A System in Need of a Cure

an anarchist analysis of the Irish healthcare system

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The healthcare system, upon which people in Ireland depend, is an apartheid system. Simply put, some lives are worth more than others. Rare attempts at reform have been stymied by historic, chronic underspending and vested interests. This legacy has forced the vast majority of working people to take out private health insurance and has laid the foundations for a neo-liberal push towards an American-style system of private medicine.

Despite the "economic miracle" called the Celtic Tiger that has led to Ireland having a higher GNP per head of population than much of the rest of the EU, it lags behind in terms of health outcomes. At age 65 we have the lowest life expectancy in the EU for both men and women. Indeed, the gap between Irish and EU life expectancy has been widening. Infant mortality rates are above the EU average. We have above EU mortality rates for cancer and coronary heart disease. Despite Ireland's incidence of breast cancer being among the lowest in Europe, the death rate in 2001 from breast cancer was the highest in EU15. To cap it all, we have a widening income gap, which analysis suggests will of itself worsen our health experience since greater inequality is associated with higher mortality rates.

This state of poor health of people in Ireland, especially when analysed on class lines, is a direct reflection of the unequal and inaccessible nature of the Irish healthcare system. The barriers to accessing care, in terms of availability and cost, mean that the level of health education and preventative medicine is severely low and that treatment for illness is often provided in an untimely fashion. The cost of private care, means that many people must wait long periods, sometimes too long, for the treatment they require to survive.

In this analysis of the Irish healthcare system, the reasons for this lack of equality and access will be discussed. This will be followed by a review of the systemic problems in the system itself which hamper both the delivery of quality care and genuine reform. A summary of some of the current issues in the Irish Healthcare System will provide a reference point to view the system as it currently stands and to where the ruling class intend to develop it. In response to these seemingly insurmountable problems, a series of potential solutions will be put forward, both in the short-term and in the medium-term. How these reforms could and should be funded will be examined together with some ideas on how these reforms may be fought for and secured by ordinary people. Finally, a post-revolutionary health system will be envisioned drawing on the examples of the brief experience in revolutionary Spain and the more long-running experiment in Cuba.

Equality and Access

Cost is the biggest obstacle to receiving medical care, be it just a check-up or some more necessary treatment.

Latest figures for the beginning of 2007 show that there are currently 1.2 million people with medical cards[1]. This represents 28.9% of the population. There are a further 51,000 people with "GP-Visit Cards" which qualify them for free medical consultations but no drug costs. This is a remarkably high proportion considering that any single person under 65 years of age and living

[1] A medical card entitles the holder to free visits to a General Practitioner (family doctor) and free prescribed medication.

alone has to earn less than €184 per week to qualify for a medical card[2]. Given that social welfare payments are now up to €185.80 per week and that even on the minimum wage of €8.30 per hour, one would only have to work 22 hours a week (the equivalent of a part-time job) to surpass the income threshold, it is surprising that any worker is entitled to a medical card.

Without the medical card, GP visits cost on average approximately €40, while being higher in urban areas (especially Dublin). These fees act as a disincentive to access medical care in two important ways. Firstly, they act as a deterrent to seeking out any sort of health education or preventative examination from a GP. It is commonly accepted that preventative medicine, such as cholesterol tests and smear tests, are fundamental in improving the life-expectancy and quality of life of a population. Secondly, they discourage people from seeking treatment when they are suffering from an ailment, instead waiting to see if the illness gets better or worse before reaching into their pocket to shell out at least €40[3]. Not acting in a timely manner in relation to disease is a common reason for more serious complications to develop.

Given the low level of medical card entitlement in Ireland, it is not surprising that about 49% of the population purchase medical insurance each year from VHI, Vivas or Quinn Insurance (formerly BUPA). This costs between €119 and €143 per year for basic GP cover, between €360 and €422 for minimal hospital cover, and up to €1800 for specialist treatment. Despite funding the health system through the tax system, 49% of people are forced to pay these sums to access adequate care. Of course, this leaves approximately 21% of the population who are not entitled to the medical card and cannot afford health insurance. They must fork out €40 for each GP visit and €65 for every night they spend in a public hospital bed (if they can get one), not to mention the other fees accruing.

Accessing treatment in a public hospital as a public patient is usually a test of patience and endurance. Ireland has 4.85 beds per 1,000 of population while the EU average is 6.3. Ireland has 3 acute hospital beds per 1,000 while the EU average is 4.1. There is no common waiting list to access these beds. Consequently, public patients may wait years for treatments which private patients may receive within weeks in the same publicly funded hospital, irrespective of need. It is a rationing system based on ability to pay.

