

HEALTH, EQUITY AND THE SOCIAL WAGE

The Bill Doolin Memorial Lecture

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Introduction

The concept of the social wage is derived from the requirement for society to provide itself with certain public goods or services necessary for decent living. Amongst these education, health and welfare safety nets are most commonly accepted as being essentials to be provided by the state. They are also the big spending departments of Government and for this reason, and because people depend on them, they are seldom far from the centre of public discourse.

A unique feature of the Irish Social Partnership model over the twenty one years of its existence is its concern to link pay determination and the provision of public goods in a series of distributional settlements aimed at improving the quality of social justice. The extent to which this has been a successful blending is open to disputation. Nevertheless it cannot be contested that the social wage as well as the money wage has been at the core of the bargain in each case.

It follows that health care is a major concern of the social partners. Everyone relies upon it for themselves or their families at some stage of their lives. It accounts for one third of all public spending by the state and it employs 110,000 people, more or less. When times are difficult, as they are now, its the first port of call for retrenchment and that retrenchment when it happens is keenly felt.

Health is very political in every country including our own. One need only recall the failure of the first Clinton Administration to reform health care in the US. The controversy over the Mother and Child Scheme in 1957 is the best known example here. In more recent times our current Taoiseach described the Department of Health as ‘the political equivalent of Angola’.

About five years ago the then Minister for Health Micheál Martin requested Government approval for 5000 new hospital beds at a special cabinet meeting in Ballymascanlon. He was beaten up, metaphorically speaking, by the then Finance Minister, Charlie McGreevy, and the figure was reduced to 3500 – very few of which ever materialised.

There followed a period in which a significant number of reports on aspects of health were published and became controversial in their own right. The process culminated in the establishment of the HSE under Professor Drumm in 2004. Since its inception the HSE has experienced mixed fortunes. A series of scandals relating to the detection of

breast cancer has arguable contributed to an erosion of public confidence in the organisation. It turned out to be overly centralised in structure causing a rethink and some element of reversion to nine regional authorities which are scheduled to be in place by the end of this year.

Current Status of Health Care Delivery

The series of controversies concerning diagnosis and treatment of cancer, together with problems of bed availability convey an image of a health service in a permanent state of crisis.

The truth is though that the experience of most people is positive once they manage to access the system. But this explains a fundamental reality which separates public services from other parts of the economy; we ration public services. So this question of access is crucial to the value of the social wage and consequently of social justice.

As Ruth Barrington, former head of the Health Research Bureau, has pointed out there is a crucial link between ability to pay for marketed health services and free publicly provided, but rationed, health services. The cost by her analysis is 5000 premature deaths every year.

Money would also seem to be a factor in cancer survival rates according to a report published earlier this week by the National Cancer Registry (NCR). A review conducted over a four year period reveals that women treated for breast cancer in private hospitals had a significantly higher survival rate than women treated in public hospitals. This held true even in respect of hospitals designated as the state's eight cancer treatment centres.

The statistic also holds for men with prostate cancer where the five year relative survival rate was 92.1 per cent amount those treated at private hospitals and 82.9 per cent at other public hospitals.

Of course there are many socio-economic factors, including lifestyle, which may affect these statistics. But they are disturbing and highlight the need for national screening and protection programmes. That is why the decision to defer the universal cervical cancer vaccination programme for young women is so wrong. A programme of this nature could help to reduce the influence of socio-economic effects.

There is a wealth of data now available which links social class to health outcomes. The *Inequalities in Mortalities* report has shown that, for all causes of death, the mortality rate of the lower occupational class was 130 per cent higher than the rate of the highest. For infectious diseases and parasitic disease it was 370 per cent higher. For TB it was 36 per cent higher. The mortality rate caused by drug dependence was 590 per cent higher; for strokes, 150 per cent higher; disease of the respiratory system, 210 per cent higher...and so on. To his credit Vincent Browne has consistently sought to call attention to these facts in his *Irish Times* column.

