MOUVEMENT COMMUNISTE/KOLEKTIVNE PROTI KAPITALU

HEALTH AS AN INDUSTRY GENERATING NEW VALUE

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The transformation of the hospital towards a modern industrial model

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PAMPHLET

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NOTE TO THE READER

We thank Mr. G. Bouvin who, as the editor responsible, makes it possible for us to legally publish and distribute this publication. We wish to point out that Mr. G. Bouvin is not responsible for the political content of the articles and, more generally, for the programmatic positions defended in our press.

PRESENTATION

This document is simultaneously published in three languages: Czech, English and French. This is not because we are such efficient translators but because it is the result of a common work by speakers of these three languages since its very conception. It is a work jointly performed by comrades from KpK, MC and others. We hope that this first step of common political work will be confirmed and amplified in a way which tends towards the unification and centralization of communists..

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INTRODUCTION

October 2020: the Covid-19[1] epidemic is back and hitting hard in numerous countries. This second wave, after a first wave on a global scale which pushed the health system to the limit of its capacity, risks making it collapse. But in June, in Belgium and France, health workers demonstrated in the streets and in their workplaces, the hospitals. Under the slogan *"Du fric pour la santé publique! Du blé pour la santé!"*[2], they demanded a rise in their wages and improvement in their working conditions. To these immediate demands they added a rejection of the commodification of healthcare, responsible for *"killing the hospital"*.

Yet, capital, and in particular the collective capital represented by the state, does not "kill" the hospital, it makes it productive of new value, in other words, profit. As for health as a common and public good, that has never really existed in societies divided into classes. Complete access to healthcare, but also to what is generally called prevention, has always been and still remains above all the prerogative of those who can pay for it. This is despite the authentically humanist enthusiasm which animates a good number of the angry health workers.

This text attempts to decrypt the important mutation which has been at work for forty years or so within hospitals in advanced capitalist countries that have a system of universal social insurance, co-managed by the state and the so-called "social partners", that can better be described as intermediate bodies of the state[3]. The healthcare sector, regulated since the establishment of the social security system by the rules of a manipulated market (prices fixed outside the market, state financing of hospital businesses), has evolved since the 1980s and even more since 2008 – following the fiscal crisis resulting from the financial crisis – towards a "classical" modern industrial model propelled and stimulated by competition.

Whether it is in public or private companies, the structure of hospitals is more and more a clearly capitalist structure intended to realise profit thanks to the sale of the commodity "health". The transformation of the hospital sector thus constitutes an "updating" of capital in the sense of efficiency and profitability. This penetration of capital into the state market corresponds to the continuing extension of capital to all spheres of economic activity and the generalisation of the commodity as the only form of wealth.

The hospital expresses the most advanced form of the concentration and centralisation of capital in the health market. To put it another way and more schematically: the family doctor recalls the figure of the artisan; the health centre is more like small scale manufacturing (gathering workers in the same place and sharing fixed costs but still relying on simple cooperation); the hospital appears as the specific industrial organisation of the capitalist mode of production by combining the division and scientific organisation of labour (specialisation, division, repetitive work), mechanisation (technology and applied science) and large-scale cooperation (the collective worker and the centralisation of applied research).

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[1] There is a bulletin "Pandemics, nation-states and capital" (March 2020) that MC has published on the subject: http://mouvement-communiste.com/documents/MC/Leaflets/BLT2003ENvF.pdf

[2] "Fric" and "blé" are both slang terms for money – think of "dosh" and "bread" maybe. They happen to rhyme with *publique* and *santé*.

[3] The healthcare systems of many European states are, of course, financed out of general taxation, rather than by a system of social health insurance. This is the case notably in the UK and Italy. There are also hybrid systems, like in Greece and Spain. See the European Observatory on Health Systems and Policies, for a complete set of reports on all European countries:
https://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits
The same tendencies are at work in these other systems, but here we are concentrating in detail on their manifestation in the "social insurance model" or "Bismarck model" (see below) of financing health services.

