defend

and extend...

MEDIBANK

THE HEALTH INDUSTRY AND THE ANTI-IMPERIALIST MOVEMENT

THE HEALTH CARE AND SOCIAL WELFARE SYSTEM IN AUSTRALIA ARE IN CHAOS. Health costs are exorbitant. Doctors and dentists are difficult to see and expensive. Hospitals are overcrowded with bursting casualty departments. Costs of drugs and prescriptions are skyrocketing. Nursing home beds are a luxury.

All this while the government makes further attacks on working men and women by attacking the unemployed, the elderly, single mothers especially. They cut and limit access to benefits, rigidly policing recipients.

This increasingly grim picture is part and parcel of the drive to fascism in Australia – where monopoly capitalism rules without the veneer of 'parliamentary democracy', but by open violence against the people.

THE FRASER GOVERNMENT HAS SET ABOUT TO SYSTEMATICALLY DISMANTLE THE FEW CONCESSIONS WON UNDER THE PREVIOUS LABOR GOVERNMENT.

These gains had two other aspects . . .

- to boost the size and maximise the profits of the private health sector; e.g. the pharmaceutical industry, private hospitals and health insurance companies, nursing homes and the upper echelon of the medical profession.
- to further shift the burden of the economic crisis away from the monopoly capitalists.

WHAT WILL FRASER'S ACTIONS MEAN TO YOU?

IF MEDIBANK IS DISMANTLED this will mean . . .

- Doctors' fees will rise.
- The cost of hospital care to the patient will rise.
- People will be increasingly uncertain about obtaining medical services and health care because of limited access and crippling costs.

PRIVATE HOSPITALS ARE BEING EXPANDED

The government forces people to take out private health insurance and consciously plans the development of an all-encompassing private hospital system.

THE PUBLIC HOSPITAL SYSTEM IS BEING DOWN-GRADED

Public hospitals and health care institutions are being strained financially. They have growing shortages of staff and difficulty providing first-rate care for those in need.

COMMUNITY HEALTH CARE IS BEING RUN DOWN

This area where health services are most needed, is being neglected or denied finances.

DRUG AND PRESCRIPTION COSTS ARE RISING

This means . . .

- More profits for the monopolist drug manufacturers.
- Destruction of viable Australian competition.

SOCIAL WELFARE BENEFITS WILL BE ERODED

As unemployment continues at record levels the Fraser government attacks working people under the smokescreen of 'dole bludgers'.

Supporting mothers' benefits are being attacked by the attempt to impose a means test on recipients, and to limit the number of children of one mother eligible for child endowment.

Already there has been an attempt to undermine the benefits of elderly people by removing the funeral benefits to pensioners.

A FURTHER WORD ABOUT MEDIBANK

IF THE FRASER GOVERNMENT WERE SUCCESSFUL IN DISMANTLING MEDIBANK, WHAT WOULD THE PEOPLE LOSE?

Medibank is purely a health insurance scheme. The original health insurance proposals in 1973 offered people in need of health care some definite benefits. These benefits included:

- security in the knowledge that health and hospital services would be available if required.
- access for all people to basic health services.
- payment for health services would be slightly cheaper. Medibank insurance was marginally cheaper for most people and some control could be made on the fees of doctors and paramedical services (e.g. physiotherapy, pathology etc.).
- some control on the haphazard operating of the 79 health insurance companies which existed.

- the money to pay for health services would be raised in a much more equitable way.

Even in the early stages of the planning of Medibank, it became obvious that the Whitlam government would back down on important parts of the scheme.

They yielded (not unwillingly) to pressures put on them by private insurance companies, reactionary leadership of some medical organisations and foreign-owned drug companies. These groups fought a united campaign against the Medibank proposals and the establishment of a government-funded pharmaceutical industry. The result was a watering-down of the proposals. Important changes included:

- controls on the fees for professional services were reduced (e.g. doctors).
- private insurance companies were allowed to participate in the scheme and were allowed to act as Medibank agents.
- private hospital bed subsidies were raised.
- the proliferation of non-public beds in hospitals was allowed to continue.