The EU-SILC (2004) report is another source of reliable information which demonstrates a clear link between lower social class, lower educational qualifications, lower incomes and poor health. The findings indicate that:

- 85 per cent of the non-poor report good or very good health. Only 66 per cent of those experiencing income poverty report good or very good health;
- If the consistent poverty index is used the differences are even wider. Only 57 per cent of those living in consistent poverty have good or very good health. The figure for the rest of the population is 84 per cent;
- Differences are wider again if chronic illness is taken as a measure of health. 23 per cent of the general population report a chronic illness. 47 per cent of the consistently poor and 38 per cent of the income poor report a chronic illness.

Interestingly, The Combat Poverty Agency argues that differences in health status are not confined to groups in poverty. Those with the highest incomes, social class or education have the best health. Health declines uniformly as income, class and education decrease. For example:

- 11 per cent of men in the highest income decile have a chronic illness. The figure for men in the middle of the income range is 20 per cent. For men with the lowest income it is 42 per cent;
- 16 per cent of men in the higher professional and managerial class have a chronic illness. This rises to 27 per cent among men in the unskilled manual social class. The pattern is similar for women, although the class differential is even higher (14 per cent versus 34 per cent).

Based on research conducted in other countries Combat Poverty concludes that differentials in health begin from a young age. In Ireland, as elsewhere, babies of unskilled manual working class parents are lighter at birth than the children of professional and managerial parents.

Combat Poverty has published research material on health inequalities which is invaluable for anyone interested in evidence based policy making. It was short-sighted in my view, and a great pity, to abolish the agency.

Nevertheless, there is a developing literature around the issue of the social importance of health which makes it quite properly a major political issue. It is also a key focus of Social Partnership although conspicuous progress in reducing inequality and enhancing the social wage has proved elusive so far. I will now explore some reasons why this is so.

The Social Determinants of Health Inequalities

The evidence of health inequalities I have referred to confirms that the patterns of health in the population closely follow the pattern of social inequalities in terms of income, education, social class and poverty. The United Nations Human Development Index consistently finds Ireland to be one of the most unequal countries in the world. Moreover, health services can only intervene after health inequalities have formed elsewhere in society.

The European Union Survey of Incomes and Living Conditions in Ireland (EU-SILC) utilises two measures of poverty:

- The *at risk of poverty* rate i.e. the percentage of people who fall below an income threshold, set at 60 per cent of the national median income (also known as relative income poverty);
- *Consistent Poverty*, or the percentage of people who fall below the income threshold and are also deprived as a result of this income. Being deprived is defined as lacking at least one of eight household items such as a roast once a week or new, not second hand, clothes.

Latest statistics from the CSO, published this week, showed that overall 16 per cent of households in Ireland are at risk of poverty. This represents about 720,000 people. 5 per cent of people are in consistent poverty. This is a significant reduction over recent years but it still accounts for nearly 300,000 people living on low incomes and deprived of basic necessities because they could not afford them. Also, most of the reduction occurred in 2007 and this may be reversed by the deteriorating economic conditions.

High risk groups include the unemployed, those who are ill or disabled and members of lone parent households. This is what one would expect to find. What may be surprising, however, is a finding by NESF that 7 per cent of people with jobs are at risk of poverty.

For many years it was assumed that getting a job was the route out of poverty. What is clear now is that it is a necessary but not a sufficient condition to achieve that end. The emergence of a cohort of people – “The Working Poor” – is a manifestation of increasing exploitation. Increasingly too the minimum wage is becoming the default wage in many service industries. The evidence lies in the strident attacks on the minimum wage by organisations representing small and medium sized employers and legal challenges to the wage setting mechanisms of the Labour Court by the Hotels Federation and elements in the electrical contracting industry. More recently the Construction Industry Federation has rejected the new social partnership agreement. There is evidence too in the hyped political reaction to the wage enforcement activities of the National Employment Rights Authority (NERA).

Perhaps a slightly tangential piece of evidence is the Millward Brown survey of the reasons why people voted for or against the Lisbon Treaty. 42 per cent of those who

voted for the agreement were concerned about working conditions as were 55 per cent of those who voted against. Overall working conditions was the single most important factor that exercised people.

