, the disabled and among children. The Chief Medical Officer, Dr Jim Kiely stated in his annual report: The Health of our Children, 2002, that 300,000 children under 14 - one in four - were brought up in a home where the income was less than €175 a week, and that almost one in five were experiencing chronic poverty. He admitted this was higher than other EU countries and that the social conditions children experienced were key influences on their standard of health.

In every country health depends on two key factors, the level of wealth inequality (the gap between rich and poor) and the level of inequality in access to health

services. Due to government policies, Ireland is on course to mimic the social inequalities and unequal health systems of the USA. It is therefore no surprise that we are starting to resemble the US in our poor health outcomes and the emergence of other social problems. Not surprisingly, the Government data on levels of health are grossly inadequate by international standards so the full impact on health of the so-called boom years is not known.

The United States has the most expensive, and one of the most unequal, health systems in the world. It spends 14% of its national income on health but one seventh of that is taken out in profits by the healthcare industry. Americans pay more for drugs than anywhere else in the world. In 2000, 16% of the population had no health insurance, and therefore no access to healthcare outside of hospital Accident and Emergency departments. That percentage means that 43 million people do not have guaranteed healthcare. This figure includes 10 million children.

The funding debate

Irish Government sources frequently hint that spending on health makes no difference. Some even speak of a black hole to explain how spending doubled without a similar improvement in services. They use this argument to undermine further requests for funding. However, the level of spending increases have been exaggerated because costs in the health service have increased at the same time.

Rising wages, drug prices and construction costs have accounted for much of the spending hike. The government also includes social spending costs, like home carers or residential care, in its health spending figures thus raising the total by a third. This is not the practice in the rest of Europe. The increased demands on the health service due to the rise in population are similarly ignored.

Poor management of the health services is also to blame, as increases in funding were poorly planned. Health board managers were too used to cutting back and are unable to plan more than a year in advance. We still have to recover from the effects of the previous cuts in beds and services by Fianna Fail and others.

One of the major problems in the Irish health service is the two-tier system of access to consultant care and the delegation of patient care to poorly supervised trainees. Our best trained staff are gaining an incentive (private fees) to attend to the patients who are, in general, less ill (non-urgent, less complicated cases). Consultants with public contracts predominantly staff the private hospitals. The poor funding of primary care - local health clinics, nursing homes, home care, rehabilitation centres, hospices etc. - leads to hospital resources being further over-stretched.

It is clear that more funding is needed if we are to catch up with other countries' superior services but the inefficient and unfair allocation of resources must also end. The vested interests of drug companies, doctors in private practice and for-profit health insurance and healthcare firms need to be confronted, but there is no political will in this government to oppose profit-making in the health service. On the contrary, they plan to offer even more tax-breaks to encourage 'for-profit' private firms to become more involved in running and owning the health service.

Endless Reports - no action

Former Fianna Fail Minister Micheal Martin spent €30 million on 115 reports promising reform. In Ireland talk of "reform" for the health service has been on the agenda for many years. There was a short-lived rise in expectations following the publication of some of these reports. The Health Strategy (2001) promised 3,000 beds but didn't deliver.

The Hanly Report (2002) threatened to close down small local hospitals and proposed to expand the bigger ones. It also promised to double consultant numbers and improve ambulance services. All we saw were attempts to close hospitals with none of the promised improvements. Hanly couldn't proceed because of fantastic protests against planned closures in Ennis and Nenagh. These protests were inspired by the resistance of a popular and organised campaign in Monaghan to stop the downgrading and closure of Monaghan Hospital.

The Primary Care Strategy (2001) promised a major increase in investment in primary care services, that the government has yet to fund. The service improvements now need to be fully funded. Any other changes must be negotiated locally to prevent any run down of local services, especially in the areas of A&E or Maternity.

The Prospectus Report (2002) recommended the abolition of the Health Boards and the formation of a Health Services Executive (HSE) to replace the Department of Health in the overall day to day running of the health service. This removal of, albeit corrupted, local democratic control and the imposition of a "top down centralised system of administration" was implemented in January 2005.

In a telling move the interim HSE had as its first Chief Executive Mr Kevin Kelly, former managing director of AIB from 1996 to 2001. The chairperson of the HSE is a member of the bosses' union IBEC. A director of a pharmaceutical company also sat on the interim body. This management structure is undemocratic and seems designed to impose privatisation on a demoralised workforce and a desperate public. The health service urgently requires the input and influence of democratically elected and accountable representatives from healthworkers and service users.

There is little prospect of the government delivering proper health reform. Fianna Fail Taoiseach Bertie Ahern appointed Progressive Democrat leader Mary Harney as Minister for Health in September 2004. This followed a Fianna Fail "think-in" in the seaside resort of Inchydoney designed, so we were told, to change Fianna Fail's image as a right-wing party, prompted by a heavy defeat in June's local elections.

In an interview in the Irish Times (January 4, 2005) Harney said: "There are people interested in providing hospital services using private capital. I want to encourage that." She went on to say she favoured greater involvement of the 'independent sector' (her name for 'for-profit' businesses) in running primary care services. It is clear that Harney will champion privatisation and Public Private Partnerships in all areas of healthcare.

Capitalism

Capitalism, the modern system of social production of goods and services for private profit, involves an endless competitive drive to accumulate. Huge multinational corporations now scour the globe looking for more and more areas of human need to exploit for profit. They constantly create markets for their products, and in turn, create products for their markets, whether or not we need or want them and, vitally, regardless of whether they are good for our health.

Energy sources pollute our environment, cause global warming and are being rapidly depleted - without a concerted search for safer and more sustainable alternatives. Housing, food and water are bought and sold as commodities for profit, driving up prices and driving down quality. Drugs are pushed as cures, ignoring prevention or less toxic alternatives. This approach to medicine creates further health problems-for example, resistant bacteria through lack of established safeguards.

Our health is increasingly outside of our control. Healthcare and education are now targets for privatisation. International agreements like the General Agreement on Trade in Services (GATS), the Nice Treaty, the draft EU Constitution and pro-market EU Service Directives actively promote privatisation.

This pamphlet aims to look at different aspects of health and the health service. In it I will argue that access to safe, good quality basic services (housing, food, water, heating, education, transport) is vital for health and that securing equal access to top quality healthcare for everyone is the only basis for a good health service. For this reason wealth inequality and inequality in access to services are a key obstacle to a healthy society.

Ireland stands at a crossroads. Change from above, from the likes of Mary Harney and business interests, will involve an increase in privatisation and public private partnerships in the primary care, hospitals, and health insurance sectors. This will give massive profits and world class healthcare to the rich while the rest of the population are forced to endure expensive, unreliable, crisis-ridden and inadequate healthcare.

This is the line of development encouraged by neo-liberals. They envisage a world where profits are kept up by keeping wages low and by cutting back public services and opening them up to for-profit investments. For big business this will change health services from an expense, through taxes, to a source of profits. Public health will lose through further wealth inequality (e.g. lower wages) and more inequality of access. The support of super-profits in the drug industry will continue.

Change from below could win a universal, comprehensive, world-class health service for every citizen, funded collectively, free at the point of use and democratically controlled by the people who use and provide services. This is why socialists must support and help to build a mass popular movement for changing health and healthcare in Ireland.

CHAPTER ONE
WHY IS THE HEALTH SERVICE IN CRISIS?

"I feel guilty I haven't spoken out. Our hospital is in crisis. We are constantly cancelling our day services. It is the public patients who are cancelled not the private patients. The Consultants take the decision, on medical grounds they say. But we see the notes, we can't see any difference."

- A nurses story at the Irish Nurses Organisation annual conference in 2001. (Quoted in Unhealthy State)

1. WHAT CRISIS?

Crisis is now a regular feature of the Irish health service. Hundreds of often critically ill patients lie on trolleys in A&E units for days, waiting long hours to be seen. Patients too sick to go home from hospital wait weeks and months for a nursing home. Either no bed is available or they can't afford private nursing care.

Many parents on low incomes are not eligible for a medical card and avoid bringing their children to their General Practitioner (GP) because they cannot afford the doctor's fees or drug costs. The number of low-income families entitled to free GP care fell by 200,000 between the general elections of 1997 and 2002. In 2005 Mary Harney introduced restrictions on new medical cards - removing the right to free medication.

At present 30,000 patients are waiting for in-patient hospital medical treatments. Almost half of the adults stay on the waiting list for over a year while two out of three children wait more than 6 months. Staff shortages result in cancelled operations. Hospitals are forced to restrict services and some patients have to travel to hospitals outside their area, even to the North of Ireland or Britain.

People have lost faith in the health service. Almost half of the population pays for Health Insurance even though they are entitled to free consultant care. The main reasons they give are fear, a long waiting list and the risk not being seen by a qualified specialist. Only a small section of society can afford the top insurance for the elite private hospitals like the Mater Private or the Blackrock Clinic. Uninsured patients wait twice as long for treatment as those with insurance. No insured patient waits longer than a year - usually only weeks or months. Those without insurance tend to be older, sicker, poorer or more disabled - yet they wait longer! Instead of resources being organised on the basis of need they are become increasingly organised on the basis of income.

2. WHY IS THE SYSTEM IN CRISIS? - CUTBACKS AND PRIVATE PRACTICE

Hospital beds

In a rich country like Ireland there is no excuse for such a poor health service. The main causes for our failing health system are cutbacks and underfunding. In the late 1980s Labour Party Health Minister Barry Desmond started cutting beds to save money. He closed eight public hospitals - equivalent to 704 inpatient beds - in 1986. He claimed he was following the 1968 Fitzgerald Report, a forerunner of the Hanly Report, but nobody was fooled. That same year the health insurance company BUPA opened two elite private hospitals - the Blackrock Clinic and the Mater Private. Worse was to come.