The "crisis of the hospital" follows from the desire of the state to drastically reduce its unproductive expenses in healthcare. In effect, as the representative of collective capital, the state devotes an important part[4] of its budget to managing the health of the population, if we understand by this the interventions necessary to the reproduction of the labour power useful to capital, directly or indirectly (since children, old people and long term disabled people are also looked after by the healthcare system). But the state, as an individual capital, and even more as the owner of the public hospital system, tries to diminish its contribution to the financing of hospitals and to invest in the most efficient entities – that is: the ones capable of generating profit. And, at the same time, it is still necessary to underwrite the tasks of reproduction of labour power in the structures of healthcare which are less efficient but still indispensable (as in the "medical deserts" or in intensive care services). The public business of healthcare is not forgotten since the state, in its quality as a shareholder of individual capitals, remains a central actor in the hospital sector.

The impact of this structural evolution is and will be paid for by those who work in the hospitals and by the patients. The characteristics and the conditions of exploitation of the labour power of health workers are not – fundamentally – different from those encountered in the manufacturing and logistics enterprises of mass production. Like any workforce in any capitalist organisation, health workers contribute to the accumulation of "their" individual capital (the hospital) and as such are subjected to constant attempts by their bosses to cut wages, lengthen working time, to degrade working conditions, to push for higher productivity and intensification of their work etc. There is no reason why this sector should be different from the others.

At the most, in the immediate future – following the Covid-19 episode – the state is going to have to reinvest in health, to provide some wage increases and adjustments in working conditions, which will increase the costs of production. But in the end, the transformation of all useful things into commodities remains the dominant and systematic tendency of the capitalist cycle, including in the domain of health. This tendency to commodification may be eased by the management of the epidemic of SARS-CoV-2 but certainly not reversed, the virus representing "only" a temporary counter-cyclical element. What's more, the virus already helps the managers of healthcare systems to define plans for restructuring and investment which are able to rapidly make up for the increased costs of production and to increase the productivity of social labour engaged in this sector.

A DAY IN THE HOSPITAL, A DAY IN THE FACTORY

Zero inventory and just in time, no time lost for capital accumulation

Capital is an intrinsically dynamic social relation: it has never ceased to conquer, to take over and to revolutionise domains which previously escaped its control. The hospital is subjected to a transformation in its concrete labour process, which includes an intensified division of labour, an intense specialisation and parcelling out of tasks with the consequence of repetitive work. All this on the basis of large-scale cooperation, that is to say a collective worker who is specialised but flexible and potentially interchangeable, in terms of time of adaptation and a more and more reduced level of skills.

The transformation of working conditions in the hospital since the 1980s[5] is comparable to the process going on in industry a century earlier through Taylorisation and mechanisation.

[4] See: www.who.int/whosis/whostat/FR_WHS09_Table7.pdf

[5] For example, the model of charging for work called "Individualised nursing care for the person cared for" (SIIPS), mentioned later in this text, was created and put into practice in France starting from 1987-1988.

The stop-watch[6] thus makes its entry into the hospital. This means that for the state as the main shareholder, even the only one, of an individual capital (as is the situation in the public hospital), as for the private capitals of healthcare (also financed by the state and social security), the hospital can be productive, that is to say be a generator of new value. The hospital was born as a pure unproductive expense indispensable to the reproduction of classes and to the good functioning of the capitalist organisation of labour, in the same way as the school for example, and progressively became a capital generating profit. Exactly as is happening more and more in higher education and has already been the case for a long time in public transport[7]. In the history of the capitalist mode of production, the productive sphere ceaselessly extends into activities where it isn't present yet, and new individual capitals (private or state) see the light of day to guarantee exploitation. The traditional "public services" which do not *directly* participate in capital accumulation are inexorably sucked into the market.

