Public Health V's Private Wealth

The Workers' Party pledges its opposition to the continued growth of the two-tiered health service, an elite tax subsidised service for the rich and an inadequate under-financed and often undignified service for everyone else.

We demand that Public Health services be provided on the basis of need and not on the basis of ability to pay.

Resolution adopted by Workers' Party Árd Fheis/Annual Delegate Conference, 1987.

The health services in Ireland face a major crisis unless there is a radical rethink. Our health care system is an illness service rather than a health service, with doctors specialising in last-ditch, patch and repair medicine. It is costly because the system concentrates resources on hospitals and drugs and gives considerable subsidies to private medicine. A new health care system must be developed and phased in over a number of years.

Irish Congress of Trade Unions, June 18th 1987

PUBLIC HEALTH versus PRIVATE WEALTH

HEALTH CARE: COSTS AND PRIORITIES

THE WORKERS PARTY

Contents

INTRODUCTION 3

HEALTH COSTS 5
Low in absolute terms/GNP very low/International comparisons/Cost of drugs/Health needs are high/Summary

FINANCING THE SYSTEM 8
Taxes and health contributions/Hospital charges

PRIMARY CARE 11
GPs and GMS/Community care/Dental services

HOSPITAL SERVICES 15
Public hospitals/Hospital Consultants/NCHDs/Reforms required/Voluntary Hospitals/Private Hospitals/Planning and Management/Psychiatric Services

THE COST OF DRUGS 22
Drugs company/Drug Refund Scheme

PRIVATISATION AND THE VHI 23

SUMMARY AND CONCLUSIONS 25
Public Health versus Private Wealth/Workers' Party demands

Introduction

Health policy in Ireland reached a cross-roads in the mid-1980s. Until then, we were progressing slowly towards a comprehensive service which was free, at the point of delivery, for the majority of the population. But the 1982—86 Fine Gael—Labour Coaltion started to reverse that trend and the present Fianna Fáil government has accelerated the process. Its clear and stated intention is to speed up privatisation of the health services.

This has led to the chaos we are currently witnessing. The ill-conceived and indiscriminate cuts in public health services are bringing about a rapid and inevitable deterioration in those services. Meanwhile, even though private health care is being encouraged — directly by state subsidies and indirectly by the pressure on public services — to expand into new areas, this has not yet happened on a large scale. We are therefore suffering the worst of both worlds: a public health service starved of resources and growing poorer, and a private service growing richer and more expensive.

We are told that the health cuts are 'necessary' because 'public spending is too high', health care in Ireland is 'too costly' and 'we simply cannot afford' such high expenditure. We are also assured that there is 'overstaffing' of hospitals and 'overprovision' of acute hospital beds. But is this really true?

The purpose of this document is to examine these arguments, to analyse where the road to greater privatisation is leading us, and to demonstrate the necessity for turning back before it is too late. Otherwise, the consequences will be even more disastrous than the present chaos indicates; and today's cuts will seem, in retrospect, like small snips at the mere edges of the health services.

For many years, the Workers' Party has pressed for movement in the opposite direction, for a better and more comprehensive public health service, with far fewer subsidies for private health care. We believe that health services should be financed on the basis of ability to pay and delivered on the basis of people's needs.

Has this become a pipe-dream? Or is the socialist alternative to cutbacks in public health care and incentives to private care more urgent and relevant than ever? In this document, we seek to demonstrate that it most certainly is, and to urge people to support the Workers' Party in its struggle to halt the health cuts and build a health service which is financed fairly and which treats people equally, and with dignity, on the basis of their needs rather than their wealth.

Structure of document

The Workers' Party sees many fallacies in the oft-repeated argument that 'we are spending too much on health and must cut back'. Chapter 2 shows that in fact, our spending is not abnormally high: it could even be seen as surprisingly low, given the somewhat abnormal demographic, dependency and other features of Irish society.

Financing the health service is of course a problem, given that a large section of its potential financiers have consistently refused to do so. Chapter 3 looks briefly at this area and proposes action.

The Workers' Party sees a number of major inefficiencies in the present health care system. We strongly favour reforms which will end these inefficiencies (and in some cases inequities) and we regard the present indiscriminate and illogical cuts as being inappropriate, unjust and incapable of bringing about the structural changes which are in fact needed. Chapters 4 and 5 describe the main deficiencies in the primary care and hospital services areas and suggest appropriate remedies.

Chapter 6 deals briefly with the cost of drugs and how this major item of expenditure could be controlled. Chapter 7 looks at the VHI and its role in encouraging increased private health care — a role which we believe must be radically changed. The last chapter summarises Workers' Party policy in the various areas and places it in the context of present political developments, national and international.

Health Costs

Health care costs have increased in Ireland, as elsewhere, over the last 20 years. This year's non-capital health spending is an estimated £1.3 billion — some 7.8% of GNP and nearly 20% of all government spending on current services.

Low in absolute terms

However, our spending is not high in absolute terms. Per head of population, it is £325 p.a. — the lowest of all the EEC countries except Greece.