In 1987 Fianna Fail ran an election campaign with the slogan: 'Health cuts hurt the old, the sick and the handicapped'. They won by making promises regarding health, but - much as with their 2002 election campaign - they lied. Their cuts were savage. FF Minister Rory O' Hanlon slashed over 3,000 beds in two years. By 1993, successive FF ministers had cut over 6,000 beds. The heaviest hospital and ward closures were in Dublin hospitals. In 1991, Fianna Fail directed that 20% of public hospital beds be reserved for private patients. In 2002, Charlie McCreevy gave tax breaks to build private hospitals.

The public beds that were cut have never been put back. In 2004, Ireland had less than three-quarters the EU average number of beds according to population size. The Department of Health recommended the provision of 4,800 extra beds in 2001. In the 'Health Strategy' in November 2001, Minister Michéal Martin promised 3,000 extra beds over 10 years. Three years later he had delivered only 299. When Bertie Ahern was asked about A&E services in October 2004, he lied and claimed that the Government was on track to meet their target, having supplied 900 beds. The Department of Health subsequently claimed that they had provided 600 new beds. They later admitted they were including trolleys and couches in their count!

In 2004, €460 million worth of new facilities lay idle due to staff shortages. Explaining this, management admitted they were not used to expanding services and were only ever allowed plan one year in advance. In 2004, the government continued in their attempts to downgrade Monaghan's only hospital. Meanwhile a fourth hospital, the Galway Clinic, opened in Galway City - it was private of course.

Staff

In the boom years some progress was made in tackling the massive deficits in staffing levels, but the system still requires 4,000 GPs and consultants to come up to EU standards. Such an increase would reduce the service's reliance on poorly supervised junior doctors in training. At least 10,000 more nurses are needed, as are thousands of staff like physiotherapists, occupational therapists, speech and language therapists, psychologists, social workers, care workers, nutritionists, pharmacists, radiologists, lab technicians, ambulance personnel and other paramedics. Not only the above, but hospitals need more cleaning and catering staff, porters, clerical, maintenance and IT staff! Unlike most doctors they are not well paid. The pay increases for most of these workers under partnership agreements were miserable and many, like the nurses in 1999, took strike action to win further small pay rises.

Staffing in Mental Health needs to be increased, but cutbacks continue. The share of health spending given to mental health services was cut from 11% in1990 to 7% in 2002. Despite regular expressions of concern regarding suicide in teenagers and young adults, no school counselling services were introduced and drug-counselling services were left grossly under-funded. Programmes to move mentally disabled patients from overcrowded, unsuitable dormitories in psychiatric hospitals have ground to a halt through lack of funds. Where successful, these community-living programmes can mean huge improvements in quality of life for people. Where they are under-funded, discharged patients can end up homeless.

The court battles and street protests by parents of physically and learning disabled children have been inspiring. They are still denied the rights-based legislation needed to secure care and education. The hosting of the Special Olympics saw Ahern snubbed by disabled people and their families. He was very publicly booed at the opening ceremony. The chairperson of the organising committee was, ironically, rich businessman Denis O'Brien. He is estimated to have avoided paying €50 million in taxes in Ireland by claiming Portugal as his primary country of residence.

Tax and spending

The day-to-day spending on health in 2004 only approached the EU average. Large spending increases were needed to fund capital investments for long-overdue hospital renovations. Increases in construction costs, and the profits of construction companies, ate up much of this money in the booming economy. Equipment and drug costs also exceeded general levels of inflation due to massive profit margins.

By 2004, despite reaching average EU levels of spending, there was still no sign of the new GP clinics and local health teams promised in the 2002 election campaign. Increases in nursing home places were almost all in expensive private nursing homes where costs of up to €1000 a week are charged. Health Board applicants are means tested to get assistance worth a mere €190. The scandal surrounding the illegal deduction of pensions of those in nursing home care has shed new light on the lengths to which successive governments were prepared to go to avoid spending on some of the most vulnerable in our society. And the 3,000 new hospital beds? They have yet to appear.

The FF/PD Government has responded to criticisms by denial and lying. They regularly exaggerate health funding by including other social service costs like residential and home care. Health spending figures from other European countries do not include such spending. This is estimated to be about 20% of official Irish health spending figures. The government also ignores inflation and the catch-up costs of making up for the long period of serious underfunding in the past. The reality is that the two right-wing government parties are avoiding the issue of

investing in the health service in order to continue the low corporate tax regime for their big business backers.

At 34% of GNP, Ireland has the lowest tax take in the EU. The rich in Ireland pay very little in tax, leading to an underfunded public service. Corporation tax is set at 12.5%. This is the lowest rate of tax on profits in the EU. Property speculators can take in over a million euros and pay no tax at all, by availing of generous tax-breaks. Tax fraud continues on a massive scale in Ireland through offshore accounts, while the Irish multi-millionaires like 'Sir' Tony O' Reilly are able to claim to live outside Ireland for more than 183 days a year - so that they can be designated as 'tax exiles' and pay no tax.

These massive untapped sources of revenue could make a huge difference to the health service but the ideology of the FF/PD government is to leave them in the hands of the rich. This lost tax could reduce inequalities in wealth and health at one and the same time.

Two-tier access and private practice

After underfunding, the second cause of crisis in the health service is the unequal access to healthcare due to private practice. Many health professionals, like physiotherapists or speech and language therapists, offer services for fees. However, only doctors control access to the health service and to other therapists, acting as 'gatekeepers'. Senior Doctors - hospital consultants and GPs - earn the highest incomes by working in both public and private practice at the same time. It is worth looking at doctors in more detail to understand why access to care is so difficult.

There are almost 100,000 staff in the health service (including 40,000 nurses), most of whom have little say in the organisation of services. There are about 8,000 doctors working in Ireland. This is 4,000 less than the EU average. In hospitals there exists a strict hierarchy. At the top, less than 2,000 doctors are qualified specialists - surgeons, physicians, obstetricians, psychiatrists and so on. They work in hospitals and hospital clinics. These are the hospital consultants.

They receive an average state salary of €150,000. Most earn, on average, an additional €130,000 in private fees. Fees are usually €100 to €200 for a brief clinic appointment and thousands of euro for tests, scans and treatments. At a total of €280,000 per year, this is about ten times the average industrial wage and over twenty times what many low paid health workers receive per annum. Their incomes can vary greatly but some consultants earn over €1 million in private fees!

Around 4,000 of the total staff comprise of doctors who are training to specialise as consultants or GPs. They work in hospitals and clinics supervised by consultants. They are known as non-consultant hospital doctors (NCHDs) and include interns, house officers and registrars. While their numbers have doubled in the last ten years or so, the number of supervising consultants has increased by only half. This has meant that available supervision and practical training have been effectively reduced. NCHDs work dangerously long hours - often exceeding eighty hours a week. Most public patients receive the majority of their care from NCHDs. Most NCHDs change jobs every 6 months. This means that patients rarely see the same doctor twice in clinics. It also means doctors are only just becoming familiar with their department when they have to move.

NCHDs have no private practice and receive an average state salary of €80,000. Half of all NCHDs are immigrant doctors mainly from the EU, Asia and Africa. They are often already well trained as specialists. They are allowed to train for 7 more years but are usually refused promotion to specialist posts. Most NCHDs, immigrant and Irish alike, eventually have to leave Ireland to take up specialist jobs abroad, as there are so few consultant and GP posts in Ireland. Consultant and GP numbers need to be doubled to sort out these problems, but can only be done in a context where they are banned from doing private work while they work for the public service. There are thousands of NCHDs ready to take up these posts - if they were offered.

The hospital system is grossly distorted by the arrangements made for private practice. Out of nearly 13,000 hospital beds only 8,000 are public beds. 2,500 beds are in private hospitals and almost 2,500 are private beds in public hospitals. Most consultants staffing private hospitals are also on full contracts to public hospitals. Working in the public hospital, they see their private patients residing in the 20 % of public beds reserved for them - by order of the government in 1991. As private patients pay fees consultants have an incentive to see them and leave the public patients to the NCHDs.

70% of public beds are taken by emergency admissions through A&E so it is very difficult for public patients on waiting lists to be booked for admission for in-patient treatment. The result is that public patients wait at least twice as long for treatment in comparison to private patients. A staggering 40% of public patients wait more than a year, while no private patients wait this long. Public patients tend to be older and less well off than private patients, and so have more severe and complicated medical conditions.

The medical case for a single common waiting list for hospitals, based on medical need, is overwhelming. Faster access and more attention from the best-qualified staff for private patients results in slower access and less expert attention for the most seriously ill. This in turn means that public patients on the hospital waiting list often end up in A&E when their illness gets worse, often requiring longer and more complex treatments as a result. As well as being obviously unjust, this is also a major cause of inefficiency in the health service, as it causes unnecessary complications and suffering by delaying treatment. A system based on need rather than fees would remedy this. The Commission on Health Funding in 1989 recommended a common waiting list for all hospital patients, yet unsurprisingly this was ignored by the then Fianna Fail government.

The remaining 2,000 doctors work as GPs, also known as 'Family Doctors'. They work in local health clinics often attached to their own homes and are self-employed. Most receive a payment from the state for treating patients with a medical card. However, most of their income is from out-of-pocket fees of €40-€50 per visit. Most GPs earn over €100,000 a year. A tiny group of doctors specialise in public health and are grossly under-funded in carrying out the vital task of monitoring and planning for the health of the population as a whole.

