Economic Crisis: Austerity and Privatisation in Healthcare in Ireland

Peadar O'Grady

Although the financial sector of an economy may be principally responsible for risk-taking related to the present economic crisis, the true costs of this risk-taking behaviour are to society as a whole[1].

Economic Crisis and Health

Economic crises are rooted in the fact that, in a capitalist economy, goods and services are bought and sold for profit as 'commodities'. This means that 'exchange value' leading to profit is considered more important than 'use value' serving human needs. Failure to maintain profit rates leads to speculation and inevitably to a crash when prices fall. Instead of addressing the underlying failure of the economy to meet human needs the response of the rich and powerful is to withdraw investment and scramble to restore profits by cutting jobs and wages and by pressuring governments to bail them out using state debt paid for by 'Austerity' programmes of cuts in pay, welfare and public services. These cuts in income and services have a devastating effect on the health of the population. However, the success of this response by capitalists depends very much on the level of organised resistance in each country.

What has been shocking in the current economic crisis has been both the scale of the slump with massive lay-offs and pay cuts but also the largely slavish obedience of trade unions and social-democratic governments to agree and impose austerity budgets. In Greece, the first EU country to be hit, despite some heroic popular opposition, the effects of austerity have been devastating. Unemployment rose from 6.6 percent in May 2008 to 16.6 percent in May 2011 (and rose from 18.6 percent to 40.1 percent in young adults). The Irish Labour Party's sister organisation 'Pasok' in government imposed a brutal IMF austerity package of public service cuts including a 40 per cent cut in hospital budgets. A Lancet study[2] reported staff and medical supply shortages meant a significant increase in people not going to the doctor when sick and doctors being bribed to jump queues in public hospitals. Public admissions increased by 24 percent in 2010 while there was a 30 percent decrease in admissions to private hospitals. People reporting 'bad' or 'very bad' health in surveys increased. There was a 17 percent rise in suicide in 2009 and 25 percent in 2010 and 40 percent in the first half of 2011 with suicide helplines reporting stress from debt as the commonest complaint. HIV infection rates rose 52 per cent in 2011 mainly due to an increase in intravenous drug-use and prostitution.

In Ireland unemployment has increased from an average of 4.5 percent between 2000 and 2007 to 14.4 percent in 2011[3] . Suicide rates increased by 24 percent in 2009 to a record high of 527. Geoff Day, Director of the National Office for Suicide Prevention said:

> 'The impact of the economic downturn in 2008, and partic-

[1] Stuckler et al 2009, p322

[2] Anne Kentikelenis et al, 2011

[3] ESRI, 2012

ularly in 2009, has led to substantial increases in both self harm and suicide numbers[4].'

The suicide rate is three times higher for men than women, which may reflect the long-term tendency of men to under-report mental health problems and use alcohol or drugs instead of seeking help and a short-term trend of high rates of job losses in the construction industry. While the suicide rate fell in 2010 by 8 percent to 486 it was still high and its fall may well reflect the high rates of emigration in young men who are particularly at risk. Statistics for suicide rates in Ireland and Greece have been criticised in the past for underestimating the true rates. Statistics in Ireland do not include 'undetermined' causes of death which they do in Northern Ireland making it difficult to make comparisons.

In the short term, sharp rises in unemployment are associated with suicide and alcohol-related deaths while cuts in health services reduce access to care when it is most needed. Government social spending on jobs and welfare benefits for the unemployed has been shown to reduce the increase in suicides associated with the rise in unemployment seen in recessions[5]. However, instead of increasing funding to services in a time of crisis governments can use the crisis to push through cuts and privatisations as emergency measures no matter how counterproductive the effects.

Shock Doctrine: 'Universal' Health Insurance

In a 2008 article in *The Guardian*, Naomi Klein (Author of *The Shock Doctrine*) explains how those opposed to the welfare state 'never waste a good crisis' as they smoothly move from bail-outs to austerity cuts and privatisation of public services:

> 'The massive debts the public is accumulating to bail out the speculators will then become part of a global budget crisis that will be the rationalisation for deep cuts to social programmes, and for a renewed push to privatise what is left of the public sector[6].'

Privatisation or 'marketisation' of public services like healthcare, education or energy, means more buying and selling of these services for profit. Privatisation can involve a range of government policy measures to run down the public service and promote the private, for-profit sector. These policies include the separation of purchaser and provider, competition, contracting-out, hospital trusts, user fees, PPPs and private health insurance, even though all of these policies involve higher costs rather than 'efficiencies'[7]. In for-profit services, profits eat up 5-10 percent of funding but also increase administration costs (billing, marketing, accounting and legal fees etc), and executive salaries and bonuses. This makes the health service in the US (the most privatised healthcare system in the world), 'so inefficient and expensive to administer that as little as 50-60 per cent of each dollar paid in insurance premiums finds its way to frontline health providers[8].'