GNP very low

Expressed as a proportion of GNP, health spending seems high; but this is partly because our GNP per capita is abysmally low. (This in turn is due partly to demographic factors, partly to our high dependency ratio, but mainly to our huge level of unemployment and the failure of successive governments' industrial and economic policies.) If national averages of this kind have to be used, then Gross Domestic Product is more appropriate than Gross National Product for such purposes.

International comparisons

Another reason why Ireland's health costs seem high by 'international standards' is that inappropriate and irrelevant comparisons are usually made. In the first place, it is debatable whether such comparisons have any relevance at all, given the wide differences between health service systems, and health problems themselves, in different countries. But if they must be made, they must take account of such differences; and comparisons must be confined to countries with reasonably similar income levels, employment and unemployment patterns, climates, diets, housing and social behaviour (the main factors determining health care needs).

When the NESC attempted such comparisons, they concluded that for Ireland, the UK comparisons are the only ones with any validity. Attention was therefore focussed on England, Scotland, Wales and Northern Ireland; and we see no reason to disagreee with this analysis.

When Ireland's health spending, as a proportion of GDP, is compared to that of Scotland, Wales and Northern Ireland — which all have high dependency ratios and relatively low GDPs per head — these three all have *higher* spending ratios than Ireland. Only

England's is lower.

The same NESC Report also compared the numbers of nursing and medical personnel in Ireland, per 100,000 of the population, with those in the UK countries. Overall, our ratio was higher than in England and Wales, but lower than in Scotland and Northern Ireland. Our ratio of GPs/population was similar to England's, but lower than the others'; and our ratio of hospital consultants and non-consultant hospital doctors was higher than the others', except for Scotland.

Thus by 'international standards' — at least, the only relevant ones — there is no question of 'overstaffing'. Our 62,000 health workers are very much needed.

The 1983 NESC Report also examined Ireland's ratio for the number of hospital beds per 100,000 of the population. We are constantly told that there is 'overprovision' in this area. In fact, however, our ratio is lower than in Scotland and Northern Ireland and not much higher than in England and Wales. And on the cost side — ours varied between 81% and 89% of the English figure — NESC concluded that this was "what one might expect from the levels of GDP per person employed in each of these countries".

Cost of drugs

A further reason why health costs in Ireland are relatively high is that the price of certain inputs, such as drugs, has been excessive. Drug prices are higher in Ireland than in any other EEC country except West Germany. We return to the reasons and the remedies for this in Chapter 6.

Health needs are high

The other main reason why health costs in Ireland are relatively high is the most obvious one: our health *needs* are high. Ours is a high-unemployment society and it is now accepted that there are close links between poor health and high levels of unemployment and poverty. We also have a high dependency ratio — so not only do we have a large proportion of the population in the two groups that use health services most, (the old and the very young), but we have a relatively small proportion of the population capable of financing the health services (and an even smaller proportion *actually* financing them).

In short, for several pressing reasons, health needs are very high in Ireland. And one reason why our health costs are not even higher than at present is that some of those needs are not, in fact, being met. This is particularly so in the case of the elderly, as several

surveys, especially in the Dublin area, have revealed in recent years.

Summary

The argument that 'we spend too much on health' is full of fallacies. In absolute terms, per head of the popualtion, our health expenditure is almost the lowest in the EEC. As a proportion of GNP, it seems high mainly because our GNP is so low (any anyway GNP is a very dubious figure to use in such comparisons).

Our health costs are also relatively high because we pay too much for important inputs such as drugs. But the main reason they are high is probably that our health *needs* are high — and this is because of our high unemployment, high dependency ratio and low living standards (the latter being perhaps the major single determinant of health needs). When compared with other countries of similar economic and social standing — like Scotland, Wales and Northern Ireland, which are the only valid international comparators — all the relevant ratios and statistics on health spending, staffing levels, hospital beds, etc. are very much in line.

The Workers' Party therefore rejects the notion that Ireland's health costs are 'too high by international standards', or 'too high in relation to GNP'.

But this is not to say that we see no need for savings and economies. We do. However, the savings we propose are very different from the ones currently being implemented; and we propose them for very different reasons from those advanced by the right-wing politicians and establishment economists who normally argue 'the case for cuts'.

Financing the system

Taxes and health contributions

About 90% of this year's health expenditure will be financed from general taxation. Health contributions finance less than 8% of it and the remaining 2% or so comes from miscellaneous sources (such as the recovery of certain monies from the EEC).

Both the health contributions, and the bulk of income tax revenue, are financed mainly by PAYE workers.

Last year, some £81.5m worth of health contributions were collected. More than 96% of them came from the PAYE sector. Farmers and other self-employed people currently owe the state more than £36m in unpaid health contributions (although the Department of Finance say that much of this relates to cases where income tax is under appeal and that only about £4.8m is actually 'collectable'). Coincidentally, £36m is precisely the amount by which Health Board budgets have been cut in 1987.

On the tax side, there is the same imbalance, but on a far grander scale. PAYE workers pay more than 90% of all income taxes — more than £2 billion last year — and the self-employed owe huge sums to the Exchequer, of which the Department of Finance reckon about £660m is 'collectable'.

The problem about these 'collectable' amounts is that no arrangements are being made, and no resources are being allocated, to collect them. The Workers' Party has long condemned this gross injustice and continues to seek its elimination.