Public hospital and private hospital

In Belgium, the public hospitals, like the private hospitals, are financed by allocations from the federal state (mostly for wages), the regions (above all for infrastructure) and from insurance schemes for health and disability (for fees for consultations and interventions, technical medical procedures and treatments). They are, unlike private hospitals, the formal property and under the direction of communes, "intercommunals", provinces or regions. 72% of hospitals are private (under association status but for-profit). *"Historically, these latter were the product of religious congregations, of mutual insurance companies, of free universities or former workplace hospitals. However, due to the great number of fusions between hospitals over the last few decades, a good number of institutions are today a heritage of both the public and private sector. The hospitals law is applied without distinction to the public sector and the private sector and their financing by public authorities is identical*[8]*."*

In France, between 1948 and 1979, the development of the public hospital (in terms of capacity and technology) was realised through massive investments by the state *via* sickness insurance and local collective entities. At the same time, the creation of private clinics grew from 1946[9] and these were progressively registered with sickness insurance schemes. In 1970, the private sector was recognised by the public sector by a law organising the hospital system[10]. Starting in 1981, a policy of squeezing public expenditure began, pushing for the consolidation of clinics, and sealed by a reform in 1987. Already in 1983-1984, the financing mechanism was reviewed on the basis of homogenous diagnostic groups and on the principle of payment by procedure (rather than on the principle of price per day established in 1941) with the aim of containing expenses and improving the economic performance of hospitals. During the following fifteen years, a national system was put in place to define and calculate the average cost of production of stays in hospital. Enterprises had to then achieve the minimum productivity norm fixed by financing, which favoured the economic autonomisation of the hospital structures which were the most profitable. In 2002-2004, the introduction of price setting to activities, in the framework of uniform financing of public and private healthcare establishment, distinguished totals charged according to the type of pathology and type of procedure (simple or complex) and constitutes a new advance in the rationalised "accounting" of medical procedures.

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[6] As referred to in the work of Benjamin Coriat, *L'atelier et le chronomètre: essai sur le taylorisme, le fordisme et la production de masse* ("The workshop and the stop-watch: essay on Taylorism, Fordism and mass production"), Christian Bourgois, 1979.

[7] See the MC Letter dedicated to the latest reform of SNCF and a balance sheet of the strike which opposed it: http://mouvement-communiste.com/documents/MC/Letters/LTMC1946%20ENvF.pdf

[8] Source: https://www.belgiqueenbonnesante.be/fr/donnees-phares-dans-les-soins-de-sante/hopitaux-generaux/organisation-du-paysage-hospitalier/types-d-hopitaux

[9] Source: Nicolas Tanti-Hardouin, *L'hospitalisation privée, crise identitaire et mutation sectorielle* ("Private hospitalisation, identity crisis and sectoral mutation"), Les études de la documentation française, 1996.

[10] Source: https://www.irdes.fr/documentation/syntheses/historique-des-reformes-hospitalieres-en-france.pdf

To describe the functioning of the work processes and capital accumulation within the hospital, it's useful to consider the similarities with a classic industrial enterprise – the car making sector, for example. There are plenty of them: from the hiring of personnel to the flow of commodities inside the company, the division of labour, the specialisation and control of the workforce.

"Thus, the contemporary portrait of the hospital system clearly takes on the visage of an industry. It reproduces perfectly the models which organise it: management of stocks and flow of goods, standardised circuits, managerial organisation, inflation of graphs, architecture of the rack and shelf type, "weak granularity" encouraging speed. The individual there has become a potential object of profitability, as they are in a system of generalised transactions […] an exchange value[11]*".*

In the hospital, the "human" flows – personnel as well as patients – are managed in a way which reduces dead time as much as possible, whether it is the transfer of patients from one service to another and one bed to another, or the movements of doctors in the numerous lanes of the various hospital services. In addition, it is necessary to continually reduce the average length of stay, with the aim of limiting the stock and speeding up the flow of patients (according to the vocabulary used by hospital managers).

In Belgium, for example, as in other European countries, hospital stays are getting shorter and, in parallel, outpatient services are growing. These represented, in 2018, 18% of treatment days and accounted for almost 60% of admissions. As indicated for 2018, the study *Model for Automatic Hospital Analysis* (Maha) put out by Belfius Bank for 25 years, said: *"To be able to lower the number of beds justified in the next few years, we need to agree on the number of hospitalisations per day, forms of alternative care (care hotels, hospitalisation at home...), organising around care at home and improving the electronic distribution of patient data."*

This management of flows is also the object of particularly attentive study on the part of hospital management so as to compress to the maximum everything which does not relate to the (chargeable) medical procedure itself, and so that the time spent *at work* for medical staff is as close as possible to the time *spent working*. Every moment of the working day must be devoted to a task which can be counted in the company accounts. All the moments which are not devoted directly to "productive" time are restricted (breaks, discussions with colleagues).

