European Economic Integration and Health Policy

UNHEALTHY EUROPEAN HEALTH POLICY

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The European Union claims that the defense of its welfare state is one of today's most important challenges. This article analyzes whether the European governments and the European Union really pursue a policy that strengthens their health and social security systems, or one that is in itself a threat to health and social security. After a summary of the origin and evolution of the European health systems, the authors pinpoint underlying reasons for reform and demonstrate how, since the 1990s, the European Union has built a strict financial and political straitjacket, forcing these systems to carry out privatization and cutbacks. Reform measures can be divided into three interdependent categories: (1) the increasing influence of governments on health care organization, to enable restructuring; (2) measures aimed at reducing public expenses, including higher financial contributions by patients and restrictions on the range of services provided; and (3) measures that establish competition and hidden or open privatization of services and insurance systems. Through these mechanisms public expenses are reduced while private health care expenses (and private profits) rise freely. Ongoing European health care reforms thus struggle with the contradictions between responding to growing collective needs and securing or increasing private profits.

The Organization for Economic Cooperation and Development (OECD) claims that without a major change in European public health care and pension policies, "transfers" from the shrinking working-age population to the growing retired population will increase so significantly as to become unbearable. Without health sector reforms more fundamental than those implemented in the 1980s, tax increases or service cutbacks will be unavoidable (1). The European Commission asserts that health and disability insurance guarantees that the "European social model" protects all people against the financial consequences of illness and, at the

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same time, encourages rapid and lasting medical progress and the development of new treatments. It concludes that one of the most important challenges for the European Union today is to defend and extend this welfare state (2). But do these descriptions match reality? In this article we recall the origin and evolution of the European health systems, pinpoint underlying reasons for (calls for) reform, and analyze whether the European governments and the European Union really pursue a policy that strengthens Europe's health and social security systems, or one that is in itself a threat to health and social security.

THE EUROPEAN MODEL

The Origin and Evolution of European Health Systems

Four major periods can be delimited in the development of European health care and social security since 1880 (3). First, workers at individual enterprises obtained different forms of social protection through their organization and struggle against deplorable working conditions. In a growing number of places they ensured health insurance benefits. But even after decades of social struggle, global results remained rather limited and dispersed.

Not until after World War II did governments introduce general and compulsory social protection and global health care systems. The Soviet Union had carried the heaviest burden of the struggle against the Nazi armies and was held in great respect among the working classes of Western Europe. The Soviet national health service had a good reputation. In this second period, social security became one of the most important concessions by European governments to counter the communist sympathy among European workers (4). This generalization of social protection took two different paths. In France, Belgium, and Germany, for example, the existing forms of social security were extended and generalized to a national social security system. In the United Kingdom, Sweden, and other countries a more radical reform toward a national health service was introduced. Navarro (5) explains that each health system has resulted from a class struggle in each country. The diverse development of the systems of funding and organization of health services in different societies is based on the class relations in which the labor movement fought for these services.

During the famous "golden sixties," the relation of forces was such that the social struggle could obtain further legislative gains for social services, but from 1973 onward conditions changed drastically. In this third period, economic crisis caused financial constraints in social security systems. In the 1980s this situation led to a first wave of financial cutbacks in the health sector. Trade union leadership went along with this policy, accepting the role of "administering the crisis."

The fourth period, still underway, began in 1989 with the disappearance of the socialist regimes in Eastern Europe and the collapse of the Soviet Union. This

radical change in power relations was seized upon to launch a renewed ideological attack on the "expensive" European social security systems. In the name of improving Europe's competitive position with regard to the United States, a social and economic policy of deregulation, privatization, and destruction of social achievements is now pursued.

Two Basic Models

Before analyzing the present reform policy in more specific terms, we compare the two basic models of Western European health systems: the national health system or national health service (NHS) and the system of health insurance in combination with social security (SSS) (6).

In a *national health system* organization is in the hands of government. The entire population is covered; the system is financed mostly by tax money, and the health services are public property. Most of the care providers are public servants or are paid by the state. In these systems, where the services have been integrated in one organization, government has an important power and direct influence. This state power was a strong positive factor in creating an efficient system in the face of conservative interest groups during construction of an NHS. But when the dismantling of the system is at stake, state influence makes it more difficult for a weakened labor movement to defend its social achievements. The United Kingdom is a typical example of this NHS. It also exists in varying ways in Sweden, Denmark, Spain, Italy, and Portugal. In southern Europe the system is mixed, with social insurance (related to wages) playing an important role in the financing mechanism.

