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‘Your Wealth is your Health’: A Study of the Commodification of Health Services in Ireland

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Abstract

The commodification of health care is gathering in momentum in Ireland. Arguably, this is transforming the status of health as an inherent right for all people, to a market based commodity that is subject to cost and profiteering. This article conceptualises health as a commodity examining its implications for the provision of quality hospital services for both public and private patients. Health inequalities are prevalent in contemporary Ireland. The role of health commodification in creating these health inequalities is examined through a critical review of the literature and an original qualitative study. The research highlighted issues surrounding the access and the treatment of public and private patients in hospitals, as an illustrative example of how commodification is impacting on health service provision in Ireland. The research examined the primary issues relating to health as a right and a commodity by adopting an interpretivist perspective; using a sample of front line hospital workers. It explored whether health as a commodity is creating further social divide by promoting differential treatment based on a patient’s ability to pay. The role of policy makers has

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been assessed in order to hypothesise about the future of health services in Ireland. Ultimately the research considered how health commodification is affecting the right to equal health services.

Key Words: Commodification; Health; Two-Tier; Consumer; Access; Treatment; Private; Public

Introduction

This article explores the increasing prevalence of the commodification of health services in Ireland, specifically with respect to the two-tier hospital system. It attempts to investigate the extent to which health care, as a social right, is being diluted by a more consumer based ethos. The concept of health as a market commodity is explored in this article. The impact of health commodification in the Irish context is also assessed. The insight of medical professionals has been used to investigate how commodification affects the appropriation of health care within hospital services, with a particular focus on equality of access and treatment for hospital patients. A qualitative insight into issues such as: privatisation, the public/private status of patients, the two-tier health system, co-location, equality of access and treatment, was central to the study. The research attempted to ascertain how health commodification is affecting the hospital system and whether government policy adheres to a rights or a consumer ethos in promoting health services.

Theoretical Perspective

Health: the commodity and the consumer

Baudrillard (1998) identified the body as the finest consumer object, which has become an entity of salvation in consumer societies. The commodification of the body can be closely related to the consumer's desire to escape the insecurities and uncertainties that have plagued health service users in the past. There are many health commodities available such as: health insurance, specialised surgery, cosmetic surgery, health food products, health foods, health supplements, cleaning products, counselling services, alternative medicine and therapies, gym membership and other fitness related equipment and services. By promoting themselves on an ability to

enhance, protect or combat changing, aging and dying bodies, health markets contrive a type of consumer that is distinctive from other markets. Health investments are often associated with the comforting conviction that a product may potentially protect and enhance our health or longevity, representing a consumer desire to escape from the mortal uncertainties of the present and the future. The product often doesn't resolve a consumer's actual health problem. It is the reassurance of what the commodity signifies that they pursue (Baudrillard, 1998; Bauman, 2000).

Healthy lifestyles are becoming more definitively linked to consumerism; many new health and bio-medical markets emerging nationally and internationally. Bauman (2000) argues that these markets have transformed the health status of people who are well. People are increasingly becoming 'unhealthy' in light of new health products, which are promoted on the basis of need more than desire. These new needs are often a creation of the market itself. What was once considered to be a normal state of health is now more likely to become abnormal. Reconciling health and the fight against disease have become a fulltime tasks for every individual (Bauman, 2000). Additionally, according to the consumer character, 'needs' often require a display of value for money and a reassurance of correct decision making and prestige (Bauman, 2000). Arguably, the willingness to pay for health services is rooted in a belief that the individual cleverly paves their own destiny through admirable consumer choices rather than through state generosity (Bauman, 2000). The rising prevalence of these concepts in capitalist consumer culture is a testament to the changing condition of society and its relationship to health services. Health services are no longer allocated according to need but for profit.

A Problematic Market

The marriage of health and the consumer market has inspired controversial debate relating to health as a social right and health as a market product. Consumer culture is fundamentally linked to an ethos of difference, which is a dividing force in society (Baudrillard, 1998). Hence, health as a commodity is set to create division between people, based on income and expenditure power. The growing element of market provision in health care adheres to the neo-liberal political direction that is currently

prevalent in Ireland and much of the Western world. This promotes individualism which is in direct conflict with the concept of society and social entitlements, such as health (Baudrillard, 1998).