We see it as nothing short of criminal on the part of the tax-evaders, and criminal negligence on the part of successive right-wing governments that this obscenity is continuing at a time when health services are being dismantled, hospitals closed and vital health care curtailed, because of alleged shortages of finance.

If outstanding health contributions and income taxes were collected, and part of the latter allocated to the Department of Health (along with all of the former), this would at least provide an opportunity for rescinding recent cuts pending thorough analysis and consultation over the way in which savings *could* be rationalised and economies achieved in the future.

The Workers' Party therefore demands immediate collection of these amounts owed to the state; and the introduction of effective mechanisms for the prompt collection in future of income tax, health contributions and other levies from the self-employed and farming population. We also believe that interest should be charged on outstanding health contributions, in order to encourage prompt payment and penalise defaulters properly. Once this has been achieved, and once all sections are paying health contributions on an equal basis, we believe that the 'horizontal equity' thus achieved across all groups should be matched by 'vertical equity' between people at all income levels. Thus health contributions would become payable on *all* income, irrespective of its source, and without any ceiling as currently applies; so that high income-earners would pay the same proportion of total income as those in the lower income brackets. At present, the reverse is the case, with low-income earners paying a higher proportion of income than those who are 'over the ceiling' (currently £15,000 p.a.).

Hospital charges

The Workers' Party is totally opposed to the new £10 hospital charges. There are several reasons why.

First, we are opposed to all charges made at the point of delivery of health care services. We believe that health services should be financed according to people's ability to pay; and that resources should be allocated, and services delivered, according to people's needs.

The second reason why we oppose the new hospital charges is, therefore, that it imposes an additional financial burden on the sector already financing most of the health service — the lower and middle -income PAYE workers. The £10 taxes are not payable by medical-card holders and a small number of exempted groups; and those in the upper-income groups, who are already covered by private health insurance, will find the amounts refunded by the VHI. So the people paying the new hospital taxes are workers on low and moderate incomes, who have just suffered an increase from 1% to 1¼% in their health contributions, and who must now either join the VHI (at major expense which they can ill afford) or risk major unforseen expenses being incurred in the event of any accidents or illnesses.

The third reason why we oppose the £10 taxes is that its real purpose is to drive people into the VHI and the private health care sector — to dismantle the general hospital scheme and replace it with an insurance-based hospital service for some 60% of the population.

The fourth reason for opposing the new charges is that they will be utterly ineffective as a way of reducing people's demand for hospital services. Most people arrive at hospitals involuntarily, following accidents or GP referrals. While a few people may be deterred from seeking hospital treatment — or from seeking GP attention, if a

hospital referral is the likely outcome — most will continue to require hospital services until such time as health policy is radically reorientated towards better primary and preventive care (and even then, hospital care may just be postponed, rather than avoided altogether).

Therefore, the likely effects of the new charges are to increase the incidence of untreated illness, to increase the financial pressures and inequities already suffered by PAYE workers, to accelerate the trend towards more and more private health care and to take us further away from the goal of a comprehensive public health care system. For these reasons — not to mention the immorality of extracting money from people at a time when they tend to be particularly vulnerable and under stress — the Workers' Party totally opposes these charges and seeks their immediate withdrawal.

Primary care

GPs and GMS

The Workers' Party is in favour of a radical reorientation of health policy in favour of better, cheaper and more effective primary and preventive health care. However, we do not see this as a panacea for all ills; or even as a way of necessarily reducing overall health care costs in the future.

One of the principal recommendations of the Tussing Report was that there should be an improved General Practitioner service which is free, at the point of use, to the entire population. This basic reform is essential if people are to be treated at the earliest possible stage of their ailments, before the necessity for expensive hospital care arises. However, for a free GP service to operate properly, it is also essential to change the present system of GP remuneration and Tussing suggested replacement of the existing, 'fee-per-item' method with a salary system based on capitation, or numbers of patients.

At present, 38% of the population have medical cards. With the growth of unemployment and dependency, this group is composed almost entirely of social welfare recipients and their dependents. Medical card-holders receive free GP services and the doctors and pharmacists are paid, respectively, per consultation, or per item prescribed, by the state.

This system has proved expensive, both here and elsewhere. Tussing aguees that it encourages over-prescribing and the prescription of unnecessarily expensive drugs. Also, in some cases, unnecessary 'repeat visits' are required because drugs cannot be prescribed for periods longer than a month. It would therefore be in-adivsable, and probably prohibitively costly, to extend the existing system to 100% of the population.

A free GP service for everyone would, however, be feasible and effective if accompanied by a change to a capitation system of payment for doctors. This would form the basis for an expanded role for primary care, since all doctors would have a known list of patients and could therefore plan screening services and other forms of effective preventive and anticipatory care. It would also help to remove GP services from the realm of a 'cottage industry' and bring them into the realm of late 20th century medicine. Doctors should be encouraged to work in groups, out of purpose-built health centres, in conjunction with other members of a 'primary care team' — such as District Nurses, Home Helps, Health Visitors, Physiotherapists, Speech Therapists, etc.