The FF/PD strategy is to undermine the medical card system. In 1977, 38% of people had a medical card. By 2004 this had fallen to 26% - with 200,000 people

cut off the scheme since the FF/PD coalition came back to power in 1997. Before the 2002 election Fianna Fail promised to restore medical cards to these people. They lied once again. The denial of medical cards means that people who are just over the means-test limit for receipt of a medical card avoid going to the doctor when sick. As a result they often end up going either to their GP as an emergency or directly to A&E. Once again resources are eaten up by this inequality of access to the health service.

The philosophy of making people pay for healthcare also affects wider issues of GP practice. GPs are paid a fixed amount per patient on the medical card and take fees for private patients. This means they have an incentive to spend less time with public patients and call them for review less often. GPs who treat medical card patients SIMILARLY to their private (paying) customers make less money. As a result, poor areas have three times fewer GPs than higher income areas. Lack of investment in local health centres and teams results in less access to nursing, physiotherapy, home care and other preventive community-based approaches to health and healthcare. A private patient with lower back pain is likely to have scans, referral for an orthopaedic surgeon's opinion and weeks of physiotherapy. A similar public patient is likely to get painkillers, a sedative and advice to rest.

If Bertie Ahern and Mary Harney get their way there will be worse to come. As Minister for Health, Mary Harney is likely to deny that there is any lack of funding. She will argue against taxing the rich. She will use the crisis in the health service to argue for more private practice not less. She will argue in favour of the role of for-profit companies in providing insurance, hospital beds, staff and other services. The bias towards private patients will increase and a new slice will disappear from funding - money wasted in administering insurance and healthcare corporations and, of course, the money taken out in profits.

CHAPTER TWO:
HARNEY'S IDEOLOGY - HEALTH AND THE MARKET

"Tax incentives fuel a clear appetite for investor interest in public health, and Mary Harney is likely to support Privatisation and Partnerships… Harney's ideological bent is that [the VHI] will be sold." - Journalist Brian Carey, Sunday Tribune, 3/10/04

"I do not take my politics from any ideology; I am not an ideologue." - Mary Harney in the Dáil on why she was moving to Health - quoted in Village, 2/10/04.

An ideology is just a set of ideas that influence your behaviour. In that way everyone has an ideology. So why, in the weeks following her appointment as Minister for Health, would Mary Harney repeatedly deny she had one? It is because she is known to support a set of ideas - neo-liberalism - that she would not like to draw attention to just now.

Harney, as a principle, criticises 'tax and spend' policies. She recommends increasing the involvement of the private sector in public services. She supports privatising state agencies like the Voluntary Health Insurance (VHI), and advocates the entry of new private health insurers and private hospital operators to 'increase competition'. She blames the children of elderly parents for not paying for private nursing home care for their parents and passed legislation to allow state pensions to be deducted to pay these bills. In the past Harney attacked Community Employment (CE) Schemes even though they provided care for children and the elderly and also gave much needed employment in poor areas.

The PDs oppose free GP services; support the opening of private hospitals and the closing of rural publicly funded local hospitals. In all these policies Harney and the PDs have the support of the Fianna Fail leadership because they too share her neo-liberal approach. The PDs justify all this by saying that what is good for the rich is good for the economy as a whole and therefore everyone benefits.

Neo-liberalism, literally 'new liberalism', is an approach to capitalism which was inspired by Milton Friedman - a right-wing economist who argued that all restrictions on the free market be removed. Margaret Thatcher and Ronald Reagan were its early promoters. Neo-liberalism's key aim is to remove any regulations that restrict the ability of companies to make profits. It promotes the idea that the market, left to its own devices, will produce the best possible economy of goods and services. Neo-liberals praise competition and individualism. They dislike spending money on social services or regulations protecting human rights, workers' rights or the environment.

The large and powerful transnational corporations, particularly American ones, promote this ideology globally. As rates of profits fell in the 1970s, and continue to fall today, corporations have sought other markets to exploit for profit. Neo-liberalism is the banner under which these markets are opened up. It is backed up by the economic and military power of the United States as the world's dominant economic and military power. The aim is to break down any social protection of work and trade offered by individual countries and to open up their economies to foreign investment.

Organisations which are used to push these policies include, among others, the World Trade Organisation (WTO) and the International Monetary Fund (IMF). The WTO is using the General Agreement on Trade in Services (GATS) to open up public services to competition from multinational 'service providers'. Countries that do not allow these multi-nationals to enter markets and 'compete' can now be sued before a WTO court. The IMF operates more widely in developing countries where it threatens to refuse credit or to refuse to soften loan repayments if countries do not adopt Structural Adjustment Programmes (SAPs). SAPs involve countries reducing subsidies on essential goods such as food or fuel, introducing 'user fees' like water charges or bin taxes and privatising public services.

Ever since the large anti-globalisation protests in Seattle in 1999, resistance to these policies has grown globally. In Cochabamba in Bolivia, for example, there was a successful mass campaign against water privatisation. In response to this popular resistance, the neo-liberals have used other methods to get their way. These methods include using smaller trading blocs like the European Union (EU) to introduce rules like GATS and treaties like the Nice treaty and the EU constitution. Later, linking up these blocs would introduce a world system of 'free trade'. The bigger the company of course the freer they are to take advantage of 'free' trade. Larger companies can use their competitive strength to undercut the prices of smaller companies, raising prices again when the smaller company goes bust.

Individual countries like Ireland have also followed neo-liberal policies without much prompting from abroad. They have relaxed their legislation to allow private companies to run their public services. Eircom was sold off in Ireland while the train network has been privatised in the UK.

This has meant massive profits, higher prices and poorer services including safety levels. The political establishment has also used Public Private Partnerships (PPPs) to further the process of privatisation. These involve complicated and secretive arrangements for private companies to finance, design, build and operate public services like hospitals, schools, prisons and roads or bridges (like Dublin's West-link bridge). The government then leases back these facilities over 30 to 60 years.

Money is borrowed by these firms at higher interest rates than those available to governments, while profits are maximised in the building phase by incurring cost overruns, the costs of which are borne by the taxpayer. In the operating phase profits are further milked by cutting back on expenses, particularly staff and wages, and by introducing user fees. This leads to expensive, poor quality and often dangerous levels of service with high staff turnover as staff quit and move jobs.

Neo-liberalism and Health

In the health services there are already many areas which operate on a for-profit basis. Private companies have contracts for the construction of buildings like hospitals or clinics. Drugs are manufactured by giant companies and sold by pharmacies for profit. Drug companies like Pfizer or Glaxo-Smithkline (GSK) are, in fact, some of the biggest and most profitable enterprises in the world. Supplies of food and equipment to hospitals are also provided by private companies.

Privatisation has meant expanding the areas which have some private input, like nursing homes and hospitals. It has also meant bringing in private firms to run some elements previously run as part of the public service, for example, cleaning, catering or security. This 'outsourcing' has meant that companies push their employees to work faster and they cut the conditions of staff to make increased profits on the payments they get for providing these services. Wages are cut; holiday and sick-pay entitlements slashed and pension contributions stopped. No wonder some low-paid workers end up on poverty wages.

These changes directly affect the health of patients. Cleaning staff that previously worked closely with medical staff now work for private contractors that have their eye only on profit margins. The high turnover of staff and pressurised, speeded-up work leads to falling standards of hygiene in hospitals.

This has worsened the rising levels of hospital-acquired infections like the 'superbug' MRSA (initially caused by the overuse of powerful antibiotics) or the winter vomiting bug. Cutbacks in the number of beds due to privatisation or management cost-cutting causes overcrowding and a lack of single rooms, both of which further increase transmission of infection. International guidelines recommend a maximum bed occupancy rate of 85% but in Ireland it regularly exceeds 100% - with patients on trolleys and in corridors. Disorganisation of admissions due to a scarcity of beds also means that doctors are moving across more wards than is advisable.

All these effects of privatisation disrupt hospital infection control policies. Frequently hospital authorities fail to identify privatisation as the cause of these problems and instead overemphasise hand-washing as a factor, which places the blame back on to staff.

In Ireland the FF/PD government has promoted the building of private nursing homes and private hospitals by providing generous tax breaks. Up until 2002 these tax breaks were reserved for hospitals which were 'not-for-profit' or run by 'charitable' voluntary bodies like religious orders. The 2002 Finance Act gave tax breaks to 'for-profit' private hospitals for the first time. Coincidentally the 'Galway Clinic', a 100 bed Hospital, which was the first state-subsidised 'for-profit' hospital in Ireland, opened in September 2004. It is estimated to have received □20 million in state subsidies. It is difficult to understand why Monaghan's only hospital should come under pressure to close while an unplanned fourth hospital opens in the Galway City area.

Private Hospitals cherry-pick the healthier, wealthier patients who require common procedures with predictable outcomes. No private hospital yet has A&E services. They don't take AIDS patients or haemophiliacs. They don't carry out organ

transplants. They don't contribute to training specialists but take advantage of specialists' skills when their expensive training is completed, paid for by the taxpayer. It is easy for these hospitals to seem efficient when they avoid the most complex and expensive services to patients and staff. They are also state-subsidised, as health insurance and medical costs are tax-deductible. Harney also plans to divert public patients to these hospitals through the National Treatment Purchase Fund.

At the height of protests over the A&E crisis in October 2004, Mary Harney announced that the high-support nursing care beds promised in the 2001 Health Strategy had been delayed because of problems with the 'Public Private Partnership' (PPP) negotiations with private companies. PPPs had been used to build schools and roads previously in Ireland but this was the first mention of it in health. It was a clear warning of what is to come from Ireland's 'Maggie Thatcher'.

PPPs - the UK experience

In the UK, as in many European countries, the development of a welfare state in the period after the Second World War meant the building of a National Health Service. The British NHS became one of the best health services in the world. However, in recent decades it has been undermined, by both Tory and Labour politicians. The heavy defeats inflicted on the British trade unions by the Tories in the 1980s were exemplified by the loss of the Great Miners' strike in 1984, and has hugely weakened resistance to moves to cut back and privatise the NHS.

