The counter-reform of social security and hospitals in France and our proposals

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This article is based on one of the reports at the European healthworkers conference, held in the International Institute for Research and Education in May 2011. See (ESSF article 22173): Statement from the European Conference for the defence of a public health service and (article 22172): European conference for the defence of a public health service and other national reports.

Contents

In France, as in the other European countries, the health system, like the pension system, is at the heart of the liberal counter-reforms carried out by governments of right and left since the end of the 1970s.

The determination of the ruling classes to present the bill for the present crisis of capitalism to workers and the popular classes is accelerating the speed and the extent of the attacks. The counter-reforms of pensions, health insurance and hospitals have been unceasing since 2002. To this Sarkozy is adding, this year, the question of “dependence” (the financing of the services that make it possible to compensate for the loss of autonomy of elderly people who have become “dependent”).

In an internal note revealed by the Médiapart information site, the MEDEF (the organization of big employers in France) estimates that the time has come for a “profound structural reform” of the health-care system. “We cannot give any more time to time” affirms this note, which details the programme of the counter-reform.

We will deal here with the following two aspects:

What are the aims of the counter-reform?

What alternative do we counterpose to it?

1) The objectives of the counter-reform.

In the relationship of forces after the war, which was very favourable to the working class, a health-care system was established in France that in principle gave everyone access to quality health care.

This system developed over the thirty years of economic expansion which followed the war, based on two pillars: health insurance, a branch of the social security system, which financed health care on the basis of solidarity, via national insurance contributions (the social wage,); and the public hospital, a public service providing access for everyone to quality care.

So we went from assistance (public charity) for the poorest, supplemented by insurance for those who could pay for it, to a system that made it possible “for everyone to have the best care”.

This principle was never completely applied. Nor was it accepted by the ruling class, which never stopped fighting it. It is in fact situated within a logic that is opposed to a society based on the laws of the market and on profit

1) National insurance contributions, indirect wages that are added to direct wages, are considered by employers as an unbearable “load”, whereas for them it is a question of reducing the “share of wages” in the wealth that is produced, in order to increase the share of profits.

2) The social wage prefigures a society where needs are satisfied by drawing on the wealth produced, and not according to people’s individual monetary resources (to each according to their needs and not according to their means).

In the beginning, the social security system was mainly managed by the elected representatives of the workers, and not by the state, something which has since been called into question.

The attacks increased with the turn towards liberal counter-reforms, at the end of the 1970s, under all governments (both “right” and “left”).
Since 2002, the objective, more and more clearly proclaimed, is the global revision of the health-care system (in order to “save” it, of course!), the return to the liberal duo assistance+ insurance, in other words health care “on several levels”, where people receive care according to their means and not their needs.

This return allows, moreover, the opening up of the health market to private insurance and private hospital groups.

The main obstacle to counter-reforms is the attachment of the great majority of the population to this health system. In spite of the attacks and the real deterioration that it has undergone, it remains largely perceived as an asset which must be defended.

To justify the counter-reform, there exists a consensus between employers, the Right and the social-liberal Left. This is the dogma of the “bringing under control” of health expenditure. This expenditure, digging deeper every day the celebrated “hole” in social security, can apparently not continue to increase, or else it will bankrupt “our model” of social protection.

This ideological construction is aimed at making people believe that the alleged “deficit” is an objective economic reality, and not the result of a policy option, the real question being, as with pensions, how wealth is distributed.

The goal of the counter-reforms is not, however, the reduction of spending on health - It is on the contrary the opening up, and the development, of the market in health, to the insurance companies, to the private hospitalization commercial trusts – a market that has been until now restricted by the existence of a public source of finance, based on solidarity (health insurance) and of a public service structuring the whole system of care (the public hospital system).

The real goal of the counter-reform is in fact to reduce massively the share of socialized financing,

(the social security system) in order to open up the market to private insurance companies. It is also to almost completely exonerate employers from paying contributions, to shift the bulk of the “load” onto the workers (via taxes).

