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European Union

Towards a European mobilisation in defence of public health

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If the various European Union Treaties do not specify the direct competence of EU institutions in the area of health protection, for around twenty years a challenge to social rights and benefits in this area has been observable in all member countries. These rights, in some countries such as France, are the result of the social relationship of forces which emerged from the Second World War. Thus the Constitution of the World Health Organisation (WHO) stipulates: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". .Hence the protection of health largely escaped market relations.

“Liberalisation” and privatisation...

Health has experienced a growing “liberalisation”, implemented by the WTO in 1995 and concretised by the signature of the General Agreement on Trade and Services (GATS), accelerated again since the bursting of the financial bubbles in 2001 and since 2007. Potentially it constitutes a very broad sector for the accumulation of capital, and the systems of health protection appear as a milk cow for capitalists in search of new sources of profits and liquidity.

Following neoliberal policies, the central concern of the EU governments has become that of financing of health protection because of the growing gap between income (reduced by the numerous reductions in social contributions and the taxation of capital) and expenditure (which continues to grow because of the aging of populations and the continued increase in the price of drugs and medical equipment). As the standard of competition is at the centre of European neoliberal construction, attempts to control health protection expenditure, that is budget cuts, have led to the introduction of market style mechanisms: the German reform of 1992, strengthened in 1997, introduced competition among health insurance funds. In France this competition has been generalised though supplementary coverage by opening mutual funds to the competition of the market, so that the previous coexistence of public and private non profit making health networks was definitively undermined by the establishment of pricing in activity and price convergence with the sole aim of profit making.

In Britain the reform of 1990 introduced competition at the level of health care supply between district health agencies and general doctor's surgeries, the management of the property stock being handed over to the private sector. This competition was increased by a new reform in 1999. These “quasi-market” mechanisms established In Britain have served as a reference model for Spain. Competition between public and private establishments has been most clearly implemented in Catalonia.

These developments, transforming carers into “care entrepreneurs” have led to the theme of the “enterprise hospital” which is reflected by the internal managerial reforms of hospital institutions, accompanied by an evolution of the sociological profile of their directors. Neoliberal ideological hegemony has led to the generalised diffusion of competition between care providers and the setting up of performance measurement instruments for care as well as the transfer of "solutions” (organisational schemas and so on) from one country to another. In the health sector, as in others, we have witnessed the appearance of a veritable international élite of “specialists” who impose in their countries the neoliberal recipes drawn up at a European and international level.

A recent report from the research department of Deutsche Bank [1], devoted to the possible growth of income from competition, indicates that there are “benefits to be derived from the privatisation of government services of general

interest, e.g. water supply and disposal, healthcare facilities and non-sovereign administrative tasks" because "Fundamentally, these are private goods".

It continues: "facilities (such as hospitals) that are not covering their operating costs and/or are in debt can probably only be disposed of at a corresponding discount. Nevertheless, privatisation will usually make sense here, too. This is one way the government can reduce its future payment obligations, while offering the facilities the chance to be successfully restructured in private hands". And as governments have obligations in the area of health services, the report announces that following privatisation of the health sector "the government should procure these services from private providers and pay for them. One example here is the requisite capacity reserves in hospitals in times of crises such as epidemics". In short governments should sell health institutions at a discount so as then to pay, without discount, for the reservations of the necessary capacities. The authors then indicate, in note form, that if the governments hesitate to sell off public property, because of a substantial civic opposition and accusations that they were "selling the family silver", then "a sizeable part of the potential is at the municipal level. As the municipalities are more or less autonomous…" â€" thus municipal representatives are more approachable … or corruptible [2].

These recipes seeking the "restructuring" of the health service are consistent both in challenging the benefits of health employees (wages, working conditions, social protection and so on) so as to reduce labour costs and reorganising health institutions with a view to distinguishing that which is profitable, so that it can be privatised, and that which is not.

... and their results

Poland is an example of the results of this policy. Here the financing of care has been transferred to a national health fund, divided into regional structures, which finance fixed annual contracts â€" thus independent of developments in patient needs â€" for health services in public or private institutions. This system has first allowed the blocking of expenditure, then rendered the public hospitals, which are obliged to care even when their contract has been bypassed, loss-making. The ownership of local hospitals has also been transferred to the localities and to the cantons, although they do not dispose of the necessary budgets. A new law envisages that all the indebted hospitals should be "commercialised" (transformed into public limited companies) by the end of 2012, or their public "owners" should repay the debt in six months. The desired effect has been attained: hospitals have been massively privatised. These private hospitals, oriented towards profit maximisation, profit from all the flaws of the financing system. A recent research report carried out in its region by the Medical University of Gdansk (GUM) concludes that "non-public institutions: 1. Offer a more restricted range of care and frequently use more than 50% of their contract for a single procedure; 2. Carry out the procedures whose profit margin is the highest; 3. Avoid patients whose hospitalisation could be lengthy; 4. In certain situations select patients on the basis of age." [3]