A *social security system,* compulsory by law, is a wage-based system financed by premiums based on a percentage of wages paid, augmented by tax money. The system is managed by workers' and employers' organizations and functions through funds organized by profession, region, or political group. An important feature is the mix of public and private providers of hospital services. Most of the doctors work independently and are paid per procedure. The principle that insurance is an individual choice (those who do not contribute are not covered) has been embedded in a collective redistribution. This results in (almost) universal access to care and a high degree of equity. Still, certain groups fall through the cracks (7, 8). Because of the number of different institutions involved, government control is much more complex. Social security systems exist in France, Germany, Belgium, Austria, the Netherlands, and Luxembourg.

Countries with an SSS spend more on health care than countries with an NHS (Table 1). According to the OECD, SSS patients are more satisfied because they have the freedom to choose their own doctors and because paying for service improves the quality of medicine (9). But during the 1960s and 1970s, the period in which their NHS was adequately financed and functioned quite well, the British flaunted their health system and progressive forces on the European continent held

Table 1

Comparison of expenses for health care

	Expenses for health care, 1998		GDP per head, PPP, 1999
	Total, % GDP	Per head, PPP[a]	
Social security system			
Belgium	8.9	2,172	24,200
France	9.6	2,102	21,897
Germany	10.5	2,488	22,404
National health service			
United Kingdom	7.0	1,532	22,640
Italy	8.2	1,830	20,751
Spain	7.0	1,202	16,730
Other			
United States	13.1	4,180	30,600

Source: Word Development Report 2001, www.worldbank.org.
[a]PPP, purchasing power parity in U.S. dollars.

the U.K. NHS in high esteem. The subsequent governments of Thatcher, Major, and Blair then deliberately dismantled the country's NHS.

The European Commission confirms this analysis, by stating that the built-in stronger resistance of an SSS to governmental intervention has protected these systems against exaggerated governmental cutbacks. Therefore the SSS has been more successful in keeping its budget at a steady level and in slowing attempts to diminish the quality of the care provided. But another phenomenon developed: the drastic increase in patients' contributions and co-payments (2).

"European" versus "American" Models

In the United States there was no direct threat of a revolutionary uprising in the post–World War II period. A strong anticommunist campaign led by Senator Joseph McCarthy neutralized communist sympathy. One of the consequences was that U.S. social protection has always remained limited to (mainly) insurance at the employer level, with the extent of the services dependent on the prosperity of the enterprise. The U.S. health system developed in three parallel tracks. The government took care of a selective system of minimal health care, a "medicine for the poor," financed by taxes, while employers and economic sectors agreed to set

up health insurance and pension funds, buying social peace with social benefits. But this social protection remains very insecure. If you are laid off or your employer closes down, you lose not only your job but also every social protection. Finally, there is a large commercial system of private medicine for those who have enough money and/or have an expensive private insurance contract.

Results are dramatic. Although the United States spent 13 percent of its gross domestic product (GDP) on health care in 1998, there is a crying inequality, with commercial overconsumption for a restricted group and chronic shortages of access to and quality of health care for large groups on the other side of the social gap—resulting in a lower score on almost all global health indicators compared with Europe (Table 2).

Whereas U.S. employers are responsible only for the health care of their own employees (in Marxist terms, for the reproduction of the labor force for their own company), European employers have been obligated to pay a "surplus" cost, which finances social insurance for the general population. As of the early 1990s, indirect wage costs in the United States were only 28 percent of total wage costs, compared with 40 percent in Europe. During a period of economic crisis and increasing international competition, this difference is a thorn in the side of

Table 2

Comparison of some general health indicators

	General health indicators			PYLL at <70 yr (all causes) per 100,000 inhabitants, 1995[a]
	<5 yr child mortality per 1,000	Life expectancy, yr, 1995–2000	% probability at birth of death before 60 yr	
Social security system				
Belgium	6	77.9	10.5	4,537.0
France	5	78.1	11.4	4,579.8
Germany	5	77.3	10.6	4,440.7
National health service				
United Kingdom	6	77.2	9.9	4,061.6
Italy	6	78.2	9.1	4,455.9
Spain	6	78.1	10.3	4,110.0
Other				
United States	8	76.5	12.8	5,894.3

Sources: General health indicators: Statistics UNICEF 2000, www.unicef.org; Human Development Report 2001, www.worldbank.org. PYLL: OECD Health Data 2001.