Even though it is decreasing, the share of care that was financed by the social security system was 75.5 per cent in 2009, whereas that of complementary organizations (mutual and private insurance companies) was 13.8 per cent, including only 3.6 per cent for private insurance companies). [1]

In the same way it’s a question of limiting the scope of the public health care system – which is still preponderant (60 million euros as opposed to 18 million for the private sector) - in order to allow the development of chains of private clinics or private commercial homes for the elderly (their shareholders talk about “grey gold”).

We can thus synthesize as follows the objectives of the counter-reform.

a) To reduce the share of socialized health expenditure (compulsory health insurance, AMO), to a minimum level of assistance “to the very poorest” and to the financing of “uninsurable” risks, to everything that is “unprofitable” from a capitalist point of view.

b) To make this expenditure profitable, repressive measures of control, hitting those who are the most socially fragile.

c) To exonerate the employers from financing the socialized part of wages, by a massive reduction in national insurance contributions, and to transfer (by means of taxation) this expenditure to the workers themselves.

d) To replace socialized financing by individual financing (“franchises”) or by complementary insurance (at the expense of those insured), from a mutual or private insurance company.

e) To transfer to complementary insurance, the insurance of the “profitable” segments of care activities, in particular everyday treatment defined as “minor risk”. Those defined as “major risk”, major operations, long and expensive chronic illnesses would continue to be covered by compulsory insurance.

f) To reduce the role of the public hospital by reducing its functions to non-profitable activities (unprogrammed treatment, expensive, complicated and risky operations), aimed at the most fragile public.

g) To outsource hospital logistic activities to private companies.

h) To transfer the “profitable” activities of hospitals to the private hospital sector.

i) To limit the functions of the public hospital system, transferring “upstream” primary treatment to private doctors and “downstream” to the medico-social sector.

2) What alternative policy?

We cannot fight these counter-reforms by simply defending what exists.
For us, on the contrary, it is a question of defending an alternative policy based on the “right to health”.

Our proposals are organized around five main chapters:

1) To prevent disease, to create the conditions for everyone to live in good health.

2) To guarantee free health care for everyone.

3) To defend the public hospital system and to broaden it so that it becomes a real public health service.

4) To transform private health practice, in particular by putting an end to payment for each consultation.

5) To establish a public medicine policy.

1) Prevent: act on the social and environmental causes of health.

The preventive dimension of the right to health will have to be the object of attention in all fields: health at work, with not only the reinforcement of, but the right to veto of health and safety committees over any working conditions that are harmful to health.

Policies concerning the environment, agriculture, town and country planning…. etc., will have to integrate the "health" dimension

2) Ensure free health care for all.

– Equality in access to treatment necessitates free health care for all. Health costs must be completely, 100 per cent, reimbursed by a single health insurance system, part of social security system based on solidarity, financed by the national insurance contributions paid by the employers.

- In order to avoid having to pay in advance, which often dissuades people, the "payment by a third-party" system must be generalised.

– Abrogation of any form of "franchise" and "user fee".

– Prohibition of any kind of extra payment.

– The mutual insurance companies would no longer reimburse costs of health care. They would continue to play a role in prevention.

– Nobody would be able to make a profit from health care; the private insurance companies would be removed from the sector.

A self-managed social security system.

– We propose to return to the founding principles of social security.
National insurance contributions are part of the wages that are "put in common", socialized. This part of wages must be managed by the representatives of the employees themselves, without any intervention by the employers or the state.

– Election by those paying social insurance of their representatives to the insurance funds.

– Consultation of those paying social insurance on all important decisions concerning health, after an open and pluralist public debate informed by the point of view of experts (health professionals, economists, associations of patients, etc).

- Abrogation of the vote by Parliament of the law fixing the level of health expenditure (the Juppe Plan)

3) Defend the public hospital system and expand it to become a real public health service.