The cost of extending free GP services to the entire population would not be prohibitive if accompanied by a change over to capitation-based GP salaries — even if salaries have to be raised somewhat to encourage GP support for the new system. The increased costs of GP salaries should be recouped through reduced prescribing (especially of expensive drugs), reduced use of hospital services and the abolition of the Drug Refund Scheme and Long-term Illness Scheme (since all patients would, in effect, have medical cards).

The cost of drugs, and the Drug Refund Scheme, is discussed further in Chapter 6.

Community care

The Workers' Party is in favour of treating and caring for people within their own communities, rather than in large institutions, wherever this is possible and desirable. However, unlike some advocates of this currently 'fashionable' approach, we do not see community care as 'cheap care' and a way of saving money (at the expense of patients and their families).

We are totally opposed to the idea of 'dumping' patients out of hospitals and other institutions, into families or communities whose resources are inadequate to meet those patients' needs. We are particularly wary and suspicious of 'community care' which involves the substitution of trained, skilled, professional carers by untrained, unprepared, unpaid and sometimes unwilling, 'home-workers', most of them women.

This is a particular source of concern in relation to psychiatric service. There is widespread support for the rundown of the large psychiatric hospitals. However, we have yet to develop alternative services on a sufficient scale to meet existing needs. Likewise, while there are many people who should never have been admitted to psychiatric hospitals, these hospitals may represent the only home and security which they have.

The Department of Health blueprint on the future of psychiatric services was called "Planning for the Future". However, experience so far has seen very little planning and a great deal of ad hoc decision making, based mainly on economic consideration. It has resulted in a great deal of distress and trauma for many people.

We believe that adequate resources must be devoted to the development of community care services; and that once these are properly funded and firmly in place, any surplus space, beds, etc. in hospitals can be examined with a view to rationalisation. Attempts to reverse the order, and reduce hospital space first, are completely

unacceptable.

Dental services

The dental service is another area in which major anomalies exist, reforms are required, and significant moves towards greater privatisation are being suggested. The Workers' Party is opposed to such moves and seeks a number of urgent changes.

At present, some 270 dentists cater for nearly 2 million public patients and the rest of the population (mainly the self-employed and others without social insurance, plus the dependents of insured workers) are treated by some 700 dentists. As everyone knows, the public Health Board Dental Clinics are starved of resources and unable to provide an adequate service. Those using them must endure long delays for routine treatment; rapid treatment is confined mainly to extractions; and there is no question of preventive care.

Recently the Irish Dental Council commissioned a report on the service by Coopers and Lybrand Associates. Predictably, this report echoed most of the Council's own views, recommending limitations on the numbers of dentists to be trained in future and stimulation of the demand for private dental care. Through reductions in the scope of PRSI cover for dental services, removal of present limitations on advertising and the encouragement of privately-funded insurance schemes to cover dental expenses.

In other words, dentists' incomes should be kept high, and if possible be increased, by restricting the number of dentists (who currently take a large share of the £50m spent per annum on dental care) and by encouraging more patients out of public and into private dental care. Same old story!

The Workers' Party seeks an extension and improvement of public dental care, together with controls and safeguards in relation to private care. We favour an entirely free dental service for all, in the long run, with perhaps payment of dentists on a capitation basis (although there are certain difficulties with this which require attention). In the short run, price controls should operate in this area, which is currently unfettered by any such restrictions. We are opposed to present attempts by dentists and others to stop the extension of free dental benefit to insured workers' spouses, but agree that other groups should also be included and that there is an urgent necessity to devote more resources to the public scheme to enable it to modernise and cope with the increased numbers.

The Workers' Party also supports the demand for a new Dental Hospital; and seeks immediate improvements in the staffing levels, equipment, facilities etc. in the Health Board Clinics. We also favour

the introduction of more trained auxiliaries to dental practices and believe that all dental graduates should be required to spend at least one intern year working in the free dental scheme. Finally, we see a need for much more preventive dental care, involving routine checks and monitoring of the entire population, but believe that this can only be successful within a fully comprehensive system where dental services are freely available to all.

Hospital Services

It is often said that we have more hospital beds in Ireland than we 'really need'. This particular myth has already been dealt with in Chapter 2, where we showed that Ireland's bed/population ratio is lower than in Scotland and Northern Ireland — two of the most relevant comparators for us.

While it is difficult to determine an exact level of 'true need' for hospital beds, it is easy to say with certainty that the current cut-backs will cause increased hardship and suffering for the majority of people depending on public hospital services. These people will be forced either to endure a worsening service, or to take out VHI cover which most can ill afford.

The reduction of bed numbers in public hospitals is being paralleled by an expansion of bed numbers in private hospitals. In the very week that it became clear that 1,000 public beds are to be axed in the Eastern Health Board region during 1987, the luxury Blackrock Clinic, whose existing beds were seen as being of doubtful viability in 1986, announced a 100-bed extension of private, elite care for the rich.

The Workers' Party believes that it is not a question, at present, of 'too many beds' — but of too many *public* beds and too few *private* beds to suit the needs of vested interests in the medical business, and the advocates of greater privatisation of health care. We are totally opposed to decreases in public bed numbers whose primary purpose is to force people into private beds and private health care — and we believe that this is precisely what is happening at present.