The daily "Gazeta Wyborcza" sums it up: "A patient affected by complications, necessitating a prolonged hospitalisation, will not go to a private institution because it is not profitable. Where will they be treated? In the public hospitals, where the majority of patients are not profitable, like them". [4]

The other side of the coin: the employees see their employment contracts challenged. An employee of the N Piekary Slaskie Medical Centre, which has been transformed into a public limited company held (still) by the municipality, wrote recently in a letter to the press: "Our respected CEO has had an excellent idea: that all the care personnel resign and she will take them back as hired labour, (…) women, who have twenty five years seniority, who are already exploited by hard labour, who accept such contracts will have no paid holidays, or sick leave. They will simply be destroyed. And what a farce â€" they will not be dismissed, they must dismiss themselves! (…) The women are broken, they don't know what to do, and they don't dare to say NO in a loud voice. So, in their name, I launch an appeal for help!"

Let us stress that the international media incessantly stress the fine economic health of Poland (growth rate in 2011: 4 %) and present it as an example, unlike Greece. But in Greece, following the memorandums of the Troika, we see a real humanitarian and health crisis. Whereas a movement had in the 1980s imposed a system of free public health, only the ruins of it remain. During the first nine months of 2010 the national health service budget was reduced by 60%, leading to the closure of care services, suppression of jobs and reduction of wages. Psychiatric hospitals, deemed dispensable, have been closed. Three million people, or nearly a third of the population, are without any social cover, because health insurance is linked to employment. The hospitals no longer have the resources to provide drugs. And all access to care institutions is conditional on payment of an “entry ticket” of 5 â‚¬. Finally a racist offensive has targeted immigrants, deemed “responsible for the deficit” and carers are asked to reject those without papers and denounce them. Immigrant women have suffered the “confiscation” of their newly born, returned to their mother after payment of the price of the confinement!

The Polish examples are not isolated. Alexis Benos writes: “The reality in the different countries is remarkably similar. Belgium has cancelled the right of universal access to health services and legalised the selection in the name of profit of patients of the private sector. In Britain, the list of diagnoses which are not covered by the free health services because they “are not immediately life-threatening” gets longer. It includes knee, hip joint and cataract surgery! In Spain, after the closure of beds in public hospitals, health is now recognised by the law as a commodity, and the treatment of immigrants is no more generous than that meted out by Papadopoulos and Loverdos [in Greece]. In Germany, 30% of public hospitals have already been handed over to the private sector. (…) In Italy, the share of patients in the payment of their medicaments has gone from 35 % to 40 %.” [5].

We should add that in Germany there has been an increase of more than 11 % in the financial cost transferred to households, thus a fall in access to care, and in Belgium, where the hospitals still belong essentially to the non profit making private sector (associative, mutualist and so on), the services are little by little being “externalised”. Old people’s homes are experiencing a differentiation: the more profitable (the most expensive) are commercialised, which is accompanied by a deterioration of the working conditions of employees. In Italy, the Monti government is preparing to increase its expenditure cuts plan to 25 billion Euros. In this context spending on health “should be reduced by 1.5 billion Euros”.

Victorious struggles against health privatisation

These policies justified by budgetary reasoning seek in reality to render the greatest part of the health sector profitable, in order to privatise it. It is the demands of capital which determine these “restructuring” projects. For example, the Penta investment group, which the Slovak doctors union LOZ/LUP has denounced as being the beneficiary of the privatisation of the hospital sector, writes on its webpage in relation to "investment criteria" that "the internal rate of profitability demanded is at least 20% for each investment” [6] For the hospitals to realise such a margin, the Slovak government must break the resistance of the doctors, in particular by rejecting their wage demands.