As a result the UK has been to the fore, among European countries, in the development of PPPs. In the UK PPPs are called Private Finance Initiatives (PFIs). The title may be more grandiose but the result is the same. They operate under a cloud of secrecy. When members of the public are concerned about the closure of a hospital, the siting of a new hospital or the costs or future plans for staffing they are often rebuffed and told that the information is 'commercially sensitive'. No Freedom of Information request made in the public interest can breach this. Business interests come first.

The other form of marketisation of public services came when Thatcher introduced an 'Internal Market' into the National Health Service (NHS). Services were split into purchasers and providers. This meant that Health Authorities spent increasing amounts of time negotiating contracts of services with hospitals and less and less time planning what services were needed - or how these services would work. These changes meant that the necessary planning skills for a good health system, such as surveying areas, looking at the make-up of the population and their likely health needs, were lost as planning departments closed down.

Instead, managers spent time estimating costs and developing guidelines for denying services instead of providing them. Opportunities for real savings through prevention or early admission to hospital were ignored.

New Labour under Blair has accelerated the process. Healthcare companies with interests in the construction, staffing, management and operation of hospitals, health insurance etc. combine together to form consortia, like 'InterHealth Jarvis', which negotiate contracts to finance, design, build and operate hospitals and clinics. These consortia often employ the laid-off planners as management consultants

to negotiate with health authorities. They have gained increasing control of the NHS.

George Monbiot describes the process in his book Captive State:

"Gradually, as hospital schemes are tailored to meet the needs of companies, as clinical services are cut to pay for the contracts with private operators, as hospitals are scaled down, beds, doctors and nurses shed, and as the only secure and unassailable part of the NHS budget will be that part pledged to private operators, the consortia will come to control the National Health Service. Companies whose shares are traded on the Stock Exchange are legally obliged to maximise their value. Whether they want to behave like philanthropic organisations or not, they are unable to do so. As they gradually take over the NHS, they will run it not according to the needs of the patients, but according to the needs of their shareholders."

In other parts of the severely underfunded NHS 'mergers' have become shorthand for hospital closures to save money. The process has often been similar to the closures we saw in Ireland in the '90s, like the Richmond and Jervis Street hospitals 'merging', then closing, to form the basis of the new Beaumount Hospital, or the closures of the Meath, Adelaide and Harcourt Street Hospitals to form Tallaght Hospital. These 'mergers' have left Dublin with the lowest number of beds per head of population in the country. Patients referred to Dublin hospitals from outside the Eastern region have further exacerbated this shortage.

In 1996, one Health Authority in the UK decided to close down the Roehampton hospital because they ran out of money. The local people were disturbed by this news. The authority hired management consultants to manage the adverse publicity. They found allies in the doctors' training bodies - the Royal Colleges. Following a visit one college withdrew approval for training for Paediatrics (children's doctors). As a result, approval was then withdrawn from A&E and Maternity services in a domino effect. The hospital closed and this process was repeated all across the UK. Alternative solutions such as cross-cover with other hospitals weren't even considered.

Professor Allyson Pollock in her book, NHS plc, explains:

"…the government could now present decisions to close hospitals and services as being driven by the medical profession, in the interests of patient care and quality. Members of the public felt they had to bow to the inevitable. They were never given the real reasons that led to their local hospitals and services being closed, namely the high cost of introducing market mechanisms in a context of static or even shrinking resources."

The Neo-liberal plan for Ireland

Even though Ireland has not yet experienced this level of market mayhem we have experienced closures and cutbacks. To make matters worse, the current 'reforms' planned by Harney involve introducing similar market-driven changes. These will involve protecting private medical companies' interests and the running down of public health services.

Tax-breaks for private hospitals and the promotion of private health insurance are designed to maximise control of the health service by private companies and

multinational corporations. Different levels of insurance cover will mean increasing inequality in access to care.

The National Treatment Purchase Fund (NTPF) and PPPs will be used to purchase care for public patients in new private facilities. This trend will cause a further run-down in public health services while diverting public funds to private care. In the long run, public patients will have nothing to fall back on as wealthier patients with better insurance policies are given priority in private hospitals and clinics while regional planning is skewed by the profit motive.

In 2005, the private Beacon clinic in Dublin was offered public kidney dialysis patients to treat at €67,860 per patient per year - €19,000 per year more than those sent to the NHS hospital in Newry. The HSE said this was 'value for money' for 'additional capacity within a short time-frame'. But Irish Kidney Association Chief Executive put it more honestly when he said: 'They had no choice but to embrace the Beacon dialysis facility at any cost because of the crisis indecision left them in.' Meanwhile patients from areas like Carlow, Kilkenny and Sligo continue to make the long journey to Dublin three times a week for this life-saving treatment.

The new Health Services Executive (HSE) is designed to introduce cost-cutting, outsourcing and privatisation. The old Health Boards were distorted by political corruption but their abolition leaves a major democratic deficit. Political vested interests will be replaced by big business vested interests. Local health activists urgently need to fill that gap with campaigns bringing together staff and community representatives.

In Britain, where local protests were determined, hospitals and services were kept open. When campaigns faltered however, hospitals closed. The experience in Ireland in Monaghan, Ennis and Nenagh certainly bears out the first part. The improvements in staffing and beds promised in the Hanly Report could only be safely introduced under the close scrutiny of active local campaigns to maintain A&E, Maternity and other services locally.

We must be vigilant for any signs of the market madness that is afflicting the NHS. The opening up, with no public debate, of the Irish health insurance 'market' to Vivas, its first 'for-profit' insurer, means that the privatisation of health insurance is now a reality. Mary Harney plans to strengthen management in the public service so that they cut costs and public services. She wants to use privatisation through tax-breaks and PPPs so that health services are bought and sold as a commodity like any other. She will get full support for this project from Charlie McCreevy, in his role as EU commissioner for the 'Internal Market'. He also wants to push through more changes to EU rules to open up public services to private companies. This will lead, as it has in the US and Britain, to more expensive, more unequal and poorer quality public services.

CHAPTER THREE:

WHO PROFITS? - DOCTORS, DRUG COMPANIES AND THE HEALTHCARE INDUSTRY

"I stuffed their mouths with Gold"

- Former UK Health Minister Aneurin Bevan on how he convinced Hospital Consultants to join the National Health Service (NHS).

There is money to be made from healthcare. While the vast majority who work in healthcare are poorly rewarded a growing number of "vested interests" make billions. By far the biggest earners are the giant transnational drug companies known as 'Big Pharma' and their shareholders. Ireland is now a major centre of drug manufacturing, employing 24,000 workers, for companies like Pfizer.

Health has long been a source of profiteering. Banks, construction companies and advertising agencies, as well as medical equipment companies and pharmacy chains like Uniphar, make massive profits in healthcare. Pharmacy chain Touchstone Ltd. is looking to build and lease a chain of GP/Pharmacy enterprises. The first of these is currently being built and is due to open in Dublin in 2005. The failure of the government to fund the primary care strategy means GPs are being forced to look to private investors to build clinics.

Since the 1980s, health insurance companies and private hospital operators have grown in size and profitability. Billionaire speculator Dermot Desmond and AIB Bank are the main investors in Irelands new for-profit health insurer, Vivas. AIB bank outlets are now used to sell Vivas' policies. US insurers like Cigna already base their claim processing operations in Ireland. These developments open up the prospect of privatisation for the state-owned health insurer VHI. In 2004 VHI and BUPA spent a combined total of €2 million on advertising alone.

Multimillionaire beef baron Larry Goodman is the main investor behind the 'Galway Clinic' private hospital, supported by €20 million of tax breaks. A rapid and unplanned expansion of thousands of beds in private nursing homes in the late 1990s was also due to tax breaks. It is not clear what standards of inspection, staffing or training these new institutions will be subject to.

Private companies like Harlequin Healthcare Holdings or Eurocare International plan dozens of small new private hospitals. Three 40-bed units are proposed for Waterford alone. A new private hospital in Sandyford, Dublin will be financed by an Irish company, Beacon Medical Group and run by the American multinational, Triad Hospitals. Triad runs 250 hospitals for profit in the US but this is their first venture in Europe. In the US some of these companies have been involved in massive fraud. For example, in 2003 HCA Healthcare (which runs 200 hospitals) was

required to pay $1.7 billion in criminal fines for defrauding the US government and paying kickbacks to doctors, the largest case of health fraud in US history. Another hospital operator, Quorum, was required to pay $95.5 million in fines in 2001. It is now owned by Triad.

As a result of these trends, increasing amounts of money allocated for healthcare are being wasted on managing and administering insurance premiums and claims, on advertising and in profit creation.

The Doctors

Doctors play a vital role in these developments. Neo-liberal policies target public services like health for privatisation. In the process they are changing medicine from a cottage industry to a corporate industry. The corporations' need for doctors' co-operation in this process gives them an importance beyond their numbers or professional role.

Historically, medicine developed alongside the huge changes in society brought about by the development of capitalist production and science. From the seventeenth century on, medicine developed a 'scientific' approach, increasingly viewing the sick person like a broken machine.

At first 'bedside medicine', for mainly wealthy patients, saw sickness as an imbalance and the doctor paid much attention to the views of his, usually socially superior, patient. At this stage their treatments, like bleeding and purging, were little more than quackery. 'Hospital medicine' developed as large cities grew and poor conditions meant large numbers of, mainly poor, sick people were housed in huge hospitals. Patients were then, increasingly, physically examined, seen as having diseased organs, and were perceived as socially inferior to the doctor.