Medibank and other social welfare issues were used as rallying points for the reactionaries. At a time of growing economic and political chaos, social welfare and health benefits were seen by these groups as areas of spending which should be cut back. They sought to shift the burden of the crisis even more onto the backs of the working people of Australia.

The catch cries of "freedom of choice of doctors, hospitals", "loss of quality of service" were used as a cloak to cover up the real aim of their campaign. This was to protect private health interests and foreign-

owned drug companies, and to increase the repression on an increasingly rebellious Australian people, at a time of economic chaos. In this the reactionaries in health care worked hand in hand with reactionary forces in Australia and overseas to bring down the Labor government. The 'coup d'etat' in 1975 was the first resounding success of these forces in Australia.

MEDIBANK NOW

The attack on the Australian people has not stopped there. For many months before coming to power, the Liberal Party made clear its opposition to Medibank. Statements by one liberal, Chipp, just prior to the December 1975 election highlighted this.

The actions of the Liberal government since the elections have confirmed the truth of their stated intentions:

- One of their earliest actions, to demonstrate their allegiance to the foreign-owned pharmaceutical industry, was to sell the government-acquired drug company, Fawnmac.
- The Medibank Review Committee was set up in January 1976, following hysterical cries of "wasted millions". It was directed to explore 'alternative' forms of health insurance.

In reality the plans are to dismantle Medibank to further line the coffers of the high-profit private health sector. The mechanisms to be used are unclear at this stage. Possibilities being discussed include:

- a flat percentage levy on taxable income unless proof of private health insurance is given.

- imposing a means test on government benefits.
- handing over the Medibank administrative apparatus to private health insurance companies.
- abolition of bulk billing – patients would have to pay the 15% difference between the rebate from Medibank and the 'most common fee' charged by the doctor. This would severely limit government control of medical and paramedical fees.

This would mean:

- downgrading of public hospitals with growing staff and service shortages.
- expansion of high-cost private hospitals as patients are forced from the inadequate public hospitals system.
- the uncertainty of coping with the rising cost of medical care. Middle income earners would be most affected initially. Working class people will suffer most in the long term as public hospitals become second-rate charity institutions.
- slashing the availability of social welfare.

SO WHAT OF THE WELFARE STATE?

The real power in a bourgeois democracy is not in the hands of each man and woman but in the hands of the corporations that control the economic life of the country – parliamentary representation is just a puppet show.

The Labor Party came to power at a time of deepening economic crisis. They offered some "solutions"

but their 'solutions' were capitalist 'solutions' and were basically offering social benefits for industrial tranquility and a wage freeze. They were attempts to win acceptance of a wage freeze by offering a package deal – better social services and the uplifting of the very poor was offered for across-the-board wage restraint in the form of indexation.

But even this mild programme could not be tolerated, and both overseas and locally, reactionaries organised in political and industrial circles to defeat the original National Health Insurance Programme and the growth of community health centres was thwarted whenever possible.

Medibank was the watered-down compromise. Significant concessions were made to maintain the high profitability of the private health sector. But even this was bitterly contested by the State Liberal governments hand in hand with the organised right of the medical profession, the private health insurance companies, private hospital organisations and the foreign-dominated drug industry which poured money into the campaign funds.

The Liberal government has highlighted their subservience to foreign and private health business interests by their capitulation to the foreign drug industry and the Medibank sell-out. Their attempts to disguise the economic crisis and unemployment by calls of "dole bludgers" and viciously cutting social welfare benefits simply identifies them more clearly as pathetic 'Gerry Gees' of foreign imperialism.

THE HEALTH INDUSTRY

Medibank is simply a health insurance scheme which allows people to have greater access to the same system of health care. Health care in Australia is dominated by companies which make products used in medicine and organisations which manage health services. Their only concern is profit-making and not the prevention of illness or the encouragement of people's good health.

WHAT IS THE HEALTH INDUSTRY?