Ultimately, these forms of inequality and inaccessibility for those that need care in the Irish Healthcare System is caused by an unwillingness to invest.

Primary care has never been emphasised by any government in the history of the state in terms of funding for equipment, buildings or staffing levels. For this reason, the level of health education and preventative medicine being performed is chronically low. GPs routinely refer patients onwards for procedures which are within their competence and which they could perform in a well- equipped local surgery. As a result, a disproportionate amount of medical care takes place in hospitals, putting them under undue pressure.

Likewise, Irish hospitals have been historically massively underfunded, meaning that we have a lower bed ratio per head of population than any of the EU15 countries. The Minister for Health, Mary Harney, and her colleagues in the neo-liberal Progressive Democrats Party trumpet the fact that Ireland is now spending more per head of population than other OECD countries. However, this comes on the back of 30 years of neglect. Over the 27 years from 1970 to 1996, Ireland

[2] The figure for a married couple under 65 years is €266.50 per week although there are additional allowances for children in the family. All people over 70 years of age in Ireland receive a medical card.

[3] Further costs would be added where minor surgery or prescription drugs were required. Drug costs are capped at €85 per month per patient.

invested on average each year 63% of the EU average (capital expenditure). As recently as 1990, Ireland was investing 38% of the average. It obviously takes more than a few years to rectify this.

Systemic Problems

These barriers to access, and discrimination between patients, is exacerbated by the balance of power in the health system. Essentially, the Department of Finance has too much power. Furthermore, the contract agreed between the State on the one hand and consultants or GPs on the other gives too much power to the doctors.

General Practitioners

GPs are self-employed. Generally, they practice on their own premises (often a converted room or two in their house) and view their practice as a private company where they charge what they like. They tender to receive a list of patients covered by the medical card, for which they receive a "capitation", that is a set fee per patient depending on their age, gender and distance from the practice. This capitation is relatively low (approximately €120 per annum on average for people under 65) so they generally supplement this income through private practice. For this reason, GPs do not setup a practice in predominantly working-class areas with high rates of unemployment. These communities must go without a doctor and are forced either to travel to the nearest GP or to the nearest hospital.

Given that they receive far more money, proportionally, from private patients, given that they can charge per appointment and relative to the treatment given, they naturally have an incentive to focus their time and energy on their private patients. As they are self-employed and often exist as virtual monopolies, there are few incentives to expand their practice to include a larger range of services provided by a team of health workers using state-of-the-art equipment, something which would provide a holistic approach and optimal healthcare for patients.

In addition, in the GP contract there is no stated minimum level of service, no incentive towards maximal service, and no mention of preventative procedures. Quality of service can therefore not be expected.

Consultants

Consultants' current contract allows them to earn between €143,000 and €186,000 per year for being present in a public hospital for a mere 33 hours per week. During this time they are under no obligation to treat their public patients but can treat their private patients who happen to be in the same hospital.

Consultants do not provide the majority of care in public hospitals instead delegating it to Non-Consultant Hospital Doctors (NCHDs), also known as Junior Doctors. The consultants are the specialists with the training required; yet they do not provide it in many instances. Of course, consultants provide treatment in person for private patients.

Finally, the consultant contract is such that the work balance the consultant strikes between emergency/elective, private/public, and teaching/research is none of the hospital's business. Consultants are not accountable to anyone, either administratively or clinically.

Employment Cap

Since 2002 a cap has been placed by the Department of Health on further employment of health workers in many areas. As a replacement, hospitals have been hiring agency workers on temporary contracts. Instead of employing a health worker in a full-time position, including the benefits (pension, health insurance, etc.) that this entails, they take on temporary workers as they need them, paying a premium to the recruitment agency for the convenience. Given the need for more staff in all areas, and given the increase in the population in Ireland in recent years, this will cause greater and greater problems and means meaningful planning for the future is impossible.

Current Issues

Having described some of the more glaring institutional problems in the Irish Healthcare System, a brief examination of some of the current issues is illuminating in seeing where mistakes continue to be made and where the system may be heading.

The National Treatment Purchase Fund (NTPF)

This policy aimed at buying treatment for public patients from the private sector (either in Ireland or abroad) in order to cut waiting lists and waiting times. To a certain extent this narrow ambition has been achieved. However, this advance has come through an odd circularity in policy: private patients are given preferential treatment in public hospitals, and the public patients whom they displace may in turn be treated in private hospitals. This is neither an efficient use of public money nor an equitable way to treat patients. One particularly bizarre statistic is that 36% of all procedures carried out under the NTPF occurred in the same hospital the patient was referred from — that is to say that the consultant is getting paid an additional private fee to treat a patient s/he is supposed to be treating anyway!