The interesting thing, though, is that all the focus of political concern seems to be about issues like whether Ireland retains its Commissioner. Personally I don't think whether we do or not amounts to a hill of beans. But I am suggesting that avoiding the issue of peoples' concerns about employment rights is a political decision and it is at the root of a much more profound philosophical issue which I will try to explain.

The Political Determinants of Health Policy

It is at the core of public policy that Ireland ostensibly follows the model of a Developmental Welfare state. There is at least a stateable case to the contrary; that Ireland could more accurately be described as a 'Competition State'.

A Developmental Welfare State is one based on a trilateral bargain regarding the economy and society between Government, labour and capital (and perhaps other civil society actors). A Competition State privileges the interest of capital and investment over those of its own citizens.

The bottom line is that the competition state is a political construct derived from a liberal, free market paradigm. Just as the competition state makes no pretence at reducing inequality in society so the health system which serves it eschews equality.

In fairness the Irish healthcare system was always a hybrid based on a public/private mix. It is not that the current policy direction is moving away from the ideal. It is not, but the policy being followed will attenuate the inequality inherent in the system.

The principal manifestation of this is co-location, a euphemism for significantly altering the balance within the hybrid further in the direction of private health care. In my opinion co-location is an ideologically motivated policy based on free market liberalism. If it proceeds it will have the following consequences in my view:

- It will alter the balance within the hybrid model of health service delivery in a way that will push the middle classes out of the public hospitals. The middle class are the people in any society with political power. If they leave it the public hospital will become less important in the system and more vulnerable to resource rationing;
- If private care is moved out of the public system and provided on a real cost basis it will push up the cost of health insurance.
- The collapse of the Community Rating/Risk Equalisation model has already pushed up the cost for older people. When associated with the collapse of occupational pensions it is inevitable that most older people will not be able to

afford health insurance. Apart from the injustice of people paying health insurance all their lives, and not being able to afford it when they most need it, the very economics of this situation undermines the viability of the co-location project. The burden of these formerly insured people coming back into the public system will place huge pressures on the capacity of the public system.

- Financing co-location with tax incentives is a waste of payers' money which would be better spent in the state providing hospital capacity directly.

Ironically the crisis in the banking system may undermine co-location because banks may be more risk averse towards such projects.

It is worth mentioning too that it was the liberal, free market, preoccupation with liberalisation of health insurance that gave rise to the shambles in which the Community Rating/Risk Equalisation model has failed.

In summary, we can clearly see that the political determinants of health policy have been shaped up by the political ideology of free market liberalism. That that model has failed in Ireland is also clear. However, it remains the guiding force in health policy even as the party mostly, but not exclusively, associated with it leaves the political stage.

So, how is it possible to move forward?

Challenges Facing the Health Service

It seems to me that the most immediate challenge facing the health service is how to survive the €400 million budget cuts. It is hard to see how this level of cost reduction can be achieved without having an impact on service.

Secondly, it is to be hoped that the regionalisation proposal for the HSE can be implemented in a way that makes the organisation more effective and responsive to patients' needs.

The establishment of a functioning primary care infrastructure and an infrastructure of care for older people are also priorities as is the integration of all services into a seamless whole.

This takes me to the question of reform. Just like the Israeli-Palestinian question everybody knows the shape of the final settlement in health. But equally like the Middle East question people are less sure of how to get to the end game.

The restructuring of the hospital system with a consultant delivered health service, with a changed role for non-consulting doctors, more responsibilities for nurses and greater numbers of care assistants – all more in line with the continental model – is the end objective.

Finding a path to that destination, while keeping everybody on board, is the challenge. For two years my colleague, Peter McLoone and I, have been promoting the idea of a Health Forum to work out this puzzle. Political support and HSE support for the idea has been lukewarm but now at least the concept is built into the new social partnership agreement.

A complication which is obvious is the difficulty in practical and industrial relations terms of moving forward on a reform agenda while simultaneously trying to make €400m of resource cuts. But it has to be done. My own view is that the best antidote to politically motivated attacks on the public service is to make it as efficient as effective as possible so that the public will see it as part of their social wage and brook no interference with it.