“All men are equal before need and before the principle of satisfaction, since all men are equal before the use-value of objects and goods...they are unequal and divided before exchange value” (Baudrillard, 1998:49).

Consumerism produces difference and social discrimination. The individual strives to super-differentiate and super-distinguish themselves through a style of consuming (Baudrillard, 1998). The transfer of social services, from a state run capacity to private markets, represents an amendment of social rights and entitlements (Baudrillard, 1989). The commodification of health is placing in jeopardy equal health services for all, based on need and not profit. The presence of profit incentives within medical practice conjures up many ethical questions and uncertainties for the consumer, due to their status as outsiders. A profit incentive may obscure ethical considerations in favour of the patient being treated (Baudrillard, 1989). The repercussions and the personal costs of treatments can be detrimental to the length and quality of a person's life, yet a customer cannot change their minds once treatment has been completed and compensation for ill-treatment is rarely quantifiable in terms of having good health. The transfer of health from being a right to a commodity has raised many contentious issues relating to patient access and treatment to health service and the quality of health care available in both the public and the private sector.

Background to the research

The Irish Health System

Health services in Ireland have traditionally been problematic in creating inequalities within Irish society. Health service inequalities have been documented by key policy commentators such as Barrington (1987), Nolan (2001) and Quinn (1999). Health inequalities are a major social concern as they are entangled with many other elements relating to social and economic inclusion (Barry, 2005). Irish health policies have traditionally maintained differential provision between different socio-economic

groups, through a two-tier health system. Historically the absence of a socialist/welfare based influence in Irish politics and the profound influences of hierarchical powers, such as the catholic church and the medical profession, ensured that private health care remained an emphatic element of health services in Ireland, since the 18th century (Barrington, 1987; Geary, 2004). The dearth of a political will to transform how healthcare is provided has circumscribed the possibilities for a more equitable system, confounding the existence of the two-tier health system. The two-tier health system is the term used to describe a dual system of provision of both public and private health care, side by side (Cantillon, 2001). Recent policy direction in Ireland has seen the institutionalisation of the two-tier health system, indicating a disconcerting shift towards more commodified health services (Allen, 2007).

Commodification can be defined as the conversion of a service or an object into a product that can be bought and sold for profit, in a market place. Wren (2003) exposes the two-tier system as a testament to the commodification of health care in Ireland, describing it as an unequivocal failure in providing care when needed to all citizens. Compelling evidence suggests that Irish policy has promoted the creation of a two-tier health service, by augmenting the role of the private sector in health service provision. Commentators suggest that this commodification may pose a threat to fundamental social values (Nolan and Wiley, 2002). Unequal access and treatment of patients, based on their private or public status, frequently presents itself in the discourse surrounding the two-tier health system. Wren explains that private patients receive privileged and timelier care, elucidating the rationale for over half the population choosing to invest in private health insurance (Wren, 2006). This may explain a readiness to pay for health services in Ireland that are available as a right. According to the 2005 Health Expenditure Statistics, it is estimated that private health expenditure has risen from €1.018 million in 1995 to €2,597.3 million in 2004 (DoHC, 2005). Rising numbers of private hospitals have inspired further debate surrounding the existence of health markets in Ireland. Private hospitals tend to focus on profitable niches within the health market and generally don't provide basic care and emergency services to patients (Wiley, 2005). Private hospitals tend to avoid the costly and risky essential health services that are provided by public hospitals. They

‘cherry pick’ profitable and low-risk treatment; hence private patients are forced back into the public system for essential and emergency care. The hospitals themselves are designed on cost cutting and profit making foundations; hence quality, sufficient staffing and upkeep are questionable in the face of profiteering priorities. O’Connor (2007) describes private hospitals as overspecialised, fragmented and depersonalised. This conveys a neo-liberal based government tendency towards the Americanised model, as indicated by Health Minister, Mary Harney, in 2002 (Kirby, 2002).