In the US about twice as much is reportedly spent on healthcare as comparable EU countries (18 percent of GDP versus 9 percent) with poor international rat-

[4]HSE, 2009
[5]David Stuckler et al, p322
[6]Naomi Klein, 2008
[7]John Lister, 2005, p17
[8]S. Woolhandler et al, 2003

ings for effectiveness. This is clearly because only about half of this spending is going on healthcare; the rest is eaten up by profits and bureaucracy. If costs go up in a privatised system when the argument is supposed to be 'cost-cutting' or 'efficiency' there is obviously a different motive. The answer is in the term 'for-profit'; the policies are for profit to be increased and have nothing to do with costs or efficiency. Under-funding the public health service is a double reward for capitalist investors: profits go up with lower labour costs as taxes are cut but also a source of profit in trading healthcare services is opened up further.

Running down public healthcare can take many guises. In the past decade, small public hospitals such as Monaghan, Loughlinstown, Roscommon, Ennis and Nenagh were targeted as 'too small' while equally small private hospitals like the Galway Clinic were opened up and there are plans to build a private hospital in Ennis. Where threats of closure have met resistance in these cases, a slow death is ensured by the government restricting or closing Emergency Departments as well as surgical and other services. Since 2007 the economic crisis has been used to put an embargo on employing staff in the public service, including the health service, with the assistance of trade union leaders in the Croke Park Agreement of 2010; and continued by the Labour Party in government. This has resulted in a dramatic fall in staffing in services funded by the Health Service Executive (HSE): from 111,000 in 2008 to 105,000 in 2011 and to 101,000 by the middle of 2012. The HSE plans to cut staff further to 98,000 in 2012. This has resulted in ward closures (on top of already very low bed capacity) and service reductions. Despite claims by health minister James Reilly that the waiting lists were being reduced the reality is that the numbers waiting for hospital treatment increased by 24 percent between 2011 and 2012[9]. In 2012 the HSE is also engaged in a systematic closure of 500 beds in public Nursing Homes, accelerating the increasing dominance of owners of private for-profit nursing homes. The double reward of these policies of underfunding the public service is now obvious: the embargo makes more staff available and bed closures make more patients available to the private 'for-profit' sector.

'FairCare'

Fine Gael's *FairCare*[10] health service policy is the other side of government plans to privatise healthcare. Central to *FairCare* is the introduction of 'Universal Health Insurance' by 2016. UHI is a mandatory health insurance system supposedly along the lines of the recently-introduced system in the Netherlands of regulated competition in Health insurance. This model is a combination of the Mandatory Health Insurance system introduced in Massachusetts and the 'regulated competition' model of economist Alain Enthoven[11] ; certainly closer to Boston than Berlin. In the US context it is arguably a progressive step to reign in the market madness of unregulated private health insurance and extend coverage but, obviously, taking out the profiteers would be far better. In Europe however, introducing 'managed competition' is a way of getting the for-profit insurers more involved, a backward step.

UHI was recommended by a report in 2009, *FairCare*, which was produced

[9]Susan Mitchell, 2012

[10]Fine Gael, 2011

[11]Pauline Vaillancourt Rosenau and Christiaan J. Lako, 2008, pp1031-32

by a Fine Gael commission chaired by Alan Dukes (now Chairman of Anglo-Irish Bank/IBRC) and influenced by right-wing european 'think-tanks'. The report used a high ranking for the Dutch Health service based on the 'Euro Health Consumer Index' which is produced by a right-wing Swedish think-tank the 'Health Consumer Powerhouse' which lobbies for privatisation of health services[12]. However, a study, in partnership with the World Health Organisation and the Dutch Government, in 2010, reported that in terms of 'quality and efficiency of health services', compared to other wealthy countries, the Netherlands was just an 'average performer'[13].

Here is a useful summary of the new Dutch system:

> 'On 1 January 2006, a major reform of the Dutch health insurance system came into effect. The former system, a combination of a statutory sickness fund scheme for the majority of the population and private health insurance for the rest, was replaced with a single universal scheme. The extension of market competition is one of the key features of the new health insurance system. Health insurers, which may operate on a for-profit basis, are required to compete on premiums, types of health plan and service levels. Consumers are free to choose any health insurer and type of health plan (for example, with or without deductibles, with or without preferred provider networks) and are able to change to an alternative insurer or plan once a year. All legal residents of the Netherlands are obliged to purchase a basic health plan, but are free to purchase a complementary voluntary plan covering additional health services such as physiotherapy, dental care for adults, psychotherapy and various forms of preventive care (there is an enormous variety of complementary plans)[14].'