Co-Location

Co-Location is the policy of giving tax-breaks to the private sector to build private hospitals on the land of public hospitals. Those behind this policy argue that it will create more (private) beds in the hospital system, freeing up beds in public hospitals.

This policy would be objectionable enough if it simply amounted to the giving away of public land and the waste of €500m on tax-breaks to the private sector. What makes it a more fundamental crossroads is that it will institutionalise two-tier care in the Irish Healthcare System. It is difficult to see how this system could be reversed or reformed if it goes ahead. Indeed, these private hospitals may well require a second-rate public health service to survive — depending on treating public patients that the State is paying these private operators to treat under the National Treatment Purchase Fund.

Furthermore, private hospitals cannot offer a complete acute care service since they concentrate on elective surgery in less complex and more profitable areas and simply do not deal with chronic illness. For that reason, co-located private hospitals will not free up private beds in public hospitals for public use on anything like a one-for-one basis. In fact, there will be a net increase in private beds, for which taxpayers will pay through tax breaks for private hospitals.

Although this policy was initially opposed by many hospital boards and by the Green Party, it appears inevitable that this policy will be implemented with their consent.

Consultants' New Contract

In some ways, the introduction of a new consultants' contract is an attempt at much needed reform. Firstly, it brings back the public-only contract, whereby consultants may only treat public patients. Secondly, it starts the process of doubling the number of consultants in the Irish healthcare system, something which has been recommended for a long time[4]. Thirdly, consultants would be expected to work in teams around the clock reducing current reliance on NCHDs.

Of course, considering the fact that the contract is upsetting the status quo, the vested interests of the consultants have been given some serious sweeteners in order to get them to accept the deal. Currently, hospital consultants are paid between €143,738 and €186,922 every year. The new deal offers a new salary of up to €240,000 — an enormous salary for a mere 31 hours a week of public hospital work. Such a salary would seem sufficient. However, the consultants have carried out industrial action and have refused to cooperate with the hiring of new consultants.

Finally, increasing consultant numbers at this salary level will be a huge drain on public finances. It is estimated that if consultant numbers were to be doubled at the proposed salary levels that it would consume one eighth of the entire health budget.

Congested Accident and Emergency Wards

The main cause of congested A+E wards is that old people and mentally ill people are forced to stay in A+E beds because there are no facilities to transfer them to. The government has been using tax-incentivised private nursing homes as the way to create some of this extra capacity. The reason that it is such an issue in the media, in comparison to other problems in the health service, is that it is the only place where private patients must wait in line with public patients and experience the long delays and low standards of care.

Short-Term Solutions

What follows are the most important reforms that could be carried out in the next 5 years:

1. The income thresholds for eligibility for the medical card should be increased so that 40% of the population are in receipt of one and this threshold should be indexed to the average industrial wage.

2. There should be a common waiting list in all hospitals so that treatment is provided according to need rather than ability to pay.

3. More students need to graduate in many areas — doctors of all types, children's nurses, dieticians, chiropodists, radiographers and radiation therapists. Funding for the creation of places on these courses should be provided.

[4] Of course, doubling the number of consultants is ineffectual if the requisite numbers of nurses and administrative staff are not there to support the expanded capacity.

4. There needs to be massive investment in the creation of capacity in public hospitals, and in nursing homes and community care to free up space in A+E wards.

5. The GP contract should be re-examined so that they become public sector employees, paid a set salary, with incentives to work in deprived areas. A minimum level of service should be stipulated, incentives for a maximum level of service should be provided, together with an emphasis on preventative medicine.

Medium-Term Solutions

Further reforms that may take up to ten years to achieve would be:

1. Medical card provision should be expanded to the entire population, providing a universal healthcare system, free at the point of access, to encourage preventative medicine.

2. Private practice should cease in public hospitals.

3. The number of patients per GP should fall under the 1,000 threshold to improve access for patients and improve the doctor/patient relationship.

4. Waiting lists should be phased out by moving towards a booking system as they have in France. There, all surgery is planned under a booking system in which the patient is given a date for surgery immediately it is prescribed, although this may involve a few months wait.

5. A modern primary care system, with GPs, practice nurses, public health nurses, physiotherapists, social workers and others working in teams from modern, well-equipped, computerised primary care centres in every community and large urban neighbourhood.