In all the controversy about public services in recent months one can see that the real issue is the health service. No other public service reform, however far reaching and innovative, will make any impression on public opinion unless the issues in health are resolved.

Finally the key to the long term sustainability of health funding, in my opinion, lies in a state managed insurance model. I say this in the context of the market failures associated with the private insurance model and the social policy objectives of Community Rating and Risk Equalisation. Likewise I believe that relying on co-location to increase capacity in the public system, against this background, will also fail. Co-location must be abandoned.

But the most important thing of all is to admit that the world has changed.

For the last twenty five years we have been told that the phenomenon of globalisation, and the financial system which underpins it, are unalterable. Free markets are possessed of an inherent and irresistible logic with which the state must not interfere. Economists, politicians, academics, commentators and business people of the neo-liberal school have foreclosed all debate about the subject asserting that 'There is no other way'.

The onset of the global financial crisis and the election of Barack Obama have given rise to comparisons with the Presidency of FDR and the New Deal. Friedrich Hayek, widely recognised as the progenitor of neo-liberalism, published his most famous book *The Road to Serfdom* in 1944. By coincidence a Hungarian socialist, Karl Polanyi, published *The Great Transformation* in the same year. While Polanyi's work celebrated the New Deal in the United States precisely because it placed limits on the influence of market forces, Hayek's book insisted that the New Deal was the road to perdition. Hayek went on to be a tireless advocate of market liberalism in Britain and the US. He inspired such influential followers as Milton Friedman and was responsible for the policies of deregulation, liberalisation and privatisation pursued by Margaret Thatcher and Ronald Reagan. In time they deconstructed the last vestiges of the New Deal leaving us with the catastrophe we have today.

Polanyi's great attraction for me lies in his concern to advance freedom and social justice. He believes that allowing the market to control the economic system was a fundamental error because it means no less than the running of society as an adjunct to the market. Instead of economy being embedded in social relations, social relations are then embedded in the economic system.

The problem we have to transcend is that many intelligent people who think of themselves as rational and urbane have put their faith in the idea of self-regulating markets as piously as others put their trust in God. Now that this God has failed perhaps people will have the freedom to see things more clearly again, and to reclaim responsibility for their own lives and begin organising the future in its more promising terms.

We face enormous social policy challenges in the years ahead. Pension provision, childcare, care of the elderly and proper funding of health care are all going to press down upon us. Whatever happens our existing approach to these questions is not viable and will have to change. Neither will the free market liberal paradigm of the last thirty years be recreated when the waters of the recession subside.

Something very big is happening. What started out as a series of pragmatic ad hoc responses by Governments and Central Banks is moving the boundary between states and markets. We are watching a bonfire of the old orthodoxies as well as of the vanities.

My proposition to you today is that we have to go back to the drawing board on health policy. We have to admit to ourselves that values do matter. Constructing a model of health care in which every citizen is treated on the basis of need is not beyond our capability. This is what the concept of the social wage is about – the availability of public goods and services necessary for decent living to all.

For advocacy to be persuasive it cannot deny the material facts of the situation it seeks to address. Given the debilitated state of our public finances how can we hope to advance a progressive agenda on health?

If President elect Obama was asked this question I know the answer he would give....Yes we can!

And he would be right because this is really a question of choices and values. We are still a wealthy nation. It is a matter of what we hold to be important and how we choose to distribute our Gross National Product.

I will conclude with a quote from another American who gave people hope in a better life but who never made it to the White House.

In 1968 a short time before he was assassinated, Robert Kennedy, made a powerful speech at the University of Kansas. In the course of it he said this:

“Even if we act to erase material poverty, there is another great task. It is to confront the poverty of satisfaction – a lack of purpose and dignity – that inflicts us all. Too much and for too long, we seem to have surrendered community excellence and community values in the mere accumulation of material things.... The gross national product does not allow for the health of our children, the quality of their education, or the joy of their play. It does not include the beauty of our poetry or the strength of our marriages; the intelligence of our public debate or the integrity of our public officials. It measures neither our wit nor our courage; neither our wisdom nor our learning; neither our compassion nor our devotion to our country; it measures everything, in short, except that which makes life worthwhile”.