The health industry consists of those companies which supply equipment, finance, build for, sell drugs to and sometimes manage the way people receive health care. The health industry includes predominantly foreign-owned medical electronics, drug and hospital supply companies, private health insurance groups and private hospital and nursing homes.

Its aim is not to promote the patient's wellbeing or to encourage preventive medical services in the community. It is simply to exploit existing profit-making markets and develop new ones. Its emphasis is not on products and services which would improve basic health care for the people, but on luxury, prestigious and high-profit hospital supplies; e.g. electronic thermometers, expensive combination drugs, disposable equipment etc.

THE DRUG INDUSTRY

The drug 'revolution' of the 1950's and 60's was the first major step of industry into the health field. The whole emphasis of this so-called 'revolution' has been to emphasise curing and not preventing disease. The best-sellers have been those drugs that have been used to treat the results of social disease; e.g. Valium – "band-aid" treatment for people's problems caused by the evils of the capitalist system.

Much of the money which flows through the health care system to the industry's companies, never returns to the health care system in any medically useful form, or in any form at all. The enormous profits generally vanish overseas, going to stockholders, and to finance that company's expansion into other enterprises. More and more of the health industry's firms are conglomerates whose holdings in drugs and hospital supplies help finance their expansion into other health industry fields and acquisitions in everything from pet foods to cosmetics. And of course the high profit in the health industry attracts companies from outside fields; e.g.:

American Cyanamid (Lederle Labs); Pfizer; Smith Cline & French; . . . into cosmetics.

Upjohn; Searle; . . . into medical electronics (computers in Shepherd Foundation, Melbourne).

Dow Chemicals (of napalm fame) . . . virtual monopoly of measles vaccine.

3M . . . into pharmaceuticals (Riker Labs), hospital supplies.

Honeywell . . . into medical electronics.

There is no way of auditing the health industry

companies to determine how much of their costs are actually 'necessary'. Prices are high and the health companies claim that this is not on account of profits but due to the "enormous cost of research", "skilled manpower" and "meeting exacting standards", etc.

But perhaps an inkling of what the profits are can be gained from Britain, where on the advice of the Monopolies Commission, the British government in 1973 ordered Roche Products to cut its selling price for the tranquilisers Valium and Librium by 60–75% and to refund the equivalent of 6.7 million dollars in "excess profits". In the hearings Hoffman-La Roche, the Swiss parent company, named Beecham (Penbritten – an antibiotic), Boots, Fisons (Intal – for asthma) and ICI as concerns which make equivalent profits; also cited were the non-drug companies Eastmann Kodak, Kelloggs, and Proctor and Gamble.

The British subsidiary Roche Products was paying its parent company $925 per kg for an active ingredient which could be bought in Italy (where there are no patent laws) for $22.50. For the other active ingredient the prices were $2,305 per kg and $50 per kg respectively. And as Roche pointed out, even with these mark-ups its products are cheaper in Britain than elsewhere (the Australian price being 120–140% higher than the British price).

A drug representative with Lilly pharmaceuticals in Australia has said that in one instance payments to the American parent company were made by raising the price for an active ingredient from $500 to $50,000 per kg. And there were no questions asked!!

Covering up this enormous 'profitability' was

probably the major reason for the drug industries involvement in the Medibank dispute and the opposition to the formation of a government-funded pharmaceutical industry. Since the establishment of the drug firm would enable the government to monitor the actual production cost of drugs in the 98% foreign-controlled drug industry even if open competition for various drug lines was not allowed.

FROM WAR PROFITEERS TO HEALTH PROFITEERS

The 'space race' and the Vietnam War saw a large upsurge in the computer/electronics industry.

The by-products of the space and war industries were used by the profiteers; e.g. Honeywell, IBM, Lockheed, Du Pont, Johnson & Johnson etc., to make massive profits by adapting them for use in other areas, especially the Health Industry.