[a]PYLL, potential years of life lost, is an overall calculation of the "premature mortality" in a country.

European employers. Reducing this "indirect wage" (i.e., dismantling social security and generalized health insurance) is one of the most important aims of the so-called "modernization" that the European bourgeoisie wants to impose on workers (10).

REASONS FOR REFORM

Analyzing the Official Story

Health expenses in the OECD countries doubled between 1960 and 1999, from almost 4 to 8 percent of GDP. To analyze whether this increase is "unacceptable" and "has to be corrected urgently," we need to understand the causes on the demand and supply sides.

Economic development contributed to a fast-growing demand between 1960 and 1980. An increased average income implies that more people have a higher disposable income for health care. With increases in average income, differences in income also increased drastically. Collective and compulsory social security—and even more so, systems funded exclusively by tax money—ensure that growing inequality is tempered in the field of health care.

During the 1960s and 1970s social security coverage rose gradually. Inevitably this caused a heavy increase in costs. But contrary to what the overall figures suggest, this coverage was crumbling again by the 1990s: patients pay more and more out of their own pockets (11). If we want quality health care to remain accessible for everyone, effective redistribution mechanisms (through social security and/or taxes) should be preserved.

The aging of the population leads to an increasing *need,* reflected in an increasing demand. On average, people older than 65 have four times more health care needs than younger people. The OECD calculated that aging of the population over the last 30 years was only a marginal factor in the increased expenses for health care. But in the next 20 years this factor is expected to lead to an annual increase of 0.4 to 0.7 percent of the health expenses in most of Europe (1).

Regarding the increasing supply, the OECD refers to the technological diagnostic and therapeutic developments and to factors related to health care organization, such as a growing number of physicians and new payment procedures. The medical-pharmaceutical industry has an enormous impact on total health care expenses. A European Commission study concluded that the pharmaceutical sector provides a particularly sharp challenge in the search for a balance between trade policy and health policy. But instead of restricting "market" and "profit" in the health sector, European institutions have created an economic framework favoring pharmaceutical manufacturers (8). With the "health industry" (mainly the pharmaceutical industry and the high-tech medical market) having developed toward a very profitable business, this supply side is the main cause of the increase in health care costs: 40 to 75 percent (1).

The Discussion That Never Took Place

With this increase in mind, European governments defend the "simple economic logic" that social expenses can only be as high as the available funds, and that consequently—if we want to "save" social security—drastic cutbacks cannot be avoided. But this approach leaves many questions unanswered. Who determines the available funds? Who determines what percentage of GDP can be devoted to health care? Why does the ordinary citizen have to carry the burden of the cutbacks while the medical industry and the pharmaceutical multinationals make outrageous profits?

Within the European Union, the total (public plus private) expenses for health care differ widely: in 1998, for example, from 7 percent of GDP in Spain to 10.5 percent in Germany. The U.S. costs are 13.1 percent of GDP (Table 1). For public expenses we also see wide variations: from 4.7 percent of GDP in Greece and 5.3 percent in Finland to 7.8 percent in Germany (11) (Table 3). Nevertheless, countries that spend a very different percentage of their GDP on public health care all jump to the same "inevitable" conclusion: we pay too much, the expenses have to go down!

Yet another viewpoint is possible. The establishment of social security after World War II shows that whether or not money is available for social security

Table 3

Comparison of public expenses in health care, 1998

	% of total exp. for health care	% of total public exp.	% of GDP
Belgium	71.2	12.0	6.1
Finland	76.3	10.5	5.3
France	77.7	13.9	7.3
Germany	75.8	16.4	7.8
Greece	56.3	9.3	4.7
Italy	67.3	11.3	5.5
Netherlands	68.6	12.9	6.0
Portugal	66.9	12.2	5.1
Spain	76.4	12.4	5.4
Sweden	83.8	11.4	6.6
United Kingdom	83.3	14.3	5.7
United States	44.8	17.3	5.8

Source: OECD, Health Data 2001.

is primarily a result of the political balance of power, of the struggle between class interests. The question is not what a government can pay but, above all, what it is prepared to pay for the social security of its population. Or to put it more precisely, what the organized working class can force the government to pay in a capitalist society.

Underlying Reasons for Reform

Which objectives are pursued today? Whose interests are served by the reforms proposed by the European Union, the OECD, and the World Trade Organization (WTO)?