Funding

How such reforms would be funded is an important question.

The existing Irish tax-funded system could be reformed overnight in a Bevan-type manner[5] by introducing free primary care in which the state would pay GPs by salary, and by banning private practice in public hospitals and investing in public care so that the majority would opt to be treated in one-tier public hospitals by salaried consultants. This would be similar to the system in the UK or Denmark. The health insurers would revert to insuring a much smaller proportion of the population for elective care in the small number of private hospitals. Provided the state invested sufficiently in the public system, private medicine would lose its appeal. However, if the state did not invest sufficiently in the public system, there would remain a risk that patients and doctors would take flight into the private system and the chasm in Irish healthcare would deepen.

And that is the fundamental question. As tempting as it is to simply say, "Tax the rich", how do we guarantee future funding of the health service? How do we lock in future governments into

[5] Aneurin Bevan was a Welsh Labour politician. He was the Secretary of State responsible for the formation of the National Health Service.

such a system and prevent them running down the American privatised route? No one really wants to have to run campaigns to defend the health service every time a right wing government is voted in.

Universal Health Insurance (UHI) is an idea bandied about by diverse groups of people – Labour, Fine Gael, economists, etc. all of which have diverse ideas about how it would be implemented. In this system every citizen is obliged to be insured for their health care needs. It is a compulsory as opposed to a voluntary health insurance system.

The state may pay these premiums directly, funding them from the central exchequer, or individuals may pay their own premiums, with the state paying for those on lower incomes. A third option, the system in France and Germany, is that the individual is insured through PRSI with both employers and employees contributing through payroll taxes. The state picks up the tab for those who are not in employment or on low wages. This is a progressive route since contributions are proportionate to income and corporations are obliged to support health care as part of the social security system.

A carefully designed universal health insurance system could deliver equity and a relatively dependable flow of funding. It can be seen as an earmarked, ring-fenced form of taxation. Consequently, society would perceive the cost of its health care preferences more transparently and could debate cost/benefit trade-offs more openly.

If each citizen is insured to receive the same medical care and hospitals and doctors have no incentive to discriminate between them, then this is an equitable system. It would end the distinction between private and public patients.

If everyone is covered by a premium then the fund for health care should rise as costs rise and in line with population growth. Health care funding should no longer be subject to the whims of the Department of Finance. These universal insurance-funded systems have consistently allocated a much higher proportion of national income and a higher per capita spend to health care than the UK's universal but tax-funded NHS.

However, it is important that the such a system is not open to private insurers. Free market competition drives up costs. In the US where 13% of national income goes to health care, it has been calculated that the profits of insurance companies and medical care organisations account for one to two percentage points, one to two per cent that is of the entire income of the United States. Every television advertisement increases health care costs.

In conclusion, therefore, progressive funding options are available, provided they stick to certain principles. These funding options can introduce equity into the healthcare system and provide certain guarantees of funding into the future.

The Failure to Reform and the Road Forward

So how do we win these reforms? How do we guarantee that the health system is funded in a progressive and redistributive manner?

"The political system is one of the barriers to reform, if not the major one". This quotation rings true. No government in the history of the Irish state has attempted genuine reform of the health service in order to create equality of access. In earlier times, the pressure of the church, who saw any sort of equivalent to the NHS in the UK as a stepping stone to "atheistic communism",

prevented governments taking such steps. Noel Browne, and the 'Mother and Child Scheme'[6] was about as close as Ireland has got to moving towards a universal health system. Since then, government after government have been unwilling to invest in public healthcare, taxing the rich in so doing, or to take on the vested interests of the consultants and GPs. This, unsurprisingly, despite the best "promises" of all political parties in Ireland.

The trade unions have likewise been found wanting. Despite having a report especially written to outline the problems in the health service and to suggest solutions, it put up no fight to secure reform in the recent corporatist "social partnership" talks.

Even popular campaigns, when they have existed, have either been overly parochial in concentrating on local services, or overly naïve in being satisfied with "lobbying" the government for change.

There have been a number of such campaigns over the past number of years. They have had local success, mobilizing 10,000 in Monaghan and with active groups in Roscommon, Clare and Tipperary. Given the anger of ordinary people, this level of activity, even with small-scale organising, would suggest that more could be done.

Unfortunately, these groups have not broadened their horizons from their own local issues, to form a national campaign for genuine reform. When they have involved themselves on a national level, it has been through weak "lobby groups" such as the Public Health Alliance or Patients Together. Invariably, once an election is called they pin their hopes to a politician and vote for him/her, hoping s/he will deliver the reform they seek.