The promotion of medical electronics products has become particularly conspicuous since the mid 1960's, especially those products for use in Coronary and Intensive Care Units and research laboratories. This is fast becoming one of their greatest profit-making fields and is certainly the 'glamour' area of health care, with various hospitals and doctors vying for the biggest and the best.

DOES THIS IMPROVE THE HEALTH OF THE PEOPLE?

For all the drugs and technology used in health care, people are simply not becoming healthier. On the

contrary, they are becoming sicker with the rise of diseases that are obviously related to social problems. Over the last 30–40 years the mortality rate has not altered significantly, nor has the male adult life expectancy altered significantly in the last 60 years.

WHAT ARE SOME OF THE SOCIAL REASONS FOR PEOPLE BECOMING SICK?

Heart disease . . . smoking, poor dietary habits, tension.

Motor car accidents . . . shoddy unsafe cars, advertising aimed at selling speed, alcohol.

Liver disease . . . alcoholism, drug abuse.

Bowel disease . . . poor diet.

Kidney disease . . . abuse of drugs such as aspirin.

Suicides . . . tension, loneliness, frustration, social pressures, etc., etc.

Ulcers . . . diet, alcohol, smoking and tension.

Lung Cancer . . . cigarette smoking.

Bronchitis . . . cigarette smoking, pollution, dusty work environments.

Tooth Decay . . . eating habits.

WHO PROFITS FROM THE CAUSES OF ILLNESS?

Car manufacturers . . . 100% foreign-owned.

Drug manufacturers . . . 98% foreign-owned.

Food Processing companies . . . 87% foreign-owned.

Cigarette manufacturers . . . 90% foreign-owned.

These companies actively promote their products with virtually no government restriction, and

concentrate on the most vulnerable sections of the community; e.g. women, youth.

Millions of dollars are spent on expensive electronic equipment and drugs while 7,600 old people are awaiting placement in government nursing home beds, which simply don't exist; mental health care is archaic; what exists of aboriginal health care is being undermined; migrant health care facilities are appalling; dental health care almost inaccessible; and inadequate staffing in hospitals disallowing an adequate level of basic care.

This has been well epitomized as poverty of health in the midst of a scientific abundance in a society of disease.

HOW THE HEALTH INDUSTRY EXERTS ITS INFLUENCE

The health industry obviously has effective ways of influencing policy on health service organisation. The very existence of equipment which can only be used in hospitals and other large institutions encourages the development of a highly centralised health system instead of a decentralised one serving the needs of the community. More directly it can present itself to a government as an enormous lobby with threats of closure of factories and deprivation of products as some of the means of influencing policy.

But there are more direct and intimate ways to influence policy. Management members and upper level staff of medical schools are always welcome on boards and top staffs of health industry firms. Many top medical school professionals moonlight as consultants to

the health industry. This consultation between the industry and the institution is probably more important in terms of volume and potential policy impact.

The following are examples of what has been discussed:

- Taking over of Australian drug and medical electronics companies (e.g. 3M's attempted take-over of Telectronics in 1973) or preventing their formation (e.g. their campaign against the government-funded pharmaceutical industry, and the Liberal government's sale of the company acquired by Labor, Fawnmac, within weeks of Fraser's coming to office).
- They attempt to bribe doctors with expensive gifts when promoting products. In 1968 it was estimated that $1,000 was spent on advertising for every doctor in Australia by drug companies.
- They have company reps. sitting on hospital boards of management and research centres, to influence policy-making and spending; e.g. ICI on Alfred Hospital Board.

Besides hospitals and medical schools being used by the health industry to undertake research, large-scale research is also being undertaken in these institutions into projects useful in warfare and political repression; e.g.:

U.S. Defence Dept financed projects at Microbiology Dept, Alfred Hospital.

U.S. Public Health Office (CIA financing organisation) financed projects at Biochemistry Dept, Monash University.

Research into social control for political repression

at Flinders University by Prof. Russell, who was placed in Australia by the Australian-American Education Foundation, which is chaired by Prof. R. R. Andrew, Dean of Medicine, Monash University.