After weeks of protest actions by the doctors and strikes by medical students to “save the public care system” and fruitless negotiations with the government, a third of Slovakia’s hospital doctors announced that they would resign on November 30, 2011 if their demands were not satisfied. These demands were: respect for the labour code and safety at work regulations, modification of the hospital financing system which does not reflect real costs and allows five health insurance companies to make profits, an end to the transformation of hospitals into public limited companies governed by the commercial code, a legal guarantee of salaries for doctors of between 1.5 and 3 times the average salary. Although the government declared a state of emergency (allowing the requisition of doctors) and brought in Czech military doctors to replace them, 1,500 doctors blocked the functioning of hospitals and forced the

government to capitulate on December 5, 2011. “By this action, the doctors have saved the public character of the medical services in Slovakia. The transformation of all the hospitals into public limited companies has been stopped. The real price of medical services, including the salaries of health professionals, has been adopted. A law on the minimum wage of doctors has been adopted â€” currently it is fixed between 1.05 and 1.6 times the average wage in the economy; starting from July 1, 2012 it will rise to between 1.2 and 1.9 times the amount of the national average salary”. [7]

In Rumania at the end of December 2011, in the context of the austerity demanded by the IMF, the World Bank and the European Union, President Basescu's government began an attack on the health system. Its counter-reform specified a reduction of medical cover and the entry of at least four supplementary private insurers on the health insurance market as well as the “commercialisation” of health institutions,. Raed Arafat, a doctor of Palestinian origin and under secretary of state for health, criticised the reform on a broadcast televised on February 12, 2012. Basescu then intervened on air and insulted Arafat, the latter then resigning. The day after the Romanian population, harassed by austerity, went onto the streets of Bucharest and other cities. Although the president had already announced the withdrawal of the reform and Arafat had rejoined the government, despite the snow and the cold, thousands of people occupied the streets demanding the resignation of the government led by Emil Boca, on February 6. A new coalition government of the right, led by Mihan Razvan Ungureanu, resigned in its turn three months later. Elections are to be held in November 2012. The mobilisation against the health “reform” has opened the way to opposition to all austerity policies.

In Germany, the privatisation of the hospitals has already advanced. The multinational Frasenius, first centred on dialysis machines, than on dialysis clinics, before broadening its activities to the pharmaceutical industry and to hospitals, already owns 75 hospitals. The decentralisation of the health system â€” that is, the decentralisation of spending â€” leads the local administrative bodies to try to slough off the weight of health expenditure. It is in this context that the Dresden municipality has tried to merge the two municipal hospitals that it manages inside a public limited company and transfer its management to a private group, a first step towards its sale. To oppose this an “Alliance for hospitals” has been set up, bringing together hospital staff, the trade union Ver.di, the collective “Hands off the hospitals”, and the political parties (Die Linke, SPD and so on). 37, 000 signatures were collected for a petition for the maintenance of the municipal status of hospitals. A referendum was forced and on January 29, 2012, 84% of votes cast favoured the maintenance of the two hospitals as communal enterprises, which the municipality will now be obliged to respect for the three coming years.

A European resistance movement is born!

These victorious have three characteristics. First, they mobilise force well beyond health workers alone, as in Rumania and Dresden (Germany). Secondly, the dominant trade union confederations, forming part of the European Trade Union Confederation (ETUC), do not play any motor role, indeed do not support them. Sometimes - as in Slovakia â€” it is a sectoral trade union that plays a central role. Finally, the ETUC, which has enormous resources which could allow it to publicise in all EU member countries information on the employers’ and governmental attacks of which its members are victims and the struggles waged at the national level does not do so. Whereas the capitalists have multiple structures of coordination, the European coordination of struggles waged by the health sector employees remains to be put in place. It is the ad hoc structures and sometimes European sectoral associations (like the European Federation of Employee Doctors) who publicise the demands of mobilisations in defence of health.

The bursting of the speculative financial bubbles (that is, the collapse of what Marx called “fictitious capital”) and the recession (in other words the reduction of capital investment possibilities at rates deemed to be “profitable”) have accelerated the search for new spaces of capitalisation. In health this leads to a qualitative leap in “liberalisation” and

to an acceleration of “restructurings” to “open to the market” a sector which was largely protected. It is “a uniform international policy, whose characteristics are coherent. These main stages are the commercialisation of health services (creation of the internal market), dismantling of the public health service and social protection (which rests on its under-financing, leading to obsolescence of equipment and the reduction of the labour force, the elimination of services, the pillage of public insurance funds and so on) and finally the privatisation of services, characterised by the transfer of the costs to the individual budget of the patient and their family” [8].

The great majority of the dominant trade union leaderships do not take initiatives to react to this new situation, which demands breaking with routine, be it only to defend the right of unions to exist. For, as indicate by the example of the privatisation of hospitals in Poland, capital no longer needs “partners”: the transformation of employees into “auto entrepreneurs” â€” with business contracts rather than employment contracts imposed on them â€” deprives them of their right to join a union, because Polish trade union law (correctly) does not allow entrepreneurs to be members. Trapped in the ideology of social partnership, the ETUC limits itself at most to protesting that it is no longer invited to negotiate at the European level.