European Union. The European Union has built a strict financial and political straitjacket that forces European health systems to carry out privatization and cutbacks (12). In 1992, the Maastricht Treaty set the standards for the monetary policy of the European countries, leading to the introduction of the euro. One of the most important consequences was the drastic cutbacks imposed on the social sector. In 1993 the European summit in Brussels concluded that the United States had recently performed "miracles" in the field of job creation. Jacques Delors, chairperson of the European Commission, defended the same policy in the European Union (10). Besides creation of "hamburger jobs" (temporary and low-wage jobs) at below the statutory minimum protection and a drastic increase in the labor flexibility, the policy especially included a reduction in employers' costs. Indeed, European employers considered their contributions to social security (pensions, unemployment insurance, and health insurance) to be hampering their competition with U.S.-based companies. Since then, Europe has been carrying out a two-pronged policy: on the one hand it restricts the state's social outlay, and on the other, employers' contributions to social security have decreased sharply.

Organization for Economic Cooperation and Development. In 1994, the OECD published a report tackling the question of why health expenses balloon and at what point there is a lack of efficiency. The report develops a series of measures to improve efficiency and argues for a profound reform "to save the health care systems" (1). The key parts of the study elaborate arguments supporting a strategy for imposing drastic cutbacks. They present the need to reduce social expenses as an unassailable fact. No consideration is given to how much a rich industrial state can and should invest in social welfare and health care. Though the report argues that "exaggerated" demand and supply must be opposed, the failure to define this concept leaves the door open to a strict financial interpretation. Also, the need for "high-quality health care" for everybody is defended but not specified. Competition and (of course, socially sound) privatization appear as a panacea.

World Trade Organization and General Agreement on Trade in Services (GATS). Through GATS, the WTO wants to force governments to open their public services, including social and health services, to market forces and foreign investors. These WTO concerns and proposals show clearly how the drive for profits threatens health care systems. In 1995, during the Uruguay Round on liberalization on a global scale, it was stated that the social sector and health care were public services and therefore were excluded from GATS' rules. But since then, the WTO has stated repeatedly that in a constantly increasing number of countries, the hospital sector is managed by a mix of state and private organizations and that these countries therefore can no longer be allowed to protect their health care markets from foreign corporations.

Encouraged by the multinational corporations united in the European Services Network in the European Union and the Coalition of Service Industries in the United States, Europe and the United States are very eager to push through this GATS liberalization. No wonder: the service sector has increasingly replaced the industrial sector as the principal source of economic growth. In the second half of the 1990s, export of services was responsible for one-third of U.S. economic growth. It also makes up one-fourth of E.U. exports (13).

These GATS measures will have the consequence, among other things, that a country that refuses to completely open its health care sector to multinational corporations can be prosecuted as acting "in violation of valid international rules of competition," possibly leading to trade sanctions (14).

HEALTH REFORM OR TEAR-DOWN POLICY?

Reform measures taken throughout Europe can be divided into three interdependent categories. First is the changing role of the state: the influence and decision-making powers of governments over health care organization are being extended, precisely to enable restructuring. A second group of measures is aimed at reducing public expenses, including higher financial contributions by patients and measures restricting the range of health services provided. Finally, there are measures that establish (or enhance) competition mechanisms and different forms of hidden or open privatization of services and insurance systems. Through these mechanisms, public (redistributing) expenses are reduced while private health care expenses (and private profits) rise freely.

The Changing Role of Governments

The possibility of holding back public expenses depends greatly on the degree of centralized control of the budget. In an NHS with one source of finance—as in the United Kingdom—the overall budget can be quite easily limited. At the several levels of the system the responsible persons have to sort out how they adapt to the new situation. As a consequence the social expenses are "under

control," but growing numbers of patients curse "the inefficiency" of the United Kingdom's once famous NHS, now reduced to its bare bones. So public opinion is ready to accept a privatization offensive.

In social security systems budgetary control is more complex, but also here government intervention is increasing considerably. Various measures are aimed at making care providers and health insurance funds "financially responsible."

Restrictions on Public Expenses

It is valuable to fight waste, of course, but most steps are being taken from a strict logic of cutback, at the cost of patients and even at the cost of caregivers, which are confronted with an unsupportable workload that seriously strains the quality of care.

A *numerus clausus* at the universities, leading to lower numbers of practicing physicians, is said to be followed by a reduction in health insurance costs. But it mainly causes growing waiting lists for important medical interventions, only in public hospitals. There is little planning and scientific analysis of prevention and care, or of the number of doctors and other health care personnel needed to ensure integrated and quality care. Reducing costs—that is the principal objective. The question of needs and the manner of responding to them is completely subordinate.