THE UNDERMINING OF THE PUBLIC HEALTH SYSTEM

Operating side by side with the public health system are the profit-making concerns mainly made up of the private hospitals, the private nursing homes and the health insurance companies.

In any situation under capitalism where the private and public health sectors compete, the private sector by influence and government connivance will win out.

The public health system which is paid for by tax-payers' money is being consciously undermined by a conspiracy of the health profiteers (the health industry and the upper echelons of the medical profession) and the government.

What is becoming very apparent is the very rapid emergence in Australia of a growing private hospital sector. At present these hospitals cater especially for 'profitable' patients. These are the people who can afford private health insurance, those who are in hospital for a short period of time, have batteries of tests and 'profitable' surgery and then leave.

In functioning in this way these hospitals skim the 'profitable' patients from the health system, and finance that could have been used to offset the cost of other patients in the public sector, instead enters the private health sector. Under these circumstances the

situation is rapidly developing where the public hospital system merely treats those patients that the private health sector feel are 'non-profitable'; e.g. chronically ill, 'placement' problems, etc.

An essential part of the undermining of the public health system is the conscious deprivation of adequate finance to the public hospitals and institutions.

This sets up a cycle where: deprivation of finance leads to staff shortages, depressed working conditions, lack of equipment and facilities leading to more patients changing from public to private hospitals (those who can afford private insurance), which in turn decreases public hospital income . . . and the cycle continues.

While the government is running down the public health sector, it makes statements blaming hospital and health employees for being "lazy and inefficient" and asserts that the public hospital system must be "competitive", and "pay for itself" etc., etc., therefore denying the responsibilities of the government to pay for health care.

At present private hospitals are planning to go into direct competition with public hospitals. At present the private hospitals are still rather limited in the type of patients they are able to attract, simply because they do not have medical staff on tap on a full-time basis.

But this is also a temporary state of affairs, for already a large number of the larger private hospitals have applied for rotating residents from a number of public hospitals.

For these hospitals to become fully-fledged General Private Hospitals, competing with the Public Hospitals in almost all fields, they require interns and resident

doctors – and to have these they need to be able to help to train medical students who could then stay on as residents when they graduated.

The proof of this development comes from the Syme-Townsend Inquiry into Hospital and Health Services in Victoria, 1975, which legitimised this move.

Under the cover of supporting medical students' claims for a proper medical education Syme-Townsend argue for the training of medical staff in private hospitals. We quote: "We are confident the Health Commission will facilitate any developments within its power that might be necessary *to involve the private sector in medical training*. The larger private hospitals are geographically situated so that aggregating them into one or more clinical schools would not be impossible. We are also aware of the willingness of at least some private hospitals to alter considerably their patterns of clinical work if necessary (e.g. clinical units, *employment of interns,* etc.)" (page 89 of the Syme-Townsend Report. Our emphasis.)

If this isn't enough to convince, then the appointment of the present Dean of Medicine at Monash University, Prof. R. R. Andrew to the position of Director of Postgraduate Studies at Cabrini Hospital, Melbourne (Australia's largest private hospital with around 400 beds), where there are no postgraduate studies to speak of at present, would have to be the clincher.

His appointment is an important forerunner to the development of this hospital as one which offers all the facilities of public hospitals. In this sense it is the trend-setter amongst private hospitals in Australia and follows a pattern well established in the U.S.A.

Thus if a downgrading of the public hospital system is allowed to continue, we can soon expect to see a very much more blatant two-tier health care system than we have seen for some time. The logical conclusion will be a private hospital system taking most patients other than the chronically ill, 'placement' problems and the rare and interesting cases which will, initially, go to the research-oriented public hospital system.

PATIENTS & INSTITUTIONS

GENERAL PRACTITIONERS

In Australia the local doctor is the first point of contact in the health service for most people. Long waits, short consultations, and big bills tend to be the major features of a visit to the doctor. As a result people face hardship.