The situation in the comparable industry chosen – the car industry – is identical: extreme minimisation of journeys which are not useful for the transport of commodities and movement of the workforce in the process of production; a continuous and relentless fight on the part of the boss to remove work time which is not directly productive, such as work-home journeys, going to the toilet, meals etc.

The need for the efficiency of capital manifests itself on this level – very classically – by two phenomena: constant pressure to prolong and make more flexible the working day, coupled, most of the time, with an intensification of it. The avowed aim is to increase productivity of labour by allocating the workforce more efficiently, that is to say increasing the rate of exploitation to extract more surplus value from its only source, living labour.

As in the car industry, the medical personnel are controlled by "foremen" whose main function is to ensure that the work process is as efficient as possible from the point of view of the imperatives of production. They are supported in this task by a plethora of software packages controlling the stage of advancement of tasks almost to the minute, aided by readable badges and clocking on. The central activity of the medical personnel is more and more reduced to quantifiable procedures, regulated by administrative staff who thus take command of purely technical activity, which seems to nevertheless incarnate the best "social reason" of the company.

[11] Stéphane Velut, *L'Hôpital, une nouvelle industrie. Le langage comme symptôme* ("The hospital, a new industry – language as symptom"), Gallimard, 2020.

The phenomenon of Taylorisation of work concretely translates into the cutting up of working time into clearly delimited units (identifiable on the level of accounts) and the hunt for dead time to eliminate[12]. Specialisation of personnel and the parcelling out of actions thus makes them more measurable (in time and in resources used). Some calculation systems have thus been elaborated for measuring and distributing the "care load".

Two examples:

"PRN ("projet de recherche en nursing[13]"): it consists of the minute by minute breakdown of the healthcare day and in the identification of the necessary personnel (quantity, quality). It is based on the measurement of time needed to carry out the planned care. To do this, it is necessary to establish a catalogue of "care actions" (grouped into sectors such as breathing, nutrition, hygiene, communication etc.), with the frequency of what is achieved indicated, which allows a value to be attributed to each of these actions. This value is expressed in points, and one point is equivalent to five minutes of care. The sum of points obtained for all acts of care over a period of 24 hours gives the daily PRN score, that is to say the time considered to be spent on the "care load". This time must then be used to "construct the offer" corresponding to the needs and to plan the distribution of personnel required, that is to say to determine the number of caregivers needed to provide care[14]."

"SIIPS ("individualised nursing care to the care receiver"): it consists in measuring the intensity of the work load to calculate the quantity of necessary personnel. It needs to develop a scale to assess the nursing care provided to each patient on a daily basis. This care is then classified according to its nature (basic, technical, or relational and educational care). The care is then divided into different levels, to which are assigned intensity or load coefficients (minimal, light, short, heavy, very heavy). To each combination, a weighted average time is assigned, allowing the care workload to be known by adding them together. To obtain the total workload of the service and the number of posts per day required, the SIIPS points must be supplemented by the other activities related to care (accommodation activities, information, training activities) carried out by the service's agents.[15]"

These methods for managing the workforce allow, for example, the non-replacement of departing workers if the care load can be fulfilled by a smaller number of workers, and the devaluing of some tasks by using people who are less qualified and, above all, cheaper. Nurses carry out tasks assigned to the doctors; orderlies carry out tasks assigned to the nurses, etc.

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12 *"The pace increases, delays shorten and work intensifies as more and more patients have to be treated at constant staffing levels due to activity-based financing. The rotation of beds is faster, the number of consultations per session grows strongly",* Pierre-André Juven, Frédéric Pierru et Fany Vincent, *La casse du siècle. À propos des réformes de l'hôpital public* ("The heist of the century – about the public hospital reform"), p67. Raisons d'agir, 2019.