Throughout Europe, increasing patient contributions are an essential component of the reform measures. This "financial participation" has been introduced at all levels. In many countries the patient's contribution for primary care and drugs now amounts to between 25 and 50 percent. Since the 1980s there have also been systematic increases in the patient's contribution for a hospital stay.

The idea that patients' financial participation reduces overconsumption is also used by the OECD, while it has to admit that the "access to most health care still is controlled mostly by doctors and other health workers" (1). For primary care, the main area where the patient usually takes the initiative, patients' co-pays appear to play a negative role. Many studies show that by demanding financial contributions, the health service system eliminates as many indispensable visits as "unnecessary" ones. Moreover, it is precisely those at the bottom of the social ladder and most in need of health care who reduce their doctor visits (1).

More generally, the OECD shows that the introduction of co-pays risks draining finances from the ill and less privileged toward the rich and privileged. The impact of higher co-pays appears to be greater for groups with lower incomes—the very groups that generally have greater health needs. Because income is also related to educational level, the capacity to evaluate health care needs correctly also relates to income (1). But despite all these scientific conclusions, the assumption in the OECD's propositions is that financial participation is healthy.

In many European countries, general practitioners are frustrated. Official documents constantly recognize the importance of having well-structured primary

health care available, but GPs are facing enormous problems, with increasing workloads and limited revenue.

Well-functioning first-line health care within an integrated NHS could both guarantee that all patients receive quality care and at the same time avoid unnecessary expenses. But such a rational organization of health care, based on scientific criteria, would at every moment confront the logic of a health care system based on the market, where the profit motive is ever present.

At the secondary care level, the reforms started with a drastic reduction in numbers of hospital beds. A budgetary system was then introduced in which hospitals cannot go beyond a certain maximum budget. Also, hospitals are put into competition with each other through comparisons of both general costs and diagnosis-related medical costs. To restrict the duration of hospital stays (and therefore the costs), an average duration of admission is calculated for each clinical procedure. A hospital that keeps the patient longer is fined, and a hospital that dismisses the patient (too) quickly is rewarded. A hospital was once an institution whose mission was to provide for the medical needs of a certain region. Now every hospital is working as if it were an autonomous institution, based on a business plan. Its central objective is to be self-supporting.

Concerning drugs, restriction of the existing oversupply indeed could be a healthy measure—for example, by drawing up an evidence-based list of generic medicines. For every possible affliction, the necessary and best treatments would be available. New products could be added to the list (or replace older ones) if they prove more effective or have less harmful side effects. In addition, a negative list of products could be composed, those that cannot be sold any longer and therefore should be taken off the market because inefficient or too expensive compared with equally effective alternatives. Such a policy, designed with patients' needs in mind and not for the narrow goal of cutting back costs, would allow qualitatively better health care and (practically) free medicine. It would then be up to the doctor to prescribe only what is necessary. But the opposite occurs. Official Europe has no intention of confronting the multinational lobbies, but instead protects their profits: "Controlling how doctors prescribe medicines, the profit margins of the wholesalers and the pharmacists is not among the tasks of the European medicine policy" (8). The enormous profits of the pharmaceutical industry contrast flagrantly with worldwide health care needs.

Competition and Privatization

Within European health service reform, competition mechanisms are considered indispensable to guarantee cost efficiency. The liberal dogma of "the invisible hand of the market" is brought into the social sector. When Europe defends "more market" in health care, it especially refers to two fields: health insurance and hospitals. Today, all kinds of "limited" or "controlled" forms of competition are being promoted (15).

The Internal Market. The term "internal market" means the introduction of competition in the medical care system. Organizing an internal market was a first step for introducing competition in the NHS in the United Kingdom and in Sweden, Finland, Italy, and Spain. The so-called division between purchaser and provider within an NHS allows the financing institution to negotiate contracts with several institutions (public and private) that are competing with each other to supply "adequate" services as inexpensively as possible. For hospital management this means speed-up at work, while working conditions and pay decline and support services are contracted out to cheap subcontractors. And what if care quality in the public services is becoming mediocre? No problem; the population's frustration can be used to promote further privatization.