While medical knowledge increased as a result, until the nineteenth century treatments remained largely ineffective or even dangerous. Ironically, major improvements in eradicating infectious diseases like TB and cholera in the nineteenth century, through improved housing, sanitation and nutrition, received little input from mainstream medicine. The doctors' focus on the individual patient often meant they underestimated the role of social and environmental factors in causing or alleviating ill health.

'Laboratory medicine' introduced the idea of some diseases being caused by germs and asserted that the human body was made up of cells and various bodily fluids. It was hoped that these cells and fluids might then be analysed and that diseases would be cured through medical intervention.

It wasn't until the twentieth century that medical developments like anaesthesia, vaccination, antibiotics and painkillers became successful in genuinely curing or preventing diseases. Doctors (until recently, overwhelmingly male) increased in numbers and became organised as a profession, gradually consolidating their control over other health workers, so that more informal healing and caring processes were largely superseded.

Doctors today tend to come from wealthier backgrounds than their patients and tend to socialise with people from a professional or business background. GPs are self-employed; consultants usually have a mix of salaried and private practice incomes while junior doctors work in salaried posts. Due to their high income, doctors often have an additional income from investments in, for example, property or shares. In terms of social class therefore, doctors are a mix of high-earning white-collar workers and self-employed professionals or 'petit-bourgeoisie' (small capitalists).

In the past Irish doctors often joined forces with the church, such as in the 1940s to oppose the Mother and Child Scheme. In the 1970s consultants threatened a strike if rights to free hospital care were extended. Each time the government reversed its plans and compromised. This contrasts with the treatment of other larger groups like the country's 40,000 nurses. In 1999 the nurses went out on strike for long-awaited, minor improvements in their pay and conditions. The government faced them down and the union leadership caved in, recommending poor pay awards to its members. This resulted in the loss of nurses as they left the profession or went to work abroad.

Consultants at the top of the health service hierarchy wield considerable power in controlling access to hospital beds, prescription drugs, surgical treatments and diagnostic facilities like scanners and blood tests.

They have also played a key role in managing services and can use their clinical authority to help justify cutbacks like the closure of Monaghan hospital. Power in the health service, large state salaries, combined with subsidised private fees have been the traditional rewards for their role. As a result, doctors have often played an important role in how governments have avoided allowing other health workers or patients a say in the running of the health service.

Doctors' role in prioritising care for those who can afford to pay through 'private practice' is an important source of inequality and inefficiency in healthcare. However, the neo-liberal changes in the organisation of healthcare are pushing doctors in two opposing directions. Health insurers and hospital operators are, on the one hand, demanding more say in how doctors practice - what services they offer to patients and how much they charge or how they are employed. On the other hand, they offer opportunities for investment and participation in private hospitals and clinics. Doctors can either resent the interference in their clinical autonomy and the change of their work conditions or they can be attracted by the opportunities to share in the profits.

Consultants like Dr James Sheehan have played a key role in setting up private hospitals. Sheehan and other consultants, with the backing of BUPA, set up the elite Blackrock clinic in the 1980s. Sheehan is often viewed as a conservative Catholic who ensures a conservative Catholic ethos is maintained and imposed in his hospitals. He successfully lobbied then Finance Minister, Charlie McCreevy, to subsidise the building of the Galway Clinic - giving a lucrative tax-break worth □20 million. This was the first time that state funding was given to aid the building of private hospitals.

Doctors are not always reactionary. Many doctors, like many other health workers, sincerely oppose the influence of the market in health. Noel Browne, Che Guevara or Salvador Allende of Chile, were all radical doctors who promoted public health services and opposed the promotion of private medicine. The problem however, is that if doctors do not have to deal with strong organisations who actively defend the idea of free public healthcare, they can be pulled back into the orbit of the big medical corporations.

If there were strong health unions, they could have shifted the terms of the public debate. But trade unions like SIPTU, IMPACT or the INO have been notoriously weak in arguing for better health services and more democratic control by health workers and users. Social Partnership has meant that union leaders have avoided exerting pressure on successive governments to achieve improvements in healthcare or to increase the role of its members in running the health service.

Big Pharma

Drug costs are a growing burden for the sick and for the health services. People often cite prohibitive drug costs as the reason they avoid going to GPs. When they do go, people often do not fill their prescriptions because they cannot afford them. The drug companies claim that drugs are expensive because of the high costs of research and development involved in bringing new and innovative treatments to the market. Several recent investigations show that these claims are unfounded. The major costs are: huge profits; marketing costs; executive salaries; lobbying; mergers and incentives to doctors to prescribe costlier drugs.

Drug companies are now the most profitable of all companies in the world! Even banks and oil companies are less profitable. World sales of prescription drugs are now worth $400 billion (about □300 billion). 18% of this, almost $80 billion dollars, goes to profit alone. 36% or about $150 billion goes to marketing costs and only 14% is allocated to research and development - about $60 billion. In the US drug costs are now so high that pensioners (three quarters of whom are on regular medications) are taking the bus to Canada or Mexico to buy cheaper drugs there. Others buy them on the internet. Big Pharma has lobbied the US Congress (parliament) to stop this trade. There are 625 full-time professional lobbyists employed by Big Pharma in the congress alone. That's more than one lobbyist per member of congress.

Publicly funded bodies like universities or state institutes, like the US National Institute of Health (NIH), produce 85% of the actual research that goes into developing a new drug. New drugs are developed as part of years of basic research in medicine, biology and other fields. Drug companies usually only become involved at the stage of testing the drug on groups of patients, and in the crucial approval stage - when approval is sought from regulatory bodies like the FDA in the US or the Irish Medicines Board in Ireland

The big pharmaceutical companies have enjoyed massive benefits from neo-liberal government policies in the US. The Bayh-Dole Act, for example, allowed universities and small businesses to patent publicly funded research discoveries and to issue exclusive licences to drug companies - a so-called 'technology transfer'. Up until then these taxpayer-financed discoveries were in the public domain, available to anyone who wanted to use them. Other laws were used to extend the period of patents and exclusivity rights from an average of 8 years in 1980 to an average of 14 years in 2000. In the period of exclusivity, the new drugs could not be produced under cheaper 'generic' brands, meaning billions more in profits for Big Pharma.

Many of the new drugs marketed are merely variations of existing drugs with no new benefits and sometimes, additional side effects. They are referred to in the industry as 'me-too' drugs. In 2002 in the US, out of 78 drugs submitted for approval, only 17 contained a genuinely new drug and only 7 were deemed to be an improvement on existing products.

Doctors play a key role in maintaining the profits of the drug companies through their control of drug prescribing. Doctors are given 'freebies' like pens, mugs and even holidays or conference junkets to encourage them to prescribe certain drugs. In 2001, TAP Pharmaceuticals had to pay $875 million to settle criminal charges that it had paid illegal kickbacks to doctors to prescribe one of its drugs. Pfizer, the world's largest drug company, brought 60 Irish doctors to a rugby match in France in 2004. In September 2004, Novartis paid for Irish Child Psychiatrists to stay in the exclusive K Club in Kildare for two nights, to listen to lectures about 'Hyperactivity' in order to encourage them to prescribe a drug, similar to cocaine, branded as 'Ritalin', unsurprisingly manufactured by Novartis.

An important element of promoting a drug is to promote the diagnosis. It is often termed 'creating the market'. In the US up to one-in-5 school-age boys are now on Ritalin, often for many years. There is much concern now that the 'hyperactive' condition (called ADHD) is over-diagnosed and that Ritalin and similar drugs are over-prescribed as 'first line treatment'. Many feel that those children who are diagnosed have various difficulties with co-ordination, perception and language development and that these should receive attention first from occupational therapists, language therapists and special educationalists.

Profits are maximised when a condition is a long-term one. As a result, mental illness is a prime target for Big Pharma. Stimulants or sedatives are marketed as 'antidepressant' or 'antipsychotic' even though their effects are not specific. Potential benefits also are small. In published trials patients given antidepressants are only 10% more likely to improve than those not given them. In addition, studies showing no benefit are less likely to be published. In the late 1980's a new 'antidepressant' called Faverin was followed by a host of copycat 'me-too' drugs: Prozac, Lustral, Seroxat and so on. None were any significant improvement on Faverin. Drug giant Glaxo, maker of Seroxat, was later exposed for having suppressed vital evidence of serious side-effects evident in early trials. Patients had been noted to have an increase in agitation, thinking about suicide and to experience unpleasant symptoms when coming off the drug. Withdrawal symptoms have been ignored as these symptoms discourage patients from stopping the drug thus increasing sales. Doctors were initially encouraged to interpret these symptoms as relapse rather than to see it as a feature of withdrawal. The solution, they were told, was to counsel their patients to stop the drug over a longer period - reducing the dose more slowly. The other brands have also been noted to have similar side-effects. Doctors often feel pressurised to continue prescribing the drug due to a lack of availability of counselling or social support services.

Drug Research

Researchers with drug companies joke that for drug companies there are two disaster situations. One is if the drug kills the patient. The other is where you cure them! The ideal situation is that they are made a little better so that they take the drug for a long time. A cure for stomach ulcers with a short course of antibiotics

was ignored throughout the 1990's because antacids like Losec were making $3 billion a year. This was despite the evidence that the bug involved, helicobacter, was also a leading cause of stomach cancer. Profits come first.

Of particular concern was Glaxo concealing negative information about the ineffectiveness of Seroxat in children and adolescents. New York Attorney General, Eliot Spitzer, sued them for $286 million and Glaxo settled out of court for $2.5 million. With huge armies of lawyers to back them up, even a powerful state official is loath to take drug companies on in court.