Fine Gael have claimed that a process of paying for health services based on the volume of care provided, a so-called 'Money Follows the Patient' (MFP) would save money and improve services to patients. However a World Bank study found that these sort of insurance-style separations between 'purchaser' and 'provider' increase administration costs and paperwork[15]. Since MFP was introduced in the Netherlands in 2000 the cost of hospital care in Netherlands has doubled. There are more than 30,000 different categories of treatment in the Dutch system. Indeed the Dutch experience is of rising costs (premiums increased by 100 in 2011) with no clear evidence of improved quality of care. There is also a perverse incentive to ignore preventive public health measures because falling rates of illness (and therefore opportunities for treatment) would reduce income for clinics and hospitals.

Before the change in 2006, the Dutch Health Service had built up a much higher level of infrastructure and standards of care than Ireland before it changed from a mix of mostly public health insurance and some private (mostly not-for-profit) to a system of 100 percent private compet-

[12]Dominic Haugh, 2011, pp9-11
[13]W Schfer et al, 2010
[14] Yvette Bartholome and Hans Maarse, 2006
[15]DW Dunlop and JM Martins (Eds), 1996

ing insurers who could operate on a for-profit basis. The trend now in the Netherlands is towards hospital mergers and profits. Instead of 'choice' increasing as a result of competition there are trends towards monopoly. There are 20 Health Insurers but now just four of them have 88 percent of the total number of insured[16]. Therefore, the Dutch 'Mandatory (mainly not-for-profit) Health Insurance' system is not static. As it tends more toward profit-making it will tend to move towards a 'Mandatory (for-profit) Health Insurance' system like in the US with the high-cost but low-level cover that it provides.

The most important argument against UHI is that it will increase costs in a not-for-profit system but it will further increase costs the more it becomes a for-profit system. The Dutch government proposal includes a plan to increase 'competition' in care as well as in insurance funding:

> 'The current market reform is not only intended to introduce regulated competition in health insurance, but also in the provision of care[17].'

but *FairCare* makes no mention of this. In general the more for-profit organisations are involved the greater the profit-related costs.

Fine Gael's plan may argue 'cost-cutting' or 'efficiency' or 'quality' but the evidence only supports a motive of supporting the greater involvement of for-profit business in healthcare, that is 'privatisation'. Of course any government austerity cuts in public funding would mean a crisis of profit versus care.

Here are some facts about the Dutch system[18] :

1. Current cost of UHI basic package for worker on the average industrial wage is €3,427 per year (premium of €1194 plus €2,233 wage deduction ie 6.9 percent to a ceiling of €2,233). An average Dutch household has an income of €53,000 and pays between €4,525 and €5,625 per year.
2. Dutch must pay €210 excess per year for claims.
3. 10 percent of funding is out-of-pocket for care not covered by insurance.
4. Since UHI was introduced in 2006 premia have risen by 41 percent.
5. Since 2006 Dutch GP's income has risen by €54,000 per year. Dutch consultants' income rose by 50 percent in 2008 alone.
6. 8 percent of Dutch people in a poll felt the service was better since UHI but 41 percent thought it was worse.

'Universal' services

The *FairCare* promise of 'Universal' provision sounds appealing. Public Health experts have argued that if public services, including healthcare, are not universal, that is, for everyone, then middle and higher income-earners are forced to consider private options as underfunding makes 'a service for the poor' become 'a poor service'*Richard Titmuss, 1958.*. In progressive tax systems the more you earn the higher a proportion of your income goes in tax. The Scandinavian model means higher taxes for middle and higher income earners in return for a comprehensive package of high-quality benefits including childcare, healthcare, social

[16]W Schfer et al, 2010, p31
[17]Hans Maarse, 2009, p8
[18]Dominic Haugh, 2011, p1

care and university education*Martin McKee and David Stuckler, 2011* as well as a less unequal, safer and more harmonious society[19] . Breaking with universal services means worse services at a higher cost to low and middle income earners and pressure to reduce taxes. This only suits the super-rich whose tax-cuts will mean they won't have to pay for services they would never use anyway. Strategies to undermine universal services are to demonise welfare recipients, undermine trade unions (higher welfare spending in countries with strong unions) and remove benefits from middle income earners by means-testing. *FairCare* only promises state funding of health insurance to the low paid and subsidies to those earning above an as-yet-unclear earning limit, that is, it will be means-tested. Crucially, the implications of policies like *FairCare* won't be seen for a number of years.