Health policy is increasingly reliant on market based solutions. Policy initiatives such as the National Treatment Purchase Fund and the 2005 co-location initiative raise many questions surrounding the equality of access and treatment, including the quality of services being provided. The NTPF transfers public patients from public waiting list for private treatment, if they have been waiting an unacceptable time. However this market based solution to the waiting lists problem fails to address the underlying issues regarding insufficient public hospital treatment (O’Connor, 2007). The co-location initiative, launched in 2005, welcomed private investors to build private hospitals on public hospital land. The plan set out to improve hospital service capacity with minimum cost to the public purse. Co-location was seen as the perfect market based solution to shortages within hospital services. The initiative allows patients an opportunity to choose treatment from either private or public hospitals, benefiting from the manpower, technology and resources of both. However it contradicts a main objective under the fair access goal of the 2001 health strategy that states “*Equitable access for all categories of patients in the health system will be assured*” (DoHC, 2001:24). The choice to avail of private hospital treatments ultimately depends on a patient’s ability to pay. Financial reports suggest that co-location hospitals will reduce resources available to the public patients (Brennan, 2003). The co-location initiative represents a contradiction in policy objectives between attaining health equality in Ireland and promoting market based solutions according to a neo-liberal political ethos. The policy is symptomatic of differential treatment and services for members of society who can afford to pay.

The implementation of market based solutions in health care and the infiltration of a market model system has compounded the commodification of health services. The role of the private sector appears to exist in tandem with public services in Ireland. Commentators suggest that the co-existence of public and private services has led to a substandard service being provided to public patients, who are secondary within the system, as they represent a cost and not profit (Wren 2006 and O'Connor, 2007). To date, the 'for profit' and business hospitals remain either unable or unwilling to provide a comprehensive health service for everyone. This presents many obstacles to achieving equality in health services provision in Ireland.

Research Methodology

Semi structured interviews were conducted with front line health care professionals currently working in Irish hospitals. The study employed a combined interpretive and critical stance in conducting the research (Alcock, 2003). An interpretivist approach sought to assess the commodification of hospital services, through the eyes of front line hospital workers. A critical approach sought to address a number of ubiquitous theoretical issues related to the core concept of consumerism. This exploration of consumer theory, derived predominantly from the work of Baudrillard (1998) and Bauman (2000), facilitated an evaluation of the evidence and research that was undertaken. A critical approach to the research findings revealed how commodification has manifested itself within the context of health rights and service provision in hospitals.

Methods

The primary research set out to investigate the state of Irish hospital services today, within the framework of the interpretative and critical methodological approaches to the research topic. Semi structured interviewing presented as a suitable research method; allowing for more subjectivity to meaning while capturing multiple perspectives (Bryman, 2004). The research incorporated a purposive sampling method, concentrating on recruiting hospital doctors and nurses for interview (Bryman, 2004). Snowball sampling was used to attain a suitable research sample, ensuring that participants were from similar professional environments (Bryman,

2004). Doctors and nurses were selected as they play a pivotal role in assessing the health needs of the general public. They are responsible for assessing patients, diagnostic testing and subsequent treatment, aftercare, further referrals and recommendations for patients. These groups are in daily contact with patients, their illnesses and their grievances. They also represent a main body of workers that function within the hospital system that is shaped by government policies. Additionally, the sample is heavily invested, personally and professionally, in the health care system. The data collected was analysed thematically, considering the issues and concerns which automatically emerged from the findings.

Research Limitations

Firstly, involving front line workers from other health disciplines could have provided a more comprehensive insight into the commodification of hospital care; however that scale of research went beyond the scope of this study. Secondly, time limitations for potential participants dictated the sample used, due to hectic schedules of front line workers. Finally, confidentiality issues were of prevalent importance to the participants. This proved a barrier in recruiting candidates for the sample; despite being reassured of the ethical responsibilities involved in conducting the research.

Primary Research Findings

The Treatment of Public and Private Patients

Opinion on the treatment of acutely ill patients produced similar responses. It was felt that the treatment of the severely ill was unaffected by their private or public status. Any surgery, tests or treatment is readily provided to those who urgently need it. Patients who enter the hospital through the Accident and Emergency are mostly considered to receive treatment according to the urgency of the situation, regardless of their private or public status. One nurse said in reference to emergency cases that:

“They are patients and we are not checking if they are private ones or public ones”.