The Workers' Party is also utterly opposed to the cuts in staffing which, in our view, are unnecessary, unjust and counter-productive in the long run. As already shown in Chapter 2, there is no question of 'overstaffing' in our health service; and for 3,500 workers to lose their jobs in 1987 (as predicted), in the interests of privatisation and against the interests of public patients, is nothing short of scandalous. Apart from the personal trauma inflicted on any worker made redundant or unemployed, the cost of skills and experience likely to be lost through the emigration of many health workers, and the cost of unemployment payments, medical cards and other social services to those who remain, will be extraordinarily high. *These* are the kind of costs Ireland 'simply cannot afford — particularly as they are unnecessarily inflicted.

Hospital Consultants

There are over 1,000 of these highly-trained specialists in the medical

service. They are paid for their 'public' work under a 'common contract', with salaries varying from speciality to speciality (mostly in the £30—£50,000 bracket).

Consultants are paid these salaries for looking after the 85% of the population which, until the 1987 Budget, was entitled to their services free of charge. The other 15% of the population (with salaries over £15,000 pa, at present) must pay directly for consultants' services, but are usually refunded the amounts by the VHI.

Altogether, however, some 30% of the population is in the VHI. This means that 15% of the population, comprising people who are entitled to see consultants free in the public outpatients' departments, are paying for VHI cover (on top of their health contributions) in order to see consultants in their private rooms. We all know the reason for this. Most people prefer a good service to a bad one and some are prepared to pay a high price for it.

Since VHI premia are tax-deductible, consultants are being paid twice over for looking after this 15% of the population — once directly through their salaries, and once in the tax-subsidised payment made by the private patient.

For sound economic reasons, consultants as a group have an interest in making access to their service difficult, and sometimes undignified, for public patients, thus forcing them into the private sphere. Since consultants, in the present system, are the main determiners of hospital care levels, this situation, coupled with the hospital cutbacks, must cause further declines in standards in our public hospitals.

There are of course individual exceptions, but the brute fact is that it is not in the consultants' collective economic interests to improve access and care for public patients. This must be changed, because it means that even without the present cutbacks, the public hospital services would decline (as indeed has happened).

The Workers' Party therefore calls for immediate renegotiation of the consultants' common contract so as to oblige all consultants on state salaries to make a full-time commitment to the public health service. Those who engage in private practice should do so outside the public system and without subsidies, either direct or indirect, from the taxpayer.

We return in Chapter 7 to the VHI and its role in encouraging private health care, a role which we believe must be changed dramatically.

Non-consultant hospital doctors

The NCHDs are salaried doctors, in training, who work in the hospitals under the consultants' guidance. They are involved in the routine investigation and management of patients in hospital and bear the burden of most of their medical care. They are often young, work very long hours, and are the doctors with whom most patients have most contact in public out-patients' departments and wards. And it is a common complaint of entitled patients that while their GP has referred them to a consultant, they are often dealt with by doctors who are less experienced than the referring GP.

Career opportunities for NCHDs are very limited indeed. Fewer and fewer consultants' posts are being created and there has been a complete ban on access to the GMS. As highlighted during the recent NCHD's strike, many are now forced to consider emigrating, or changing to non-medical careers.

Reform required

As well as an end to hospital cutbacks, the Workers' Party demands three major reforms in the public hospital system.

The first reform is to *completely separate public and private care*, and to subsidise the first more and the latter less. The consultants' 'common contract' should be changed, as suggested above, to oblige all publicly-paid consultants to provide a good service to public patients. Entitlement to public hospital care should be extended to the entire population. This could be financed through abolition of the upper income limit for health contributions and the withdrawal of tax relief on VHI premia — once a comprehensive, free public health service was fully in place.

The second reform would be to *improve the consultant/patient ratio*, with a pro rata reduction in the number of junior hospital doctors. In other words, the latter should be given some promotional opportunities and this can only be of benefit to patients, as long as the consultants' contracts have been altered in the manner we suggest. Patients would be more likely to be seen and treated by fully specialised doctors who would spend more time with them because of their full-time commitment to the public health service.

The third reform we propose is the introduction of a *Charter of Patients' Rights*, which would set out the basic conditions of care and information to which hospital patients are entitled. At present, many entitlements are unclear and patients may be confused, frustrated or annoyed at the very time when unnecessary stress should be avoided.

Voluntary Hospitals

There are 47 Voluntary Hospitals in the state. They provide care for entitled patients, are 97% financed by the taxpayer, but are privately-owned and controlled by boards which are self-perpetuating oligarchies.

Such hospitals are often involved in wasteful competition, especially in high-cost and high-status areas of treatment. Twenty years ago it was open-heart surgery; more recently, there was the competition over liver transplants between the Mater and St Vincent's.

Some have also, for example, obstructed much-needed reform of the system for recruitment of student nurses. They have done this so that they can maintain an individual type of control over who gains access to nursing, taking account of factors which go well beyond the person's ability to perform the job in question.