Problems associated with general practice are:

- there are too few G.P.'s in Australia, which leads to the overcrowding of consultation rooms during hours.
- the concentration of doctors is far higher in well-to-do areas than working class areas.
- the doctors who have practices in working class areas usually do not live there and therefore have no idea of the problems facing the patients they treat.
- medical students get little or no experience in general practice in their training.
- visits are usually too short and superficial.

Very often the treatment consists of writing out a prescription or referral to a specialist, without any real investigation of the problem or explanation to the patient.

- it is often impossible or expensive to gain out-of-hours medical treatment – it is much cheaper for sudden illness to occur between 8 a.m. and 4 p.m. Monday to Friday.

- still only 50% of Medibank claims are bulk-billed. The other 50% must claim an 85% rebate on the Medibank through agencies or the mail. Doctors often require them to pay the bill before consultation or leaving the rooms.
- the specialists make a lot of money from multiple referrals. Sections of them; e.g. surgeons, are a bulwark of conservatism and have led the later parts of the campaign against national health insurance.

THE HOSPITALS

When people need hospital treatment they very often face inadequate treatment as a result of the ways the hospitals are run, and the inadequate finance made available to public hospitals.

One of the biggest inadequacies in treatment results from staff shortages. These shortages exist purely because insufficient money is allocated for training and employment of staff.

As a result people face the following hardships:

- inadequate nursing care.
- treatment by inexperienced and overworked resident doctors.
- long waits in casualty departments.
- lack of interpreters for migrant patients.
- disruption of basic comforts; e.g. warm food, lack of rest, long waits for transport.

For most hospital workers the problems of inadequate staffing are not the only problems. The hierarchy which exists in hospitals attempts to keep the

hospital workers divided and 'in their place'.

For the patient in hospital this rigid hierarchy has many detrimental effects on their treatment:

- the person in the hospital bed is in the most vulnerable position. It is the patient who is forced to do things at certain times to fit the routine of the wards. It is the patient who has to wait up to 10 hours in a casualty department for treatment and who suffers when conflicts arise and disorganisation and inefficiency are a feature.
- A conflict often arises between the needs of a patient and the interests of the hospital hierarchy; e.g. the sickest people, 'the interesting cases' are the people most in need of rest, yet a wide variety of groups are interested in 'having a go' at the problem. As a result these people are often prodded and poked at all day long.
- Their treatment becomes the responsibility of different groups in the hospital. Doctors do one thing, nurses another, cooks another, etc. There is rarely ever any concerted democratic effort to co-ordinate the work of these groups to the needs of each individual patient.

For hospital staff the rigid hierarchy has resulted in oppressive working conditions and the division of strength of hospital workers to take action in the workplace on health issues.

- The groups in the hospitals often have many common problems such as inadequate pay, too long working hours etc. However they have been kept divided and the small craft mentality of these sections has been encouraged by the

hospital hierarchies. This has been an endeavour to convince the different sections that their problems are unique within themselves.

The only times that the hospital hierarchies have ever actively encouraged solidarity is when:

- their vested interests can gain from the actions and supports of a cross-section of hospital workers.

OR

- When there has been no possibility of an action by a single group broadening amongst all hospital workers to threaten their position.
- Despite this hospital workers are becoming increasingly militant industrially and are uniting in the struggle to maintain standards of living in the face of the economic crisis.

WHO RUNS THE HOSPITALS?

Hospital workers have little say in how the hospital is run; most hospitals are administered by Boards of Management.

The Boards are made up predominantly by people who gain to make money from hospitals. They include . . . drug and medical electronic companies, builders, bankers, insurance groups and various large corporations which work to control the direction of Australian political and economic decisions.

- Utah Constructions and Mines Limited, a giant U.S. firm involved in coal thievery in Queensland, has recently had a representative appointed to

Melbourne's Prince Henry Hospital's influential medical research centre.

– Alfred Hospital Melbourne – Board of Management is listed below. IT SPEAKS FOR ITSELF!! Union Fidelity Insurance Co., C.B.A. Bank, National Bank, A. V. Jennings, Drug Houses of Australia, I.C.I.A.N.Z., Repco, Leggetts, Petersville, B.H.P., G. J. Coles, Georges Australia, Associated Oil Companies, Edments Holdings, Australia Consolidated Industries.