13 It's called "en nursing" because it's Canadian French. The first experimental trial was in a maternity hospital in Montréal, the CHU Sainte-Justine, in 1969.

14 *Ibidem.*

15 *Ibidem.*

DRG: a key stage in the process of hospital industrialisation

How is hospital production subjected to the efficiency imperative? How is performance increased and how is it measured? How are "average costs" defined when each hospital deals with a collection of unique cases, thousands of particular patients present specific health problems and require suitable treatments? These questions have historically distressed hospital managements during the long decades after the hospital developed as a modern apparatus composed of a large number of employees, sophisticated machines and a more and more advanced organisation of labour.

A response was provided, starting in the 1970s, with the application of a method of managing hospital production based on homogenous groups of illnesses (DRG, *Diagnosis Related Group)*. The DRG system was developed in the US with the aim of measuring costs and results for hospitals. Hospitalised patients were first of all grouped in terms of clinical responses and the system distinguished the schema and quantity of hospital resources necessary to provide coherent care for each category. After the DRG succeeded in classifying hospital production, it was used to manage payments, for the first time in an American hospital in 1983. Following this it spread rapidly [16]. Today, the system of DRG is considered to be the most influential post-WWII innovation when it comes to financing healthcare and it is the most important system for classification of patients on a global level. The transformation of health into a "normal" capitalist commodity has been rendered possible, notably by this system.

Concretely, DRG is a tool of categorisation, of measuring and adjustment of hospital production, including aspects of fee setting and payment. The classification makes it possible to define and compare particular products which are homogenous on the clinical plain as well as that of costs, and on that basis to evaluate and attribute unitary prices by group. To put it another way, DRG, by means of average cost, allows the determination of the socially average time needed for production.

How does it work?

1. DRG groups patients according to clinical characteristics and relatively homogenous economic costs. These are the two determining factors for the definition of a particular product.
2. DRG determines a "weighting level", generally an average cost of treatment for a patient within a particular diagnostic group.
3. It converts the weights of DRG into monetary values; eventually to be adjusted according to other variables.
4. The hospital is paid on the basis of the type and number of DRGs it produces.

DRG-based payments have proven to be more effective compared to payments per day, for example, which have historically been the dominant form of remuneration in hospitals. In this case, the longer the patient is treated, the more money the hospitals receive. On the contrary, the DRG provides the hospital with incentives: to reduce costs per patient treated; to increase income per patient; to increase the number of patients. Of course, the introduction of DRG-based payment has many "unintended" consequences, such as not providing necessary care, skimming off patients who are insufficiently profitable, or artificially reassigning patients to better-paying diagnostic groups.

Advanced information technologies are the material base necessary for the daily functioning of the hospital within the DRG system. The actual classification of patients is not made by a human agent. It is almost always carried out by software. The systems must be

[16] In 1984, the "father" of DRG, Professor Robert Fetter, was invited to Europe on the initiative of the French government and representatives of Belgium, Ireland, Netherlands and Portugal. In Germany, DRG has been applied since 1985 (it is called G-DRG) and has always excluded psychiatric care. Since January 2020, maternity has also been outside G-DRG (see: mtrconsult.com/news/german-drg-system-change-2020). DRG has been applied across Europe for twenty or so years, and has been one of the bases of charging by procedure in France.

regularly updated. Without a system of analytical book-keeping on a high level, managements cannot know if hospitals are producing DRGs at costs lower than the prices fixed in the tables, therefore if hospitals are in profit or loss.

The introduction of DRG constituted a historic change which would not have happened without a gigantic development of social knowledge, modern technologies, the capacity to aggregate a massive volume of data, and the software and algorithms for dealing with them. It is another example of the way that the development of science and its application in the capitalist framework supports the penetration of the value-form into all the pores of activity of human society.