Drug companies increasingly push researchers to find new functions and markets for their drugs. In this case it was for children (Glaxo moved on to push Seroxat for 'social phobia'). There is no evidence for the effectiveness of 'antidepressants' as a first line treatment in children and yet they continue to be widely prescribed.

Companies like to use researchers in 'independent' institutes or universities. However, they use contracts that restrict the researcher's control over the methods used and how the data are interpreted. They also often have a clause to prevent results being published if they are unfavourable. Medical Journals depend on drug advertisements for revenue and have tended not to insist on their reviewers seeing the detailed results of research or to request that researchers declare any conflicts of interest, namely drug company funding. Occasionally the journals protest. The Guardian 10/9/01 reported that, in a campaign launched together, the top 13 medical journals "accuse the drug giants of using their money - or the threat of its removal - to tie up academic researchers with legal contracts so that they are unable to report freely and fairly on the results of drug trials".

Much drug company research is done on finding copycat drugs and trying to prove that they are better than rival or older drugs. When the drug company Merck developed 'Vioxx' a drug for arthritis, it spent tens of millions of dollars of research money trying to prove it had an advantage over the older aspirin-type drugs. Its initial attempts failed. It went ahead anyway with a powerful advertising campaign describing 'Vioxx' as a 'super-aspirin' even though it was no better at reducing pain and swelling.

In the course of initial trials patients were found to have three times the rate of serious heart problems of patients on the older drugs yet this was not emphasised in the ads. In October 2004, Merck had to withdraw Vioxx from the market because of an increase in heart attacks and strokes in users. Share prices tumbled but Merck had still made □6 billion more than it would have if it had admitted the dangers earlier. Soon after, in Oklahoma, a lawsuit was filed alleging that Merck had misled patients about the safety of its drug.

Research for drugs used in poor countries are almost totally ignored. The rule is 'no money, no market'. A useful drug for a fatal tropical disease, 'sleeping sickness', was found to be an ingredient in a cream for removing facial hair! Though known to be effective, the drug company, Aventis, was reluctant to develop it because there was no profit to be made selling it to poor people.

Recent victories have been made by a global network of AIDS activists - ACT UP - to allow cheap 'generic' versions of AIDS drugs to be manufactured in countries like India, Brazil and Thailand. Big Pharma has fought through the courts and used the WTO and US Trade negotiations to enforce their patent and 'Intellectual Property' rights to stop these poor countries providing effective Antiviral drugs for this devastating disease. Even still, less than one in twenty of the 40 million AIDS sufferers can afford to buy these drugs.

Profits and Healthcare

It is clear that profit is an increasing part of healthcare. The rise of healthcare companies is relatively recent and dates from the 1980's. Instead of ending the inequality and inefficiency of health, these companies plan to develop private medicine it into a multinational corporate enterprise.

The rise of Big Pharma is also relatively recent. Between 1960 and 1980 drug sales were static - between 1980 and 2000 they tripled. This is because patent laws have been extended to living processes and enforced internationally through the WTO and through US government lobbying and threats. The massive profits and the distortion of research and practice these developments are a major cause for concern. Effective medical treatments should be made affordable and available to all those who need them. Need rather than profit should be the bottom line if our health is to improve.

Science, including medical science, needs to be reclaimed as a public resource. Sharing of information and openness needs to replace the competition, secrecy and even fraud fostered by healthcare corporations and Big Pharma. Jonah Salk is famous for having helped develop the vaccine for polio. When he was asked why he had not patented the vaccine he replied: 'Could you patent the sun?'. Such values must be reasserted in health.

CHAPTER FOUR:

CAPITALISM AND HEALTH - CONTROL FROM ABOVE

In developed countries like Ireland, despite an increase in life expectancy, chronic (long-term) diseases such as heart disease, stroke and cancer are still major causes of ill health and death, and trends in their reduction are slowing. While an ageing population can explain some of these trends it does not give the whole picture. Dementias like Alzheimer's Disease and learning disabilities like Autism are devastating for individuals and families yet little progress is made in researching them. Increases in obesity, diabetes, asthma and suicide as well as drug addiction and mental illness are disturbing trends, particularly in children.

In developing countries, advances in life expectancy have slowed and even reversed in some countries. Poor nutrition and infectious diseases such as TB, AIDS, malaria and diarrhoea continue to kill millions every year despite the existence of simple and effective ways to prevent or treat them.

Improvements in housing and nutrition would massively reduce TB and other infections. Access to antibiotic combinations would cure those infected and a good health service would reduce multi-drug-resistant TB. AIDS victims could be treated effectively if new drug treatments were made accessible to the poor by allowing cheaper 'generic' production.

Malaria could be eradicated by clearing mosquitoes from living areas and improving drug treatment for those affected by using drug combinations. Better quality housing and treated mosquito nets also keep out mosquitoes. Resistance by the drug industry to research on these diseases and the refusal to allow cheap production of effective drugs is unjustifiable, yet still continues. The rule of 'no money - no market' is killing millions.

Capitalism

Health is not solely a question of the physical state of our individual bodies but is intrinsically connected to the type of society we live in. The relationship of health and social class is well known. Medical historian Tony Farmar sums up the situation in Ireland in 2004 in his book: Patients, Potions and Physicians:

"Chronic physical illness is 2.5 times more likely for lower socio-economic status people than for the wealthy; death from cancer is four times greater and from stroke three times greater; men in unskilled jobs are twice as likely to die young as professionals; women in the unemployed socio-economic group are twice as likely to give birth to underweight babies than those in the higher professional group."

Social class is intrinsically related to our relationship to the production of goods and services in society - in simple terms, whether we make our living mainly through ownership of assets or through working for wages.

Capitalism, as a system, has existed for only a few hundred years and is a class system of producing goods and services. One small class controls production and another class does the work. With the rise of capitalism, production increasingly centred on factories and offices based in towns.

This system has concentrated control of production - ownership - in the hands of a small minority (like Bill Gates or Tony O' Reilly). All production is organised on a for-profit basis. The longer the hours, the harder the work and the lower the pay for workers, the greater the profits that result for employers.

How far this class of owners, the capitalist class, can push this logic has limits of course. Competition between rival capitalists forces each employer to constantly push those limits. Pressure from trade unions, fear of revolt and the need for a reliable supply of healthy, skilled workers have often forced this class of bosses to divert some of society's wealth towards investment in social infrastructure - water supply, sewage, schools, hospitals, welfare, pensions, public transport and so on.

There is, however a constant tendency by employers to reduce these costs to a minimum, to provide them preferentially to the wealthy and to provide them for profit. As one medical historian, Kelman, put it: "At any point in time, functional health is that condition of the population most consistent with, or least disruptive of the process of capital accumulation."

As a result there is an opposing tendency for workers to demand decent wages and work conditions. They want healthcare services that are comprehensive (covering all aspects of health and illness); universal (available to all equally with no discrimination because of class, race, gender, disability, age, being travellers, immigrants, gay or part of any other group); funded by taxes on wealth; free at the point of use (no payment when you are sick); and democratically planned. This has meant a difference between those who see health as a right and health as a commodity.

Our needs

Human beings have basic needs for food, shelter and clean water. If they are not met we suffer from hunger, cold and are vulnerable to diseases from malnutrition and infections resulting in ill-health and death. As a result, we need reliable and safe ways of providing basic goods and services with the means to access them. The modern system of capitalism often fails to meet these needs. In its drive to cut costs and to make profits, employers often disregard safety in workplaces and ignore the effects of their industry on the environment.

Take, for example, large-scale food production. It involves using pesticides and antibiotics in farming. It processes foods high in fats, sugars and additives, while low in fibre, minerals and vitamins.

It then markets these mass-produced foods through advertising and massive retail-chains, supplanting smaller producers and organic methods and ignoring concerns about food quality. Fresh fruit and vegetables are expensive. A single parent in Ireland relying on social welfare payments would have to spend 80% of

their weekly income in order to provide a balanced and nutritious diet for their family.

Poverty and an insecure supply of poor quality food are a devastating combination. Across the world 1.2 billion people live on less than $1 a day and 2.8 billion (almost half the world's population) live on $2 a day. There are 8 million people starving in the world even though a surplus of food has been produced globally every year since the Second World War.

The UN estimates it would cost only □40 billion per year to provide social services to the poor. The annual budget for arms for the US alone is ten times that amount - □400 billion. The total arms spending for the world is □800 billion.

The reality of pollution and global warming are now well established as threats to health but the capitalist logic of blind competition and accumulation means corporations are unwilling to reduce the production of greenhouse gases, dangerous chemicals and packaging. Despite warnings of environmental catastrophe by the world's most eminent scientists, even the limited reductions in the Kyoto treaty will not be met.

Clean running water for drinking, washing and sewage disposal is vital to health. It was changes in water supply and sanitation that helped eradicate infectious diseases like cholera and dysentery - that it still exists in the developing world is an indictment of global capitalism. Transnational corporations have targeted water as ripe for privatisation - driving up the cost of this precious resource while reducing water quality and safety.

In the early 1990s, the Yorkshire water system in the UK was privatised. Layoffs of reservoir workers and supply-pipe maintenance workers meant that the supply channels became blocked and the reservoirs did not fill and leaking pipes were not repaired. Yorkshire ran out of water, despite being one of the wettest parts of the world!

The Nestlé Corporation has also shown how corporate greed could kill. In the 1970's they heavily marketed powdered milk in poor countries. Their ads said it was better and more modern than breast-feeding. Many poor mothers switched to their product. Millions of children suffered infectious diarrhoea because of unsafe water supplies. Many mothers found the powdered milk expensive but once they had started they found that their breasts stopped producing milk and it was very hard to restart. Many parents had to scrimp on the amount of powder they added and this resulted in infant mal-nourishment. Nestlé were warned of this by the UN and a twenty year boycott campaign began, yet they still refused to withdraw their product in the affected countries. Profits were being made.