Managed Competition or Directed Competition. The principle of "managed competition" was applied in the Dutch proposal for reforming health care, in which health insurance is largely privatized. This involves a state-controlled competition between private health insurance companies. They compete with one other for customers, based on costs and quality, but not (yet) through avoiding risks as is common practice for private insurance companies in the United States. Individuals can choose their insurance and must pay a fixed amount. The rest of the costs are paid through social security and taxes. The insurance company negotiates contracts with the health services or builds its own health services. In the latter case, an integrated private system comes into existence. The "holy principle" of division between purchaser and provider—highly necessary to make the public sector more cost-effective—is swept away in the private sector in the name of this same cost effectiveness.

Market Care (Managed Care). One major form that competition between private insurance companies has taken in the United States is in the area called "managed care." We propose the more consistent term "market care." In the United States, private insurance companies and workers are the financiers of the health system. The insurance companies are constantly looking for methods to keep costs as low as possible and have a finger in the pie concerning the quantity, quality, and cost of health care. The state's control is minimal.

We find a similar evolution toward financing and providing care within the same system as noted above. Again, while the "for-profit" private sector integrates care and financing, in the public sector it is claimed that care and financing must be separated for cost effectiveness! Market care reveals the final stage of competition and privatization: a model dominated by large private insurance groups operating under extremely limited government control. The driving forces are competition and profit, with health care turned into a commodity. This logic is making its way into the European health care system. In the Netherlands about half of the health insurance has already been privatized. In Belgium supplementary health insurance is becoming more important every day. But the so-called controlled introduction

of private insurance in Europe is a Trojan horse. In the United States, too, the system was introduced as "nonprofit." The present-day European legal framework is based on the logic of free competition between insurance companies, while the competency of the authorities to regulate the prices and conditions of insurance products is seriously reduced. This increasing private influence within health insurance means the further acceleration of the process that endangers existing solidarity mechanisms and leads to growing exclusion (8).

Private insurance companies are inappropriate providers of universally accessible medicine for the community. Their goal to make profits is contrary to the goal of social insurance and universal health care.

Does Competition Lead to Increased Efficiency?

Competition is promoted based on the assumption that it enhances efficiency and leads to more and better quality health care for less money. But since its introduction in the U.K. NHS, this objective has continuously bumped into fundamental problems. On the one hand, the organization of competition appears to lead to a important increase in administrative costs. The money saved by work speed-up, subcontracting, lowered wages, and so forth, appears to be absorbed by higher administrative expenses. The cost-saving aims are not achieved.

The advocates of competition reply that quality care is impossible without a general increase in health care budgets, through which they simply affirm what the defenders of the NHS have always stated: the problem lies not with the lack of competition but with the lack of money! Freeman (6) concludes that competition is mainly a destabilizing strategy "breaking up old rigidities and expectations" in preparation for a complete dismantling and privatization of the NHS systems.

CONCLUSION

Health care reform in Europe struggles with some major contradictions. There is the collective problem of a growing need and demand for medical care, for which—according to "official Europe"—financing has become a fundamental problem, while we find a growing commercialization of medicine and substantial profits in the medical and pharmaceutical industry. A contradiction is developing between responding to growing collective needs and securing or increasing private profits. European policy exacerbates the growth of these contradictions.

In European countries in the last few decades GDP has risen greatly. Increasing means and possibilities are available to fulfill human needs. But as in the rest of the world, there is a continuously widening gap between rich and poor. More and more people are excluded and fall back on minimal relief mechanisms.

European health policy, in line with that of the OECD and the WTO, starts with the needs of employers and multinational corporations, especially their drive to decrease social "costs" as part of their capitalist competition with the United

States and Japan. The ongoing health care reforms weaken the redistribution mechanisms: there is pressure to cut back social security payments, while patients' contributions increase everywhere. In addition, the share for private insurance companies increases. Existing inequalities are further accentuated. Health care as a right for all is replaced by health care as a commodity for those who can pay and as a (sub)minimal safety net for "the poor."

The labor movement is an essential force—insofar as it shows combativeness—for defending accessible and high-quality health care. Organized health workers and the entire nonprofit sector comprise another important force. With the introduction of market techniques into hospitals, discontent among personnel will surely redouble. Maintenance workers have seen their tasks handed over to subcontractors (cleaning, catering, linen, instruments). Work speed-ups and low salaries for nursing personnel continue. Discontent among GPs is also growing, and makes of this group a third center of conflict. All these groups share a vital interest: to defend, preserve, and extend high-quality health care and social security. A front between the labor movement, health personnel, and patient organizations would be a force to be reckoned with in opposing the plans of European employers and their European Union.

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