The majority of respondents concluded that a difference between the public and private patients in an inpatient or day patient capacity does exist. A number commented on environmental differences. Private patients receive more aesthetically pleasing surroundings, private bathrooms, single rooms and additional cutlery for their food trays. These differences were acknowledged by all but considered to be of minor importance. All participants felt that when patients received treatment from ground level staff it was the same. Half of the respondents felt that the status of patients didn't affect their day to day caring duties. One nurse stated:

“More often than not, we wouldn't even know whether someone has health insurance or not. I suppose that's from the hands on approach...the care is the same but certainly from a private point of view you can certainly make more demands”.

Major differences were identified outside the level of 'hands on' care. It is apparent that differential treatment is mostly derived from consultancy care; the speed of service delivery, the types of tests and investigations carried out on patients, the time spent with the patients and the speed of their discharge. All interviewees identified some or all of these differences. Some participants felt that the disparities in treatment, very much depends on the consultant running the clinic. These differences seem to arise due to the patient's paying status. .

One interviewee described the situation from the doctor's point of view:

“You have a whole rake of jobs to do for the day... But you do go around and make sure that the private patients are done like, at the expense sometimes maybe of the public ones... So they'll be seen more often”.

According to all the interviewees, private patients get seen by the consultancy team more frequently, for longer periods of time and generally receive more tests and treatments at a faster pace. One doctor said that:

“Working, for me, in a private ward and a public ward is completely different. In private wards people just get better faster and stay well for longer...Its like fire fighting, what's happening on the public wards, where as in the private

wards, it's more intensive treatment, personal face time, one to one, it's problem solving team work".

Some of the interviewees felt that consultants order expensive scans, tests and investigations for private patients while they are slower to investigate the public patients in the same health situation. One of the respondents felt that this was common in hospitals.

"I suppose if I can speak about the atmosphere of public and private, when you're working with consultants... they will see the public patients and they will go through the various investigations. But there's a quantitative difference for me between going through the motions and versus when it's a private patient... holding them in for extra days in hospital when its for no particular reason, ordering extra scans that don't necessarily need to be ordered..., this is a recurrent trend and its not one or two consultants, its across the board. It's a bad habit they all seem to get into at one point or another".

Two notable variations emerged. One doctor felt that consultants, particularly in psychiatric care, don't allow the status of public or private patients to interfere with the treatment of the patient. A number of the interviewees acknowledged that some of consultants do their best to prevent the public/private status of patients from affecting their work. One doctor stated however that in their experience this is an exception to the rule.

The majority of participants felt that the treatment in public hospitals was excellent, once you could gain access. The quality of staff was considered better than in private hospitals and most agreed that staff were more reputable due to public licensing and regulation. Every respondent was in agreement that access to hospital care was the fundamental and the most obvious distinction between public and private patients.

When answers were compared, there was a 100% consensus that private patients receive timelier care and access to elective treatments or non urgent care. One nurse stated that;

“The private patients whose symptoms mightn’t be as bad would definitely be seen beforehand and would be bumped up the waiting list”.

Private patients are prioritised on waiting lists because they are paying. One doctor described clearly the extent of the disparity between waiting lists for public and private patients:

“There’s only a waiting list for public people...the reason people go private is because they know they won’t be waiting...waiting for two or three weeks to see somebody is like not waiting at all, especially when on the public side, you might be waiting six or nine months to see the same person, for the same problem”.

All the interviewees felt that long waiting lists for public patients are unfair and some described the problem as being detrimental to the quality of life, social health and mental well being of public patients; affecting their ability to live life to their full potential. It was felt by some of the interviewees that delays in diagnosis or treatment can be devastating to a person’s condition and at times life threatening or the cause of a preventable death. The ability for private patients to surpass public patients, based on paying status rather than need, was agreed by all to be unjust and regrettable. Most commented on this being the nature of the system they work in. One doctor highlighted the role played by private insurance, in consultancy decision making in the treatment provided to patients as outlined:

“the profit imperative is enormous, it is not a phantom, it is the sole reason a lot of people are at work. Some consultants ... would have the reputation of being known as 21 day consultants. What that means is, your VHI will pay for that period of time in hospital ... 21 days and magically they have cured the person...So there’s a lot of cynical games being played”

Market Based Health Care Solutions

Management are increasingly adhering to a business model in the provision of services. A lack of health care workers involved in management has reduced management’s capabilities to knowledgeably appropriate funding and resources, to

needy areas. One doctor proclaimed this to be a very negative situation that is negatively affecting staff decision with regard to the availability of care resources and funding and the subsequent treatment of hospital patients. The HSE's over reliance on people who are solely qualified in business management or other, non caring professions, to run the hospitals was criticised by workers.