A number of such politicians, such as Paudge Connolly and Gerry Cowley were elected to the Dail in 2002. This was inevitably a dead end. Two or three independent TDs were never going to be able to demand genuine reform even if, in the unlikely event, they were chosen to support the government. Instead, the result was that it subdued the local campaigns into inaction. Putting faith in electing someone as the solution to the problem succeeded in killing the local campaigns, or at least putting them into a coma.

Given the anger of ordinary people when it comes to the Irish health system, given the fact that parliamentary politics and trade unions have been historically useless at bringing about reform for an equal and accessible system, and given the fact that some of these reforms are fundamentally simple and easy to argue for, it would seem obvious that the only way and the easiest way to win them is on the streets, in communities and in workplaces – in a truly popular campaign. It would seem that there definitely exists a role for anarchists to try and help bring these scattered campaigns together to win the reforms that politicians are unwilling to give. This campaign could be popular and effective if organized well.

A Post-Revolutionary Health System

But how would anarchists like to see healthcare provided? Some of the elements of a post-revolutionary health system seem more obvious than others. It would be universal and free at the point of access. There would be an emphasis on primary care – on health education and

[6] Noel Browne introduced the 'Mother and Child Scheme' in 1950. It proposed introducing a scheme which would provide free maternity care for all mothers and free healthcare for all children up to the age of sixteen, regardless of income. It was vigorously opposed and defeated by the Catholic Church.

preventative medicine. These primary care clinics would be owned, run by and accountable to local communities. Health workers would be no different to other workers, despite their training.

During the Spanish Revolution, for the first time many workers had the benefit of a health service — organised by the CNT Federation of Health Workers. The Federation consisted of 40,000 health workers — nurses, doctors, administrators and orderlies. The major success was in Catalonia where it ensured that all of the 2.5 million inhabitants had adequate health care.

Not only were traditional services provided but victims of the Civil War were also treated. A programme of preventative medicine was also established based on local community health centres. At their 1937 Congress these workers developed a health plan for a future anarchist Spain which could have been implemented if the revolution had been successful.

A more long lasting experiment in healthcare, with many of the properties anarchists would aspire to is in Cuba.

The health of Cubans is comparable to those of richer countries with long life expectancies. This, despite the fact that Cuba is far poorer and less able to buy equipment and medicines due to the US trade embargo. Its annual total health spend per head comes in at $251, one tenth of that of the UK.

How have they done this? There are a number of important points:

1. Cuba has an average of one GP per 435 people. This is literally a doctor in every large city block/factory/school. The average in Ireland is approximately 1,666. This is important because having enough trained health workers and having curative activities under control is one of the first things that needs to be tackled — before a more sustainable preventative system can come into full swing. It also allows a closer doctor/patient relationship to develop which means people are more likely to come in for check-ups and actively take part in learning about their health.

2. The system is, naturally enough, universal and free at the point of access so there are no barriers to receiving information and preventative check-ups for Cubans.

3. It is claimed that the community has ownership of a local clinic in terms of building it, funding it, making decisions, accountability to local assembly, etc. More accurate information would be useful in seeing how this plays out under the authoritarian nature of the Cuban state.

Of course, that's not to say that Cuba has got it all right or even did so in the first place. Up until the 1980's the system was still hospital centred, without sufficient integration of preventative and curative services, and with uneven, incomplete decentralisation. But since then it's moved to a primary care focused system which appears to be working well given the difficulties it is under.

The position of the doctor in the community is exemplified in the following quote:

> "The family physician must be accepted into an already organised community with its networks, formal and informal organizational structures. For this to happen, the physician must "blend in". In order not to risk the imposition of medical and class views upon non-medical issues in the community, the physician must not be a special member of society (however separated from the rest by training, but another worker, from the same class extraction as the rest of the community). It is now that

> a generation of physicians has emerged which was born, raised and educated within the Revolution and relatively free of the socializing trappings of capitalist medical education. A majority of today's physicians are children of peasants and workers, not the traditional children and grandchildren of doctors."

It is analogous to the contrast made with the postperson in western capitalist society. The postperson is paid a specified wage and trusted to deliver every letter in his/her area every day. This is not the case for the doctor. S/he must be given a sweetener, in the form of a fee, for every patient s/he sees. What is that is so different between postpeople and doctors. The same unjustifiable inequalities that exist in terms of access to treatment are repeated in the manner in which workers get paid. Such is the inconsistency at the heart of the Irish healthcare, a reflection of our capitalist system.

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