Recent cuts, and attempts to impose cash limits on these hospitals, have thrown up further anomalies. Their private boards have attempted to defend local commitments by threatening to close national centres which are under their control. One example was in relation to the Bone Marrow Transplant Unit in St James's Hospital in Dublin; another was the Sexual Assault Unit in the Rotunda (also the only unit of its kind throughout the state); another was the National Cervical Cytology Centre at St Luke's.

We can understand their dilemma and tactics, but it is nevertheless unacceptable that private institutions should have the right to order closure of publicly-financed national services which are unavailable anywhere else in the state.

The Voluntary Hospitals must, in our view, be made democratically accountable for their policies and services, since they are almost entirely financed by taxpayers.

Private Hospitals

These are divided into two types — the elite ones for which normal VHI premia provide cover, and the new, super-elite ones whose charges are so high that a special, extra VHI premium is required. They are privately-owned and run but subsidised heavily by the taxpayer — in the case of the Mater Private Hospital and the Blackrock Clinic, most patients are on the highest marginal rate of tax (58%) and therefore benefit considerably from the tax-deductibility of VHI premia.

The Workers' Party believes that when free public hospital care and other services are extended to all — *but not before — the tax subsidies to private health care should be withdrawn. The subsidies for the two new luxury hospitals (Blackrock and the Mater) should be abolished immediately.*

Private care must, in our view, become purely private. There must be no tax subsidies and incentives to private health care. Only then can the public health service improve and only then can health costs be controlled.

The psychiatric services

Whereas social factors such as housing, poverty, unemployment and lifestyle play an obvious part in causing physical illness, they play an even greater part in creating problems which may require psychiatric care.

Psychiatric illness (and in practical terms this embraces a wide variety of other behavioural problems) is not transmitted as a disease by a virus from one person to the next.

It is substantially a response to our society as figures for admissions to psychiatric hospitals confirm. The number now being admitted suffering from depression and alcohol-related problems is a sorry indictment of how a great many of our citizens cannot meet the expectations of their society; or at least the values that are presented as criteria of worth.

The number of young people turning to drug and alcohol abuse reflects the pressures of a society in which many of them will fail to secure the training and education they want and subsequently employment.

There is evidence that the inequities of our society reflect themselves in the admission to psychiatric hospitals. There are eighteen times more agricultural workers and twelve times more unskilled workers in psychiatric hospitals than professionals.

A research project by Dr Eileen Kane in Carrickmacross showed a sixty per cent increase in the use of tranquillisers by the unemployed there.

Therefore, mental illness is not just a medical issue. It is a profoundly political issue in all its aspects.

The move towards community psychiatric services

There is a simplistic assumption that de-institutionalising care will result automatically in something called "community care". There is regrettably a great deal of very well-intentioned but extremely woolly thinking about the concept of "community" and what sort of "care" will be delivered there.

These good intentions will be easily understood by anyone who has ever been involved in, visited or been a patient in a public

psychiatric hospital. They are old, custodial and very forbidding institutions which, in their structure and layout are generally not amenable to modern variations of treatment or therapy programmes. While progress is being made, the emphasis is still on custodial care. Getting patients and nurses out of such settings is indeed desirable.

The Department of Health blueprint for psychiatric services, "Planning for the Future", made three main recommendations on the development of a community-oriented service:

- that people should be able to avail of a full range of services while continuing to live at home,
- that patients' families should be fully supported by the psychiatric team,
- that a variety of community based services should be set up; including day care, crisis intervention, out-patient clinics, various residential facilities etc.

However at a time of severe economic cutbacks, there is no reason to believe that adequate resources *will* be made available to acheive these objectives. There is evidence already of patients being de-designated as psychiatric patients against the strong wishes of some members of the psychiatric team, simply to facilitate re-organisation as a result of cutbacks. In a climate of cutbacks and given the experience so far of community psychiatric care, we believe that many of the good and laudable aspirations to community care are being used by the monetarist and anti-public sector lobby within the current government which wishes to reduce public expenditure regardless of its impact on the social services or community health.

The development of other facilities in the "community" such as mini-psychiatric hospitals for the "new long stay patients" and other hostels will not be achieved at no cost.

We believe that until adequate arrangements are already in place, to cater for patients to be discharged from existing psychiatric hospitals, they should continue to be cared for in the existing setting. Experience in the United States in particular, is that the "community" into which patients move provided no help and there is much evidence to justify the fears that community care might result in no-care.

As a result of the current round of cutbacks, and in particular the indiscriminate way in which they have been implemented, some of the very programmes designed to enable long stay patients to return to life in the community have been hardest hit. (The re-socialisation project at St Brendan's Hospital is an example but not the only one). This is not only wrong from a service point of view, but it is economic folly. It perpetuates the dependence on high cost in-

hospital care where patients would be discharged to other facilities if they were being propely prepared.

We strongly support the general trends outlined in "Planning for the Future".

However there should be no further rundown of existing arrangements until adequate, alternatives are in place. The circumstances of severe recent discharges have been scandalous. Many of the patients in our psychiatric hospitals are old or forgotten. They are one of the most vulnerable in our society and need to be protected.

We call on the Department of Health to ensure that strict procedures are adhered to by Health Boards in any reorganisation of services to ensure that rights of patients are fully protected.