The World Health Organisation recommends three important features of 'Universal' provision: 'Breadth': Who is covered; 'Depth': What services are covered (Is it comprehensive?); and 'Height': What proportion of the costs is covered (Are there any out-of-pocket payments or extra insurance?)[20] . So it is important to also ask whether or not Universal Health Insurance is likely to provide 'comprehensive' care with no 'deductibles' (additional out-of-pocket expenses). Fine Gael promise: 'Under UHI every citizen will have health insurance from one of a number of competing insurance companies, which will provide equal access to a comprehensive range of hospital and medical services.' But how comprehensive this will be in practice may well be largely left up to the insurance companies themselves. In Netherlands the 'comprehensive' basic package does not include treatment services like psychotherapy, physiotherapy and dentistry and these require additional insurance or 'out-of-pocket' payments that not everyone can afford. According to *FairCare* regulation will be by government, the financial regulator and a new agency incorporating the current HIQA into a 'Patient Safety Authority'. With Ireland's recent history of regulatory failure, this is hardly a reassuring prospect. To date in the Netherlands, Health Insurance premiums are increasing, and insurance companies report large losses on the basic policies, public satisfaction is not high and perceived quality is down[21] . These insurance companies are already lobbying for a relaxation of regulation as 50 percent of hospitals face bankruptcy. Health lobbyists for giant Health Insurers, Hospital Management Organisations (HMOs) and Drug companies in the US have a stranglehold on the healthcare system and have stymied any progressive changes in recent decades[22] .

Also appealing in FairCare is the promise to: 'dismantle the dysfunctional Health Service Executive (HSE)and end the efforts of Fianna Fil and Mary Harney to privatise the health system by favouring private over public care[23]' and that: 'Once UHI is introduced, the unfair and inefficient two-tier health system in Ireland will disappear[24].' However the solutions suggested don't in any way match the problems. Firstly the HSE has come to be hated because it has removed lo-

[19]Richard Wilkinson and Kate Pickett, 2010
[20]World Health Organisation, 2008
[21]Pauline Vaillancourt Rosenau, Christiaan J. Lako, 2008, p1031
[22]David Stuckler et al 2010, p5
[23]FairCare, 2011, p3
[24]FairCare, 2011, p4

cal democratic control and accountability. It would be progress if it were replaced by a more democratically planned service. However, FairCare only envisions the ability of individuals to become members of Hospital Trusts with probably very limited representation on the board but no say whatever in the wider planning of local health services as a whole because the 'purchaser-provider split' will mean the Hospital trusts will be providers and not purchasers[25] .

Secondly the two-tier system in health is due to the existence of private fees in Hospitals and General Practice. All that is required for a one-tier service is to remove private fees in these settings. Abolishing consultants' private practice incomes and capping salaries at a comfortable €100,000, would, on its own, save over €0.5 billion a year. Tax breaks on medical insurance and medical fees costs the state €0.5 billion a year[26]. It does not require 5 years to do this but could be done immediately. As noted above, expanding access in a tax-funded public system involves very little extra administrative costs (averaging 4 percent) while a private insurance funded system involves massive extra costs (40-50 percent in the US). In the Netherlands, instead of getting rid of a two-tier system there is evidence of an emerging 3-tier system: those with additional insurance; those with just basic insurance; and a growing number of those with no insurance at all because they cannot afford it[27].

Plans to break up the HSE and to make hospitals 'autonomous' were initially listed by Fine Gael's *Faircare* not to commence until 2014 but these plans have now been brought forward. The HSE board was abolished and effectively taken into the Department of Health in 2011. In March 2012 health minister, James Reilly wrote to then secretary general Michael Scanlan directing him to create proposals for: 'The creation of hospital groups as quickly as possible this year'. Reilly goes on to outline the plan for these 'hospital groups' to have a single budget and the power to 're-deploy' staff and 'reconfigure' services between the hospitals in keeping with the 'Framework for Smaller Hospitals' criteria including 'safety', 'cost', and 'sustainability' and "give the larger hospital the authority to manage the entire group'[28]. This is a clear recipe for continuing the downgrading and closure of local hospitals in line with the unpopular Hanly report and under pressure of a single budget enforcing competition between local hospitals. Not-for-profit 'voluntary' hospitals would be included in these hospital groups but private 'for-profit' hospitals would not.