"I think that it's very stupid that people who are in charge of where the money goes are lawyers and marketing people and business people... they're not aware of what the reality is on the floor. Obviously that's not their fault, they couldn't be, but it's their fault that they think they could be and that they have the right to say who gets what money".

Attempts at cost saving were reported by staff as directly degenerating the services available and the ability of hospital staff to operate effectively within the system. Almost all of the participants perceived management as being predominantly concerned with money saving and expense cutting. One nurse said:

"A lot of the management at a certain level don't have a medical or a nursing background. And they come from a business background...they have one vision and then you have a level of management that come from a nursing and medical background and they have another vision but it always seems like the business vision over rules...and the patient in the bed is forgotten about".

Some respondents attributed this as filtering down from the HSE and political tendencies towards market solutions in health. One nurse explained what is happening and how it is affecting services:

"So what they're doing now is closing certain areas of the hospital where there is great expense, one day a week...to try and cut back on expenditure...that increases the work load and pressure on other hospitals".

One respondent felt that it was broader government policies that imitate a neo-liberal model that prioritises market based solutions.

One variant emerged under the topic of management where a number of participants felt strongly that management could and do adhere to both a welfare and business model in the provision of services

Every respondent agreed that the two-tier health system is not ideal and is a very unfair system. This was a prominent issue in all aspects of the findings. It was acknowledged by all that it is a divided system, rife with inequalities. Many felt that money determines the timeliness, quantity and quality of care received. One nurse commented on the reality of working within such an unfair system:

“It is wrong ultimately, care should be equal for all and access should be equal for all but it is not and we’ll have to work within those confinements”.

Some participants spoke about the effect of the National Treatment Purchase Fund on waiting lists. Most felt that the Treatment Purchase Fund was a very positive thing for public patients on long waiting lists and that it wasn’t incorporated frequently enough in hospitals. However others felt that this was an idea born out of desperation and that it fails to address the underlying shortfalls in the system, representing a quick fix. One respondent also highlighted potential dangers involved for patients:

“I know that it is a practice of ... surgeons that they would allow someone to dwindle on a waiting list. Get them over the TPF time allotted to that procedure and then they’ll turn around and say oops, stick them over on the private list. I’ll do them on the NTPF and get the bonus. And if its happening in that speciality, it has to be happening in other specialities”.

Co-location was discussed by some participants. Mixed and conflicting views emerged amongst the participants. Most of the participants saw it as potentially positive for the workers in that it may provide valuable resources and cut down on time wasting for consultants, travelling from the public to the private settings which will ultimately create more patient time. However many viewed the co-location initiative as being potentially problematic in that it may also consume valuable resources for public patients. The plan also poses a danger of the possible poaching of valuable staff from the public system. Some felt that co-location was much more

beneficial to the private hospitals, allowing them to increase the services they provide with the back up of the public system. Most workers agreed that although it has pressure relieving advantages for the current two-tier system, that it was not ideal. Concern was expressed by all regarding the co-location scheme.

Private hospitals and a 'private' culture

The majority of participants gave very positive accounts of how private hospitals functioned, from their personal experiences of working in them. Most attributed high efficiency and high performance to the business ethos of these hospitals. It was generally felt that due to the presence of profit margins, staff were held highly accountable and tended to perform better. A number of interviewees felt that it was due to the difference in services provided. The ability of private hospitals to choose patients and procedures that ensure a high patient turnover and a high success rate improves the hospital's all round performance. The absence of chronically ill patients or emergency patients means that patients are generally in good health when they enter the hospitals and are discharged quickly, in similarly good health. One nurse explains the patients who attend private hospitals are unique.

"So they are fit and healthy, they walk in, have their procedure and go".