These are the crises that face us at a global level but there are other local factors that also affect health. Housing in Ireland is in crisis. Rent and mortgages are hugely expensive and eat up about 30% of an average worker's income. Nurses, teachers or factory workers despair at being able to afford a mortgage on the average house price of □300,000 - over ten times the average industrial wage. We are forced to choose a place to live based on the cost of housing rather than its suitability for us in terms of size or location. Profits for banks, landowners, speculators and landlords take precedence. Many workers are forced to live in overcrowded settings or to live and commute long distances to work - adding to the stress on them and their families.

Patterns of health and illness

All human health depends on being able to have a healthy lifestyle and being able to avoid dangerous toxic elements such as poisons, infections, accidents or trauma. If we do become ill access to good health services becomes vital. In all these three areas the way in which production is organised under capitalism is a serious threat to our health. Our ability to live well, to avoid danger and to access healthcare is increasingly subject to the profit motive. Profit/human greed - comes before health/human need. Unhealthy, pressurised working lives are exploited to produce and market unhealthy products using unhealthy methods.

Most cancers are caused by toxins from industrial pollution, car exhausts and smoking, while infections like hepatitis and helicobacter are also preventable. Major increases in asthma are also linked to air pollution. Very little research is dedicated to environmental causes of illness. Early detection of obesity, high blood pressure, diabetes, cancer and many other preventable illnesses are also neglected. A free cervical screening service in Ireland could reduce this potentially fatal cancer by over half, yet its introduction is not on the agenda. Screening, scanning and other diagnostic tests are widely available but are underused or only provided to private patients.

Heart disease and stroke are now known to be preventable. They are mainly caused by poor diet (high in fats and sugars), lack of regular exercise and exposure to toxins through, for example, industrial pollution and smoking. These lead to damage and constriction of the walls of arteries which, in turn, further raises blood pressure and reduces the blood supply to the heart muscle while increasing the strain on the heart. At the same time the high-fat diet and lack of exercise can lead to obesity and diabetes which intensify arterial disease and the strain on the heart. Increasing the amount of exercise, improving the diet with increases in fruit and vegetables and quitting smoking all dramatically reduce the risk of disease.

Despite the knowledge about lifestyle we see increasing rates of obesity, diabetes and heart disease in children and adults who find it terribly difficult to change their pattern of behaviour. Rates of obesity and diabetes are skyrocketing in children. Manufacturers have used two simple principles to encourage overconsumption of their products to boost sales. Firstly, the earlier in our lives we start to do something the harder it is to change. Secondly the more rewarding an experience is the more likely we are to continue it for prolonged periods.

Manufacturers of food and drug products have abused these principles to set up long-term patterns, or 'habits', of consumption. They design, advertise and make products that give a fast burst of high levels of artificial flavours, fats, sugars or drugs like alcohol, caffeine or nicotine.

All their massive research and development budgets are dedicated to this end. They then spend billions each year on adverts which associate these products, such as cigarettes, alcopops, cola or burgers with positive images of success or beauty. They frequently use a beautiful and successful actor, sporting personality or even a cartoon character in their advertising campaigns. They particularly target these adverts at children. Ronald McDonald is now the most recognised personality among children across the world.

Children are more vulnerable to advertising as they are only just developing their ability to critically assess a situation. They are also less likely than adults to have already developed particular favourite brands or types of products. Companies aim to alter their tastes and brand loyalties as this may win them as a lifelong customer. These tactics are widely accepted in advertising but rarely mentioned publicly. They are also, unfortunately, very effective.

The popularity of these products also makes it hard for parents to resist their children's demands. Peer pressure is a powerful influence and parents trying to alter their child's behaviour will have to contend with their feelings of being left out or different. For many parents this is often compounded by feelings of being unable to properly provide for their children or having let them down in life. Perhaps their favourite food might make up for the lack of restaurant meals, expensive schools or foreign holidays.

A further concern for parents, having to budget on a tightrope, is trying to ensure that there is little wastage of food. Conceding to demands for poor quality burgers or nuggets and sugary drinks may mean the main meal is eaten rather than refused. Experimenting with different foods often requires more time and money than overworked parents have.

Exercise and leisure activities improve health and give a feeling of well-being and enjoyment but are also difficult for people to access due to long working hours, commuting and lack of affordable leisure facilities. In many areas no community leisure centres exist. In other areas they are being closed down and replaced by expensive private gyms. Poor balance of diet and exercise on top of the other stresses of life often result in feelings of exhaustion, depression, anxiety and sleeplessness. People often resort to using drugs to stimulate or sedate themselves to cope with these feelings. Alcohol has been estimated to cause 4% of deaths - equal to tobacco.

The traditional approach to lifestyle change tends to emphasise will-power and individual change. It ignores the possibility of using society's resources to increase the availability of cheap good quality foods and restaurants. Providing good quality meals in schools and workplaces would go a long way towards preventing heart disease and cancer. So would the banning the advertising of unhealthy food and drugs while heavily taxing companies' profits from these sales - rather than the price to the consumer. Banning profit-making altogether from the food and drug sector is never considered. The savings could be used to fund restaurants, leisure centres and health screening clinics. Blaming the individual serves to remove the spotlight from the responsibilities of manufacturers and government.

The lack of control we have at work and in our personal lives often means that personal problems persist and our mental as well as our physical health can deteriorate. While developmental problems like schizophrenia or autism underlie some mental illness it cannot explain the huge bulk of mental suffering.

Mental illness is increasing at a startling rate in Ireland. More than half the population will receive antidepressant medication for depression in their lifetime. Mental distress results, in general, in patterns of depression, anxiety or disorganisation.

Approaches involving counselling and social support are sidelined in favour of drugs because they don't generate profits and because they can bring attention to

the social causes of mental illness stress at work or poverty. Suicide is now the number one cause of death in young people yet counselling and support services are sparse. Those suffering long-term disability are often left in overcrowded institutions, inferior accommodation or become homeless.

There has never been so much wealth in the world. However, at the beginning of the 21st century people are more and more dissatisfied with the ability of capitalism to meet their needs. Even in rich countries we are working harder and for longer hours than in the past and have little or no say in the important decisions about our working lives.

Capitalism works through exploiting individual workers for profit and is driven by competition and prone to the boom and slump pattern of the market. As a result it is unable to organise for human need and goes repeatedly into crisis. While work, living conditions and the influence of the profit-making system cannot be blamed for causing all illnesses, it is the key barrier to preventing and treating them.

CHAPTER FIVE:
CHANGE FROM BELOW - SOCIALISM AND HEALTH

"From each according to their ability, to each according to their needs".

" The free development of each is conditional on the free development of all".
- Karl Marx

Road deaths are blamed on speeding, drinking and drowsiness but rarely on poor roads and almost never on cars. Blaming the lack of a safer alternative to cars is rarely mentioned, even when one is readily available for development. Trains are safer, faster, more efficient and less polluting than cars. Only under a wasteful and dangerous system like capitalism would cars be promoted and the train system run down. The rail disasters caused by privatisation of the public rail network in the UK further demonstrate the dangers of the capitalist addiction to profit.

So it is with healthcare. The drive to profit blames individuals' lifestyles while ignoring poor health and leisure services, environmental pollution, dangerous work conditions and the promoting of cigarettes, alcohol and junk food. Fortunately, however, the massive wealth and technology in the world means the foundations for an equal distribution of wealth exists.

We also have the foundations for a safer, more efficient alternative to the current system of healthcare. That foundation is the public health system and all the people who work in and use healthcare.

The capitalist system of profits, competition and control by a tiny elite is the major obstacle to building on these foundations. It is clear that the profit-motive is a danger to our health. As we have seen, capitalism damages the health of workers in numerous ways. Exploiting workers to extract a profit means long hours for poor pay and little or no control over how or what is produced. This exploitation, combined with the competitive rivalry between capitalists, leads to a chaotic system which cannot meet our physical or mental needs and which is increasingly dragging the world into unsustainable environmental destruction and war.

Reform or Revolution

Replacing production for greed with a system of production for human need will require a major transformation in the control of the productive forces in society. This can only come about through forms of mass mobilisation which pit 'people power' against the power of the corporations. However, while this should be the ultimate objective, we can look for many changes, or reforms, to the existing system. Many changes are urgently needed.

Changing the system will require the active participation of the vast majority and will be actively resisted by those who currently control and benefit from the capitalist system. Winning reforms is necessary to win urgent changes and, in the process of fighting for them, the majority can become aware of their ability to take control of production.

Reform

Urgent reforms are necessary to reduce the damage caused by capitalist production and the organisation of healthcare.

Ÿ As poverty is the most important cause of ill health eradicating poverty is a basic reform demanded by socialists. Demanding a universal basic income would help eradicate poverty by guaranteeing access to socially recognised subsistence needs such as clean water, sanitation, good food, clothing, housing and childcare.

Ÿ Free childcare in properly staffed and resourced preschools and schools as well as facilitating families to spend time with their children through maternity and parental leave is crucial to child welfare and long-term improvements in the health of the population.

Ÿ Curtailing the sale of poor quality food or dangerous drugs by banning advertising of, for example, junk food, cigarettes and alcohol is urgently required. Providing free, good quality meals at school and work would do much to reduce malnutrition and obesity. This could reduce illness and death from diabetes, heart disease and strokes. So would the provision of public sports and leisure facilities like children's playgrounds, gyms and swimming pools or parks.

Ÿ A reduction of the working week to thirty hours would help relieve stress and give people more time to take part in exercise, leisure and even education.