We first of all propose to defend the public hospital system:

- Suspension of any reduction in the number of beds and any closure of departments or hospitals. Whether or not a part of the health service should be maintained must be decided by the population itself.

– Abrogation of the reform known as “Hospital 2007”, withdrawal of the “patients, health and territories” bill.

– Removal of private beds in public hospitals.

– Attribution of the budgets that are necessary for medical establishments: an immediate increase of 8 per cent to make up for previous reductions).

– A “jobs-training” plan for the creation of 100,000 jobs in the public hospital sector.

– Suppression of the numerus clausus in medical studies: training of the number of doctors necessary for a preventive and curative health policy.

– Expropriation of profit-making private establishments. Transformation of these establishments into public hospitals.

– All of the employees of these establishments to be taken on by the public hospital system.

But for us, the public health service of health cannot be limited to hospitals. That is why we propose the development of a public health service including both the public hospital system and **entirely free public health centres, established in towns and in neighbourhoods**, starting with those areas where there is most need of them.

Health centres and public hospitals would form a whole, functioning in a coherent way.

The public health centres would play a role of prevention and of providing treatment, directing patients if necessary to a hospital. Treatment would be completely free.

In these centres work would be carried out in multi-field teams, comprising both general and specialist doctors, paramedical professionals and social workers.

Working daily as part of a network with all those involved in health care (private general practitioners and health professionals, social workers, elected representatives…), these teams could tackle health issues in their context and their social dimension.

These centres would ensure the “permanent treatment” on the terrain, 24/7.

The existence of these centres would make it possible to respond rapidly and to be close to the health needs of the population. They would make it possible to direct patients to a hospital if necessary, avoiding saturation of accident and emergency departments. They would not however replace neighbourhood hospitals which must keep their emergency services, their maternity wards, their medical and surgical departments.

4) Transform the exercise of private medicine, in particular by the suppression of the payment at each consultation.

We propose to challenge the way private doctors and health professionals currently operate:

– Payment per consultation as practised by the private medical sector must be abandoned.

– A new method of payment will be established, which encourages the preventive dimension of care, enabling the medical professional spend the time necessary with each patient, and does not encourage the multiplication of consultations.

– The necessary continuous training will be ensured, conducted in a way that is independent of the laboratories.

– So as to encourage general practitioners to set up in the areas where there is a shortage of doctors, and also in order to democratise medical studies, medical students who wish to will have the possibility of being paid a salary throughout their studies, in exchange for a “commitment to serve” in a sector where increasing the number of doctors is a priority.

5) Establish a public medicine policy.

Our refusal of the commoditisation of health leads us to demand the expropriation of the pharmaceutical industry, whose fabulous profits are provided by national insurance contributions.

Medical research must be placed under public control.

Medicine is not a commodity: either it has effectiveness and recognized therapeutic qualities and it is completely refunded by the health insurance, or else it is useless, and quite possibly dangerous, and it should not be produced nor sold.

The public hospital system in France (2003 data)

Hospitalization accounts for approximately 45 per cent of health insurance expenditure.
The French hospital system is divided into three types of establishments.

1) **Public hospitals.**

A very big majority of the personnel are employed under the statute of the public hospital service (nearly 800,000 employees), even though precarious work has largely developed there.

Doctors (hospital practitioners) are also governed by a statute.

In 2003 there were 303,420 beds (66 per cent of the total) in this sector.

2) **Private non-profit-making establishments, known as “PSPH” (taking part in the public hospital public service).**

These establishments do not make profits that are distributed to shareholders, but their employees are governed by private sector status. There is in particular the status of the Centres of Combat against Cancer (CLCC) .

In 2003 there were 64,917 beds in this sector (14 per cent of the total).

3) **Profit-making private establishments.**

These are private clinics whose goal is commercial. As we have seen, there has been a strong process of concentration this sector.

In 2003: there were 93,812 beds in this sector (20 per cent of the total).

Footnotes

[1] 1. DREES (Ministry of Health) Studies and Results N°736 “National health accounts 2009”