Planning and Management

The hospital service must be rationally planned and made democratically accountable. Regional variations in standards and availability of services must be minimised. And it is now generally agreed that standards of management and administration are poor. The Department of Health in December 1986 stated bluntly that "the essential management structures and expertise in hospitals have, by and large, been neglected" and that this "must be rectified *as a matter of urgency*" (our emphasis). We agree.

The cost of drugs

In Ireland, we pay higher prices for drugs than any other country in Europe, except for West Gernamy. The large, mostly multi-national, drug companies have got away with this because no government has stood up to them properly or devised ways of handling them better. Admittedly, the state's bargaining position in this is not very strong, but no real attempt has been made to strengthen it.

Drugs Formulary

One way of doing so would be through the establishment of a National Drugs Formulary — an agreed list of generic drugs which can be prescribed as substitutes for the 'big brand names' which tend to be more expensive. This would bring down overall costs and give the state more leverage with the multi-nationals.

Drug Refund Scheme

Under the Drug Refund Scheme, once a person's monthly expenditure on drugs exceeds a certain limit (currently £28), the state makes refunds. These refunds cover not only the wholesale price of the drug, but the 50% retail mark-up and the prescription charge to the pharmacist.

In the GMS, the state pays the pharmacist the wholesale price plus a prescription charge per item.

Therefore, in some cases the state pays the pharmacist more under the Drug Refund Scheme than it would pay both the pharmacist and the doctor if the patient had a medical card and was entitled to all services free. Obviously, under the DRS, pharmacists have an economic incentive to dispense the most expensive brand of drug in order to maximise their incomes. The same is true under the Long-Term Illness Scheme, in which the state pays wholesale, retail and prescription charges.

There are major savings to be made here, but not at the expense of patients. The Workers' Party will oppose any change in the DRS which obliges patients to pay even more for the medical treatment they require. However, we favour changes which would reduce the cost to the state of providing drugs; and believe that our proposals for a free GP service for everyone, accompanied by a system whereby the state reimburses pharmacists directly for the wholesale cost of drugs prescribed (and encourages the prescription of lower-cost, generic drugs) would substantially and permanently reduce costs in this important area.

Privatisation and the VHI

It is clear that the present government intends using the VHI as a vital tool in the greater privatisation of the health services. The Minister for Health has promised a "radical reappraisal" of its activities and a Bill amending its role is to be introduced "in the near future" (Dáil, June 19, 1987).

Specifically, the Minister has referred to the need for the VHI to assist in the provision of private insurance cover for dental, ophthalmic and aural services; and the questions of geriatric care, as well as comprehensive cover for GP and out-patient expenses, are also to be addressed. During the same Dáil session — moving this year's Health Estimates — Dr O'Hanlon said that since the VHI had so much financial support from the state, it had a "clear obligation" to provide cover for people and services not covered by state schemes.

It would appear, therefore, that the VHI is to be given even greater subsidies from the taxpayer in order to encourage that same taxpayer into private health care and facilitate the contraction and dismantling of public health services. Is this what we want and need? The Workers' Party says, empahtically, NO.

About 30% of the population is currently insured with the VHI (1,032,709 in 1986). Broadly, this comprises the 15% who earn over £15,000 pa, and another 15% who earn less, but have taken out cover to escape from what has become a slow, inferior public service to a quicker and usually better private one. As already stated, present developments are designed to encourage more and more people in the 'limited eligibility' category to take out private insurance, so that the state can cut back further on public services. Presumably the eventual aim is for the state to cater only for the 38% or so holding medical cards, letting the rest take their chances with private health care and private health insurance.

In our view this is a recipe for disaster.

First of all, it will do nothing, in the long run, to reduce or control overall health care costs. All the international experience, as documented by Tussing and others, is that the more health care is privatised, the more impossible it becomes for the state to exercise centralised controls.

Ireland's present health care expenditure is made up of both public and private expenditure. There is detailed data on the former, but very little on the latter — although in 1983 the NESC reckoned it was about 1% of GNP. In 1985-86, tax relief on VHI contributions cost

the state £30m, but the additional relief recently granted for premia to cover treatment in the new private hospitals will increase this to at least £36m

If the 'mix' between public and private care is altered in the manner proposed by the government, all that will happen is that reductions in public spending on public health care will be matched by increases in public spending on private health care. The reliefs on private health insurance will cost the state more and there will be no real possibility of the state controlling costs in the private area.

The second reason for opposing increased privatisation is that it has a direct, negative bearing on the quality of public health care. The greater the incentives (for consultants, pharmacists, private hospitals and the VHI) to private health care, the greater are the disincentives to providing good public services. Unfortunately, this is an economic fact of life. And the greater the gap between public and private provision of services, the more difficult it becomes to close it in the future.

The Workers' Party is utterly opposed to the development of an American-style health care system, in which those on lowest incomes are entitled only to the poorest and most basic of services and the rest of the population is forced to buy expensive private insurance — whether they can afford it or not — or risk either non-treatment when they need it, or treatment at astronomical prices. Yet this is what Irish people face in the coming years if present developments are allowed to continue.

We are determined to fight for the maintenance, improvement and extension of public health services in Ireland.