It is this note that has led political, associative and trade union activists to attempt to regroup on a European scale. In May 2011, with the help of the International Institute for Research and Education (IIRE-IIRF) (16), at the initiative of the Nouveau parti anticapitaliste (France) and the free trade union “August 80” (Poland), a first European conference in defence of the public health service took place in Amsterdam, with activists present from Germany, France, Britain, Ireland, Poland and Sweden. They were there to exchange experiences of struggles and collectivise information on attacks against public health services and the relationships of forces in the different countries. The idea of extending this experience, by a broadening of the network to a greater number of European countries and to all the popular organisations sharing this viewpoint was adopted.

A second conference took place in Katowice (Poland), in November 2011, at the initiative of the Polish National Union of Nurses and Midwives (OZZPiP), the free trade union “August 80” and SUD Santé Sociaux (France). The question of broadening of the network as well as the idea of making it a tool capable of initiating common actions on a European scale was raised. With this aim the Katowice conference called a new European meeting, which took place at the University of Nanterre (France), on May 12 and 13, 2012, with delegations from 28 organisations from Germany, Belgium, Spain, France, Greece, Ireland, Italy, Poland and Slovakia. It was co-organised by the NPA, SUD Santé Sociaux; the Coordination nationale des comités de défense des hÃ´pitaux et maternités de proximité and another French organisation, FASE. [9]

The participants adopted a declaration calling for “the organisation in each country of a week of European action for the right to health of peoples and against the dismantling of public health services and their commoditisation, from October 1-7, 2012 “and decided to participate in the “European White Village” (a camp of health employees) in Warsaw on October 6, 2012 as well as in “the organisation of a European Conference on October 7, 2012 in Warsaw”. A “campaign of coordinated communication with a common petition and posters” will be realised.

These decisions constitute a big step forward. There is nothing obvious about bringing together political, associative and trade union activists. The history of the European workers' movement has created barriers between trade unions and political parties, the unfortunate experiences of the submission of unions to Stalinist and social democratic parties still weigh, the capacities of mobilisation differ, and so on. Even if, as we have seen recently, victorious struggles in defence of public health have been led by such groupings (in Dresden, for example) and collectives of this type exist in some countries (“Notre santé en danger” in France or “Keep our NHS public” in Britain, for example), traditions die hard. It is urgent that we face up to the coordinated attacks by capital against the public health sector and the ineffectiveness of the superstructures of the European trade union movement.

The European week of action was launched through press conferences held on June 5, 2012 in various European

countries. The week of action should not be considered as an end in itself but as the point of departure for the broadening of the mobilisations to other countries and organisations not present in Nanterre. “A movement of resistance to the privatisation of health protection, against the favouring of private institutions, against the unacceptable treatment of employees and patients is born”, said Iwona Borchulska, president of the OZZPiP during the press conference in Warsaw on June 5. “Across the continent there is a struggle against the commercialisation and privatisation of hospitals, dispensaries, and medical centres. The organisation of health employees and patients will not accept the commoditisation of health” added Zbigniew Zdonek of “August 80”.

Health: Declaration of European conference in defence of health and public and universal social protection

Nanterre (France), May 12- 13, 2012

In the context of a crisis of capitalism, people’s health has been significantly degraded across Europe by the economic, ecological and social crisis that exacerbates inequalities.

The past year has seen an acceleration of the crisis in Europe. A second banking crisis has begun in Europe; the austerity policies which are being carried out jointly in all countries and by the European Union, are leading to a widespread recession, or even, in Greece and in other countries, to a veritable depression.

In successive layers, European leaders want to make austerity stronger and more irrevocable through ratification of the fiscal pact and the European Stability Mechanism (ESM).

Public debt, unemployment, poverty and inequality are increasing at an alarming rate.

Austerity and debt, presented as inevitable, have everywhere become the pretext for harsh attacks on public health and systems of social protection and social rights. Greece, which is the emblematic case for all Europe, is living through an unprecedented humanitarian and health crisis. Today the countries of southern and Eastern Europe are the most affected.

Austerity plans for health and social protection are taken under pressure from the health multinationals and private insurance systems.

These multinationals play a major role in the destruction of the social rights of collective bargaining and trade union rights (collective bargaining, freedom of union activity, conditions at work and so on), in lowering wages and the wage share of GDP (which the new economic surveillance, with control of “unit labour costs” will exacerbate) and the casualization of employment (return to daily work, explosion of temporary work, pseudo-independent so-called auto-entrepreneurs and so on).