Many respondents raised the issue of health commodification as being reflective of broader cultural changes. Many of the participants commented on the demanding nature of patients in modern times. Some attribute this to the 'Celtic Tiger' Ireland where people have become accustomed to a surplus of income and the demand culture that is associated with capitalist consumer societies. One doctor comments that this goes beyond personal monetary investment in services.

"We feel that our health is owed to us because we pay the health services so much money"

Some participants felt that a media culture was the driving force behind the commodification of health services. According to frontline workers, patients are becoming more demanding and this is seen by the interviewees as a sign of the times.

Conclusion

This study has explored the effects of health care commodification on the rights of Irish people and on the health system as a whole. The findings demonstrate an urgent need for policy makers to revise this policy of health commodification, in the name of equal access and treatment for all patients.

Commodification has increased service dependency on a business model of health care management, which prioritises value for money and cost saving methods. The over reliance on the business element to service provision is evidently affecting the treatment of patients, the resources available to them and the ability of health care professionals to treat patients according to need. Management is often out of touch with the needs element of hospital services which is detrimentally reducing the quality and quantity of care available to all patients. Market based solutions such as the NTPF and the policy of co-location are failing to reduce inequalities in access and treatment. The quality of Irish health services is increasingly dependant on cost and an ability to pay. Health is of fundamental importance within society however as a commodity its status has been reduced. This is disconcerting for the future of Irish health services. Policy is increasingly treating health service users like consumers within a two-tier system that is managed on a business model. The business model is placing the needs of the patients secondary to productivity and value for money. The profit incentive surrounding health as a commodity doesn't always lead to the equal treatment of patients, based on need and not profit. This trend is set to continue within the pervasiveness of health policies that promote the role of the market and the proliferation of the profit element within health care in Ireland.

The two-tier system represents a social health divide based on profit margins. Irish health policies allegedly strive towards equal access and treatment within the two-tier system. This research displays without doubt, that equality has not been achieved. The elementary significance of a two-tier system promotes difference based on profit incentives. Health markets need incentives in order to entice customers. In Ireland, this investment incentive is differential treatment. The divide between health consumers and public health users is indisputable. Private patients receive timelier

care. The quality and quantity of their care is of a higher standard than that of public patients. The principal disparity is evident in access and availability of hospital services for patients. Private patients undoubtedly receive prioritised access to care, except in the case of an emergency. Consultancy care is the primary driving force behind differential patient treatment, based on paying status. Decision making in consultancy seems heavily influenced by a patient's private or public status. These differences are contrary to the equity goals of health policy documents. The prevalence of a private culture within hospital care is illustrative of the inherent distinction between patients, if they are public or private. Public patients suffer at the hands of health markets and this trend is set to continue. The commodification of health has served to create differential services for members of society solely based on their ability to pay. Public patients are left to deal with substandard levels of access and care. Furthermore, it has forged a permanent social chasm between members of society based on their socio-economic status. Due to the nature of overwrought and under-resourced public hospital services in Ireland, health consumption is encouraged and arguably necessary.

Health consumption is a means of differentiation, prestige and engulfs an ethos of superiority and serves as a sabotaging force against social cohesion in Ireland. Health markets in Ireland have created inequality and social difference. The commodification of health care in Ireland has induced a conflicting relationship between health as a right and health as a market commodity. Health is no longer an indisputable right, available equally to all Irish people, regardless of their social or economic standing. Increasingly the quality of hospital care is reduced down to profit margins. As highlighted by Bauman (2000) and Baudrillard (1998), health markets thrive on individualism, which operates in direct conflict with the social. The idea of health being a social right has been compromised by the commodification of hospital services. The appropriation of hospital care according to a patient's paying status is unjust, yet market based policy initiatives and goals ensure that market are remaining an emphatic element within Irish hospital services, the co-location policy concretising this. Irish policy makers need to revise the health and social implications of health as a commodity market. Increased measures need to be implemented in order to protect



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public patients from poor services and discriminating treatment, particularly in consultancy care. Additional regulation of private hospitals is also necessary, ensuring that a comprehensive and reliable service is provided. The government need to reconsider their policy stance on this issue, if health is to maintain its status as a right, in the face of increasing commodification. Increasing social and public solutions to the health crisis is certain to help bridge a social void in Irish society, encouraging more social responsibility while promoting and maintaining a socially cohesive Irish society.

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