PATIENTS' RIGHTS – WHERE DO THEY STAND?

Against this background of members of the hospitals' boards of management, where do patients stand?

– People who use the hospitals have no say in the way they are run.
– Most patients in hospitals are totally unaware that they have any rights and consequently suffer treatment unaware that they have the right of refusal.
– The struggle to protect patients' rights has come from groups of progressive health workers in areas such as women's health, mental health, health care of minority and ethnic groups and consumer medicine. Any victories have been won by health workers and patients, united in struggle.

In hospitals in Australia huge profits are being made by the health industry while at the same time staff struggle against oppressive working conditions. Often

there is a lack of basic equipment such as forceps, pillows and bowls. Too often there are too few beds for the sick people who need them. While Australian working people suffer as a result, health profiteers are rolling in their accumulated riches.

Hospital workers have been divided and discouraged from fighting for better pay and conditions. The economic crisis and the social hardship it brings has forced them increasingly into struggle.

They are finding their interests increasingly in direct conflict with the government administering health care and foreign and private health profiteers.

PEOPLE'S HEALTH

Every Australian has the right to live free from all major social disease. When diseases do occur every person has the right to first-class health care, provided free of charge.

No person should be able to profit from disease-generating processes in the way the cigarette and alcohol industry does. To profit from the sick and dying is never acceptable in a people's health system.

Australia is a developed capitalist society dominated by imperialist interests. Under this domination, social contradictions are heightened. Social disease is one of these contradictions. It reflects increased social stress and disarray, and is the product of increased domination of every Australian's life by developed monopoly capitalist forces. It is seen in the growing incidence of heart disease, mental illness, child bashings . . . .

Capitalism is in chaos and this is affecting the lives

of every Australian. The price of this chaos has been an actual decline in the health of Australians. Despite an astronomical proportional rise in the costs of health care, Adult Male life expectancy has not altered in the last century. Environmental pollution, poor-quality foods, car accidents, smoking, alcoholism, the alarming health problems of aboriginal people . . . all these are factors which have aided the decline in people's health.

Although capitalism requires that workers be fit enough to work and make profits for the bosses, it also produces illness and even profits from that! Growing ill-health is a reflection of the capitalist crisis.

WHO PROFITS FROM ILLNESS?

CAPITALISM IN AUSTRALIA, AND IN PARTICULAR THE HEALTH INDUSTRY, IS DOMINATED BY FOREIGN-OWNED IMPERIALIST INTERESTS. Major interests are listed below:

COMPANY	COUNTRY OF OWNERSHIP	OTHER PROFIT VENTURES
THE DRUG INDUSTRY		
Merle-Sharpe & Dohme	U.S.A.	
Squibb	U.S.A.	
Dow	U.S.A.	Napalm manufacturers.
Hoechst	Germany	Had Nazi contract to produce gas chamber gas for concentration camps.
Roche	Switzerland	
3M	U.S.A.	Vietnam War Profiteers.
HOSPITAL SUPPLIES		
Johnson & Johnson	U.S.A.	
I.C.I.	U.K.	Arms monopoly in Sth. Africa.
3M		

MEDICAL ELECTRONICS		
I.B.M.	U.S.A.	Computers for B52 bombers.
3M	U.S.A.	
Honeywell	U.S.A.	Anti-personnel fragmentation bombs for Vietnam.
Kodak	U.S.A.	
Du Pont	U.S.A.	Major Vietnam War Profiteer.

SOME INDUSTRIES WHICH CONTRIBUTE TO ILL-HEALTH

INDUSTRY	COMPANY	ORIGIN OF OWNERSHIP
Motor Cars	G.M.H.	U.S.A.
	Ford	U.S.A.
	Chrysler	U.S.A.
	Toyota	Japan
Oil Companies	Standard Oil	U.S.A.
	Shell	U.K./Netherlands
	B.P.	U.K.
Cigarettes	British Tobacco	U.K.
Food Processors	Kelloggs	U.S.A.
	Westons	U.S./Canada
	McDonalds	U.S.A.
	Kentucky	U.S.A.