Healthcare reform can be guided by the values of justice, efficiency, democracy and sustainability in health services. In the immediate term socialists call for a universal, comprehensive, democratically planned, free health service that is funded through taxes on wealth. It is worth looking at each of these features of a reformed health service in turn.

Universal

The health service must be provided for all equally on the basis of need. No discrimination should be allowed on grounds of age, disability, gender, ethnicity, religion, sexual orientation or social class. Jumping the queue by buying private care should be banned. Not alone is this unfair, it is also an inefficient use of resources, as those with the most money are not usually the neediest.

It is sometimes argued that when some patients go private they take the pressure off others. This is a con however as the cost is often tax deductible and the staff of private institutions have usually been educated and trained, often to a very high degree, at public expense.

Private institutions often skim off the more profitable patients leaving the more

costly cases to fall back on the public system. This is why private care should be cut out and energies focussed on ensuring that the service is a comprehensive one that can deal adequately with everyone's needs. The right-wing argument that we can't meet everyone's needs implies that someone's needs are to be left out. The rich do not want society's wealth to be used to pay for others to have the same standard of care as they themselves experience.

Comprehensive

The health service should cover all forms of ill-health without exception. For example, there is no rational reason why optical services, dental services or drug prescription costs should be excluded from coverage. The same argument can be made with regard to access to the full range of reproductive health services -counselling, contraception and abortion. The health service should be sensitive to the effects of personal beliefs and values on the way a person engages with services but nobody should be allowed to enforce their religious views on others.

Counselling and social supports should be well developed and available as a right, with no exceptions. Healthcare should be closely integrated with residential care homes and with welfare services - including decent pensions, paid parental leave, sick leave and disability benefits.

The Irish health service requires 5,000 acute beds to be put back into the service, just to reach average EU levels. It needs similarly significant increases in nursing and other staffing to even approach manageable levels. Community health clinics should be opened in line with the Primary Care Strategy (2001). The expansion of services outlined in the Hanly report should be introduced, and any changes should be subject to veto by the local communities served. Junior doctor hours should be, at a minimum, kept below the 48 hour European Working Time Agreement.

A comprehensive health service should see preventive services as a priority. Initially, prevention of poverty is vital to a healthy populace. Within health, screening the population for risk factors and early signs of diseases like breast, cervical or prostate cancer, combined with prompt and adequate treatment would hugely reduce the incidence and level of disability caused by preventable diseases.

The delays in early intervention programmes for developmental disorders like autism or radiotherapy and chemotherapy for cancer are unacceptable in a wealthy country like Ireland. A comprehensive service would fund scientific research on environmental hazards including dangerous work conditions or domestic and industrial chemicals.

Free, and funded through taxes on wealth

Charging people out-of-pocket payments when they are ill should be ended. Sick people are least able to afford additional bills. Ill-health is a common cause of a reduction in earning capacity, as people have to cut down their hours, take unpaid sick leave or even have to give up work. To charge people in this situation is indefensible. Nobody should be unable to use health services because they cannot afford them.

Progressive taxation - taxation that ensures that contributions towards healthcare are based on ability to pay (the greater your income, the higher the taxation)- should fund public services as a whole. This means that income tax levels should be low for low earners and high for high earners The highest earners in this country have avoided paying tax for years. When we speak of taxation to fund a proper health service it is these people who should pay high taxes to fund it. It also means taxing wealth and financial transactions like currency and property speculation to fund public services. The inequity at the heart of the tax system means poorer services and more out of pocket expenses for those who depend on a public health service.

Out of pocket payments are the worst form of funding because ability to pay is usually not taken into account. Moreover, those who have the lowest income (like the elderly or unemployed) would pay most because they tend to be sick more often.

Insurance-based models of health care fail to deliver equality of access

'Experience rating' health insurance (like Vivas or BUPA policies) means the cost of premiums is based on the risk of illness. This loads costs onto the poorest and sickest. 'Community rating' health insurance (like VHI) means everyone pays the same premium for the same benefits. While better, this is still not progressive as lower paid workers will still pay a higher percentage of their income than, say, a rich banker. It is also obvious that poorer workers will opt for lesser benefits so that premiums can be difficult to compare.

Social insurance schemes arranged on the same basis as PRSI are better again but they are still not progressive because the percentage of income paid is the same for higher paid managers as for low paid workers and there may also be a ceiling on payments for the better off. It has the additional major benefit of requiring a contribution from the employer but this can be just cynically factored in by bosses in pay negotiations.

Insurance schemes add extra costs to healthcare in the form of executive salaries, profits, unnecessary paperwork, investigation of claims and advertising in competition with other insurers.

These schemes also tend to move easily from universal coverage to a system of lesser benefits or no insurance, whenever the system becomes underfunded. This is the system in the United States where most Americans do badly from their health system. The US is the number one country for wealth and health spending but number 37 for health outcomes.

The super-rich 1% don't need insurance and use the best international private hospitals. In rough proportions health insurance systems tend to push everyone else into to a four-tier system.

The wealthiest quarter at the top have good policies and feel secure; the next quarter, well paid workers, have reasonable policies but are afraid of extra payments when ill or of losing their job; the next quarter, lower paid workers have no insurance at all, have to pay out of pocket and dread becoming ill; the poorest quarter at the bottom rely on a rundown public service that they have to top up with out-of-pocket payments for basics like drugs.

Taxing the rich would provide more resources for healthcare and reduce the level of social inequality - a double bonus for health.

Democratically planned

The new HSE will introduce toothless 'forums' where people can 'voice their concerns'. This falls short of the democracy that the health service, its employees and users deserve. Health services need to plan to detect health trends and changes in population in order to plan the delivery of services accordingly. This means that the staff who provides the service and the communities that use it should plan how it runs.

The struggle for all these reforms would, in all probability, evoke such resistance from capitalists as to confront the movement with a choice between abandoning its existing achievements or pushing ahead to throw out the profit system altogether - a social revolution.

Socialism and Health

The question of an alternative system of organisation is an increasingly popular one. Rising levels of distrust of governments and corporate power have led to new mass movements of protest. Since the Seattle demonstrations and sit-downs in 1999 a global anti-capitalist and anti-war movement has put 'people power' back on the agenda in a way not seen since the 1960s. Their slogan has been: 'Another world is possible!' Even Bertie Ahern claims to be a socialist nowadays. So what would health be like in a socialist system?

As the mass of people will be involved in throwing out capitalism, they will also decide how a future society will work and will build such a system from the bottom up. It is therefore neither possible nor desirable to produce a 'readymade' blueprint. It is possible to say though what some of the early benefits and challenges will be.

A socialist system means putting human needs first. It means organising production safely and efficiently. It means that it is people themselves who must have the ability to decide what their needs are and how best they should be met. Expertise and technical skills will be highly valued but truly cooperative working will undermine hierarchies and professional snobbery. Those most affected by any decision should be the ones with the final say. Services will be developed on the basis of need, and will be close to where people live and work. This will require a complete redistribution of wealth and power and the creation of a truly democratic society.

A socialist system would dramatically improve our health and well-being. Huge resources currently wasted by capitalism would become available. Huge amounts of work time, equipment and energy are currently wasted on useless or even dangerous enterprises. The massive spending on weapons and armies would stop. Airplanes and helicopters used to transport weapons could be immediately used, for example, to move food, water and medicines wherever it was needed, to the sites of hunger or natural disasters like the tsunami in South-east Asia at the end of 2004. The destruction of lives, homes and societies through war, like what has unfolded in Iraq, would cease. Massive advertising budgets could be put to use in education and scientific research rather than producing ridiculously expensive glossy lies to encourage people to buy products.

Stockmarkets, accountants, financial houses, management consultants and armies of managers would no longer need to be supported. Their offices and equipment could be put to use in real economic planning rather than as casinos for the glorified gambling they currently engage in. Drug companies would no longer waste vast amounts on marketing or useless research for copycat drugs. Information and research will be shared, with the objective of improving health, rather than guarded jealously to secure increased profits. Health insurance bureaucracies would be no longer needed where everyone was entitled to healthcare. All surpluses would be used to benefit the community rather than creamed off as profits by a tiny elite.

Secondly, basing the production of goods and services on human need would greatly improve our health. Good quality housing, food, water and effective medicines would be priorities. In work, safety and quality rather than profit would be the priority, reducing work-related stress and injuries and ensuring products were not toxic nor produced with excessive waste or pollution. Information on products would be scientific, educational and easy to access as opposed to advertising and misleading labels. Packaging would be minimised and recycling facilities easily available in each locality. Leisure and cultural facilities would improve physical and mental fitness, helping people develop their skills and creativity and provide alternatives to alcohol or drug use.

A socialist system of healthcare would be run by those who use and provide services. Eliminating all forms of for-profit production would begin the process of ending pollution and waste. Workers' control of production would end the stress of bullying and overwork. We would make safety at work the first rather than the last priority. With less waste (useless production like banking and advertising or dangerous production like arms) we will have more human and material resources to devote to producing good quality housing, food, water and health services. Even today it is estimated that the world's annual GDP of $42 trillion is enough to feed, clothe, house and educate the world's population 500 times over! Research and development will concentrate on identifying risks to health - where possible reducing them rather than focussing on the individual cure.

Critics will say this is a utopian vision that can never happen. But over two hundred years ago we were told that Kings and Queens had to rule the earth because they were 'appointed by God'. The idea that the mass of people had a right to a say in the running of their country was regarded as a dangerous, subversive idea that 'would never happen'. Today, the big corporations claim the same 'divine right' to rule the planet. Their propagandists say every other possible form of social organisation is 'unrealistic'. But it is time to return to the vision of the great Irish socialist James Connolly who proclaimed, 'The great are only great because we are on our knees - let us arise!'

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Organisation: Socialist Workers' Party
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