We are not in favour of ending the tax relief on VHI contributions immediately; although we believe that the relief on the additional special premia, designed to give cover for the new luxury private hospitals, should be discontinued immediately. Withdrawal of the remaining relief would merely penalise, even further, the PAYE taxpayers who currently finance most of the health services and have recently suffered increases in their health contributions and the imposition of the new £10 charges.

However, when free eligibility to GP and consultants' services has been extended to everyone, we believe that the tax relief on VHI contributions should be phased out, as the final step in completely separating public and private health care.

Summary and Conclusion

Public Health versus Private Wealth

The present government and its predecessor are very much in tune with Thatcherism, Reaganism and right-wing thinking internationally. They see privatisation as the solution to the many difficulties faced by modern states attempting to run efficient national services in economies where private market forces dominate.

In no Western, private-enterprise societies have health services been free of financial exploitation. Health is a highly profitable area of business and, for obvious reasons, people are vulnerable to exploitation in this area. That is why private enterprise wants a free hand. It is also why socialists want effective state controls and an end to private profiteering. We see a stark contrast between the interests of public health and of private wealth and stand clearly on the side of the former.

It is important to recognise that the present cuts in public health services have less to do with the present-day budgetary policy of a particular government than with restructuring health care in the long-term interests of private enterprise. In an economy such as ours, where private capital has relatively few profitable outlets due to the decline of manufacturing industry and the failure to develop other sectors more fully — the pressure for it to enter new and lucrative areas are particularly strong.

The present health cuts have thrown into sharp relief — for those who care to see it — the power and persistence of vested interest groups such as the consultants, drugs companies and private hospitals. But unlike in other countries, where similar forces have been operating, we in Ireland have had very little public discussion of what is really happening, in structural terms, within the health services.

There has been very little political debate; and even less planning or action to control the powerful vested interests. The result is unfettered profiteering by pharmacists, consultants, multi-national drug companies, private hospitals and a host of independent contractors; and health expenditure priorities which are essentially, privately-determined.

Ireland cannot afford this great rip-off. We have enough other problems. Even a properly run health service would have difficulty coping with a population such as ours, which is so divided as between rich and poor and so lacking in the education and employment opportunities needed to bridge the divide. And even a top-class public health service would have difficulty reorienting health care

towards better primary and preventive care (which is the one thing everyone agrees is required).

However, a health service which is run mainly for private gain and profit, and in which priorities are determined mainly by market forces, has no chance at all of addressing everyone's health needs through comprehensive, anticipatory care — which is the only way, in the long run, of reducing the demand for expensive hospital care.

The Workers' Party has detailed policies for setting our health services back on course, towards a system which will cover everybody fully, on the basis of their health needs; with services provided free at the point of use and financed fairly by everyone who is generating an income. These have been elaborated in Chapters 2 to 7 and the main points are repeated hereunder.

Workers' Party demands

★ *reverse the trend to greater privatisation* of health services as this will have disastrous consequences for public services and will fail to control health costs in the long run;

★ instead, *move towards a comprehensive public health service* which is free at the point of use and is financed on an equal basis by all income-earners;

★ *reject the myth* that Ireland's health care costs are 'too high' by international standards, or in relation to GNP, and that this is why public services are being cut back;

★ *address the real causes of waste and inefficienty* in the health services: private profiteering by consultants, pharmacists, private hospitals, drug companies and others;

★ *introduce free primary care* and change GP's remuneration from a fee-per-item to a capitation basis; devote adequate resources to community care before 'de-institutionalising'; improve the free dental scheme and oppose current moves to restrict the numbers of dentists and boost their incomes through increasing the scope for private dentistry;

★ *change the hospital consultants' 'common contract'* so that publicly-financed consultants devote adequate time (preferably 100% of it) to public patients; ensure that any private practice is performed outside the public system and without subsidies from the state, either direct or indirect; improve the consultant/patient ratio and the career prospects and working conditions of junior hospital doctors; introduce a Charter of Patients' Rights; make Voluntary Hospitals democratically accountable; remove all state subsidies from Private Hospitals; and urgently improve the management and administration of public hospitals.

★ *reduce the cost of drugs* through a National Drugs Company which could purchase them at more competitive prices and draw up a list of agreed generic drugs available for prescription instead of more expensive proprietory products; restrict the amounts drug companies can spend on advertising; and reform (and ultimately abolish) the Drug Refund Scheme and Long-Term Illness Scheme, both of which provide incentives for abuse by pharmacists;

★ *oppose the use of VHI to assist in greater privatisation;* end tax relief on the special VHI premia to cover the cost of the new private hospitals; phase out the remaining tax relief on VHI premia *only when* free eligibility to GP and consultants' services has been extended to everyone;

★ *collect all outstanding health contributions and income taxes* from farmers and the self-employed. When this has been done, and when all sections are paying on an equal basis, raise (and eventually abolish) the income ceiling for health contributions to ensure that everyone pays the same proportion of their gross income. Introduce interest charges for those who default or delay with payment of health contributions.

★ introduce *a statutory national minimum wage and a minimum income for all*, since people's living standards are the most important single determinant of their health; devote resources to the promotion of preventive care and 'positive health' as well.