These austerity policies constitute a violation of the human right to health and destroy public health and social services. They concern all socially insured persons and especially affect certain citizens:

1. Women, very much in the majority in these public services, occupy the most precarious jobs, are the first to be laid off in the closures of hospitals, crèches, centres for the health of women and reproductive rights, and structures of

care for the handicapped, and assume the bulk of the “work of social reproduction” which austerity policies re-transfer massively to the domestic sphere,

2. The disabled, are major victims of the crisis, excluded not only from work, but also often from the institutions supposed to welcome them;

3. Migrants and those without papers are often excluded from health and social protection systems.

Beyond the necessary national response, in each country, these measures require concerted action by health professionals, patients and citizens; this implies a pooling of experiences of national struggles in defence of public health and social security, the organization of a concrete solidarity in struggle, and reflection on the construction of international initiatives for the defence of a universal public health which is egalitarian and socially responsible.

At the end of the conference in Nanterre (France), which took place on May 12- 13, 2012, participants from trade unions, political parties and associations of struggles for the defence of health and social protection, defending a public health system of high quality throughout Europe, voted for:

– the construction of a European area of exchange, mobilization and action against the privatization of health and social protection systems, open to all those who wish to take action against austerity affecting the health of peoples, and regression of social rights and social protection.

– the implementation of a European program presenting an alternative to the neoliberal goals which defends public health and social protection as universal common goods that can no longer serve the private profits of shareholders private stakeholders in health or social welfare institutions. Such a program requires equal access to health, free care, health democracy, and collective and public funding.

– a citizens’ audit of debt, including the debt of hospitals, social bodies and social protection with particular emphasis on the impact of the debt for women.

– the setting up of a permanent network of exchange of initiatives and action against the privatization of the health and social security and systems and against any prescription charges or taxation of patients and any measure to reduce universal access to health.

– the organization of press conferences coordinated around this statement on June 5, 2012 and an appeal for solidarity with the Greek people.

– the organization in each country of a week of European action for the right to health of peoples and against the dismantling of the public health services and the commodification of health from October 1-7, 2012.

– a representation of each country at the “European white village” (a camp of health personnel) in Warsaw during the week of action.

– the Organization of a European Conference on October 7, 2012 in Warsaw.

– the coordination of a common communication with common posters and a joint petition campaign.

Conscious that action for a public health and universal social protection system cannot be the prerogative of only health professionals, associations for the defence of public health and concern the whole of society, the members of the conference:

– wish to register the specificity of this fight in all initiatives to rebuild a new European public space and to build inside it a permanent campaign in defence of the right to universal and public health services.

– will be involved in the European campaign for the non-ratification of the European stability pact and the withdrawal of the ESM.

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[1] Dieter BrÃ¤uninger and Barbara Böttcher, "Revenue, competition, growth", EU-Monitor, Engl., December 1, 2011, p. 5.

[2] ibid., p. 15

[3] In Polish here

[4] Alicja Katarzynska, Bulwersujacy raport: Selekcja chorych w szpitalach, June 3, 2006.

[5] Alexis Benos, 10. "Le Monde", June 15, 2012" class="spip_out" rel="external">La conférence européenne de la santé Ã Nanterre, Epohi, May 28, 2012,

[6] About private equity

[7] Pavel Oravec, vice-president of LUZ/LUP, Report on the Slovak Health Care Situation (October 2011 - May 2012),.

[8] Alexis Benos, op. cit

[9] The conference of May 12-13, 2012 in Nanterre was attended by 82 participants from nine countries. The organisations present who adopted the declaration were: **Germany**: RevolutionÃ¤r Sozialistischer Bund (Fourth International); **Belgium**: Centrale nationale des employés (CNE/CSC, main union of employees in Belgium); Plateforme d'action santé et solidarité ; **Spanish state**: Movimiento Asembleario de Trabajadore/as de Sanidad (MATS) Coordinadora Anti-Privatización de la Sanidad PÃºblica de Madrid (CAS); **France**: SUD Santé Sociaux; Solidaires; Coordination nationale des comités de défense des hÃ´pitaux et maternités de proximité; Union Syndicale de la Psychiatrie, LSNPUM, Marche Mondiale des Femmes; CADAC; CADTM, Les Alternatifs; FASE, NPA; PCF; **Greece**: Women against debt and austerity, Greek Federation of Unions of Hospital Doctors, Union of Doctors of the Radical Left, Union of Specialised Educational Personnel, Movement for the Health of the People; **Ireland**: People Before Profit; **Italy**: Unione Sindacale di Base (USB); **Poland**: National Union of Nurses and Midwives (OZZPiP – 77,000 members or 1/3 of the profession; Free trade union "August 80" (WZZ "Sierpien 80"); Polish Party of Labour (PPP); **Slovakia**: LUP-LOZ ; "Equality" NGO.