CONCLUSION

HEALTH DEMANDS MUST BE LINKED TO THE GROWING INDEPENDENCE MOVEMENT.

It is clear that many diseases can only be treated by struggling against the cause – foreign-dominated imperialist monopolies. The Australian people must take an increasingly united and militant stand against the health profiteers. Working people in particular are in the position to fight for a health-care system which best works in the interests of all the Australian people. All groups which profit from health care are susceptible to pressure from a mass movement of progressive Australian people. Such a movement, guided by the correct demands, can win many immediate victories which will benefit the Australian people's right to a good system of health care. Such a movement can play a vital role in the growing struggle by all Australians against foreign, particularly U.S., domination. The demand for a reasonable, accessible, free health system should be a major demand for every Australian fighting for independence.

SOME TACTICS FOR WORK IN HEALTH

- Workers can attempt to form links with various progressive health-care and social welfare groups.
- Delegations of workers can meet with representatives of doctors, private health insurance,

private hospital, and nursing home organisations, and the Minister of Health and Social Security, to make their own demands clear to them.
- Chemical and electronic components have to be shipped, unloaded, transported, installed, maintained, supplied with power. Australians do all this and it represents an enormous power.
- Private hospitals need to be built, extended, have equipment installed and cleaned, be staffed. Again this is the role of working people.
- All companies and private profiteers in health can be exposed by people who work for them and go to them. They can be embarrassed and pressured by mass movements in the forms of delegations, demonstrations and black bans, as the specific need arises in struggle.

DEMANDS FOR WORK IN HEALTH CARE

MEDIBANK AND OTHER SOCIAL WELFARE ISSUES ARE ON THE CHOPPING BLOCK. Medibank is only a health insurance scheme, but it is a vast improvement on a private health insurance system. All Australians must fight for . . .

- The preservation and extension of a Medibank with free and equal access to health and pharmaceutical services, with no gradual whittling down of benefits.
- The prevention of the tax levy to pay for Medibank. Medibank must be financed from general revenue.

- The exclusion of private insurance group involvement in the Medibank scheme.
- A Medibank not sabotaged by doctors' organisations, especially the A.M.A., the Australian Association of Surgeons and the General Practitioners' Society.

SOCIAL WELFARE BENEFITS MUST BE PROTECTED AND IMPROVED. All attempts to undermine social welfare benefits must be resisted at every turn. In particular –

- Unemployed Benefits.
- Supporting Mothers' Benefits.
- Elderly Pensions.
- Invalid Pensions.

ALL HEALTH AND MEDICAL STAFF SHOULD BE SALARIED. At present 40% of doctors in Australia are salaried. This must be increased to 100%.

COMMUNITY HEALTH CENTRES IN AREAS OF NEED MUST BE ESTABLISHED AND SUPPORTED. We must fight for community health centres which are fully financed by the government and oppose any move to undermine their work being carried out now.

ETHNIC AND INTEREST-BASED HEALTH CENTRES MUST BE SUPPORTED. The aboriginal, women's and migrants' health centres must not be threatened by finance cuts or interference in their internal affairs by the government.

CHILD CARE FACILITIES MUST BE UPGRADED. We must demand the establishment and financing of child care facilities in our local areas and workplaces.

NURSING HOME BEDS MUST BE AVAILABLE FOR ALL PEOPLE IN NEED.

WE MUST DEMAND THE NATIONALISATION OF THE HEALTH PROFITEERING INDUSTRY.

WE MUST DEMAND THE NATIONALISATION OF DRUG COMPANIES, MEDICAL ELECTRONICS, HOSPITAL SUPPLIES.

THE PEOPLE, UNITED IN STRUGGLE, CAN BREAK THE HOLD OF THE FOREIGN MONOPOLIES.

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