There Is No Alternative?

Of course a truly 'universal' health policy would address more than just health services. Good health depends on access to basics such as food and housing, and poverty is a well established cause of ill health. Poor quality, expensive food and housing is encouraged if it makes for better profits. In Ireland there is a 6-year difference in life-expectancy between the richest and poorest groups but this difference is not confined to the poorest but is evident from bottom to top, that is, there is a 'social gradient' in health. Risk of heart disease and diabetes is higher in low-paid workers and related not just to low income but to the degree of 'control' in their workplace. Recently it has been noted that the

[25]FairCare, 2011, p18
[26]Sara Burke and Sinad Pentony, 2011
[27]Dominic Haugh, 2011, p3
[28]Dominic Haugh, 2011, p3

greater the degree of inequality compared to other countries, the higher the rates of physical and mental health and a range of other social problems across the different income groups (though possibly not including the super-rich)[29] .

This means that reducing income inequality and improving the control of workers in their workplace should be crucial aspects of health policy. Inequality can be reduced by 'redistributive' policies of progressive taxation, cutting tax-breaks for the rich, raising wages, full employment and increasing spending on truly universal (non-means-tested) health services and social protection such as welfare and pensions. Progressive taxation means increased taxes for the rich, getting rid of 'regressive' taxes like the so-called 'universal' social charge and indirect taxes and charges like the Household charge. Regressive budgets in the last three years have disproportionally hit low income households and widened inequality[30]. In 2009 the richest fifth of the population had 4.3 times more income than the poorest fifth, but this increased to 5.5 times in 2010, while deprivation levels increased from 17.1 percent in 2009 to 22.5 percent of the population in 2010[31]. Research has shown a direct relationship between social spending and health. For example, for each additional $100 of social spending per person, there is a 1.19 per cent reduction in deaths from all causes[32].

Public health researcher Vicente Navarro has shown that political parties with egalitarian ideologies have tended to implement redistributive policies and that reducing social inequalities improves such health indicators as infant mortality and life expectancy[33]. This is particularly true of wealthy countries with social-democratic (Labour-type) parties and strong unions. On the other hand, Christian Democratic (Fine Gael-type) parties have tended to promote restricted, means-tested social programmes[34]. This should mean supporting Labour-type parties but, the researchers note that these parties' tendency towards redistributive policies is being broken as 'during the last 30 years, many countries governed by social-democratic parties have implemented neoliberal policies'. From the UK Labour Party to Greece's PASOK to the Irish Labour Party have turned to 'market-style' neoliberal policies. The Labour Party in power in the last 18 months has led the charge in cuts to Social welfare (Burton), Education (Quinn) and public service staffing (Howlin) while supporting privatisation in health (Lynch and Shorthall) and state assets (Rabitte).

Labour have tacitly supported a health policy of privatisation couched in a language of 'universal' benefits and opposition to private provision but ignored the drive towards introducing for-profit financing and care and the vicious cuts in staff and beds in the public health service. The punishment of Pasok in Greece and the victory of the Left Coalition there is a warning to Labour but a challenge to the Left in Ireland to build with this movement against austerity and privatisation. While Sinn Féin talks of opposition to austerity in the Dáil, they cannot be trusted as they are imposing austerity in the North of Ireland.

The real alternative to market-style so-

[29]Richard Wilkinson and Kate Pickett, 2010
[30]Sara Burke and Sinad Pentony, 2011, pvi
[31]CSO, 2010
[32]David Stuckler et al, 2010
[33]Vicente Navarro et al, 2006, p1033.
[34]Vicente Navarro et al, 2006, p1036

lutions to problems of access, quality and cost of services is based on the principles of a National Health Service as recently outlined in the People Before Profit health policy:

> A National Health Service that is universal, comprehensive, democratically planned, funded by progressive taxation and free at the point of use[35].

Historically, progressive changes in health services have come about in countries with a strong union movement and a strong Left backed by mobilisations of support in the community and workplaces. Resistance to closures of hospitals and nursing homes combined with protests against austerity measures such as welfare cuts, the universal social charge, the household charge and water charges need to combine with the building of strong left-wing forces if we are to win progressive changes in taxation and social spending to build an alternative to the neoliberal Labour Party policies of bail-out, austerity and privatisation. A more radical transformation to the sort of socialist society that James Connolly had in mind, where goods and services are produced for need and not greed, can only be built by such a movement. We have a world to win.

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[35] People Before Profit Alliance, 2011

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