However, the process of industrialisation of hospitals is still not entirely realised according to the norms of DRG, which are by nature always evolving. According to the European Observatory on Health Systems and Policies[17], the availability of standardised information and (consequently) high quality comparisons of costs is limited in many European countries. Relatively few studies have explicitly identified and quantified its impact with the help of established methods, and if the objectives of DRG are clear, how to achieve the objectives is still not so well known. If the general structure of numerous DRG systems is relatively similar, the systematic details of DRG in each country can vary. For example, the monetary conversion of the weightings[18] of DRG is variable, along with the type of hospital payment[19] based on DRG. Finally, hospital payments based on DRG do not represent the totality of hospital revenues in all countries[20]. What is more, and generally, certain branches of medicine are excluded from DRG (for example psychiatry, long term care, rehabilitation).

All this means that DRG has brought about fundamental changes in hospitals, but that the route towards complete industrialisation of healthcare is still long and constantly evolving because the human body and its maladies "naturally" resist standardisation by their unique character.

Techno-hospital, labour productivity and the centralisation of capital

The capitalist evolution of the hospital has involved massive development of medical sciences, technologies applied to mechanisation specific to that activity. This formidable jump in knowledge and techniques of healthcare has allowed the hospital system to transform itself into an industry adapted to create new value. From immediately after the Second World War, the association between medicine, science and techniques made the hospital what it is, a place of high-tech care (the techno-hospital) with the hyper-specialisation of certain professions which results.

Mechanisation clearly acts on the productivity of labour. It contributes to the reduction of the average time needed to realise procedures and often allows a reduction in the volume of employment. It extends itself to all branches of the medical sector, including the most complex such as, for example, anaesthetists in intensive care, who still remain difficult to replace by a machine, but whose partial "mechanisation" is already a matter for experimentation[21].

The hospitals with a high technical composition (advanced automation), which therefore need a smaller workforce to operate, are becoming first among "normal" capitalist enterprises.

[17] Source: euro.who.int/__data/assets/pdf_file/0004/162265/e96538.pdf

[18] For example: relative weights (Sweden, Germany), net fee (France, UK) and score (Poland, Austria).

[19] For example: budget allocation (Republic of Ireland, Spain) or payment by case (France, UK).

[20] Even if it generally represents most of the revenue: in France, 80% of hospital revenues are linked to DRG, in Germany 80%, in the UK 60%.

[21] See for example:
rtbf.be/info/societe/detail_des-robots-pour-aider-l-anesthesiste-du-futur-a-surveiller-le-patient-en-permanence-pendant-toute-l-operation?id=10424867 ; or: sofia.medicalistes.fr/spip/IMG/pdf/y_a_t-il_un_iade_dans_la_salle_la_boucle_pilote_marc_fischler_suresnes_philippine_chabanel_suresnes_.pdf

These most profitable hospitals invest in cutting edge equipment (robot surgery, imaging etc.) and in new installations and technical infrastructures. These investments in constant capital are agreed to because of their capitalist efficiency, that is to say because of their capacity to diminish the total costs of production of a procedure or therapy relative to the standardised payments for healthcare fixed by paying clients, specifically the institutions of social security, the mutual insurance funds and the state (through its health budget).

The sector which is today by far the most profitable, and in which private hospitals invest enormously in constant capital, is that of diagnostic imaging (previously called the radiology service[22]). With present technological advances, this sector is almost completely automated. It's operated by extremely highly qualified doctors with capacities, on the technical level, close to those of engineers, capable of interpreting reports coming from machines (scanners, MRI, ultrasound etc.). In this way, they make it possible to dispense with a whole chain of more approximate clinical diagnoses (carried out first by the general practitioner or emergency doctor and then by the specialist, who in turn calls on medical analysis offices). In practically one step a complete diagnosis of the sick person can be carried out and it is "enough" that the doctor knows how to read and interpret test results.

This type of service allows the private hospital which provides it to impose higher prices, and therefore to achieve higher profits. In the case of the public company, on the other hand, the hospital in the vanguard will be able to minimize its costs and earn money from the differential between the reimbursement for the procedure and its own associated expenses. Another significant advantage related to imaging equipment is the retention of patients within the company, from entry to exit, without having to purchase tests from competitors.

In Belgium, the 2018 activity report of the *Centre hospitalier interrégional Edith Cavell* (Chirec), a private hospital group with one of the best operating results, is perfectly explicit: *"Watertightness, that is to say keeping the activity within Chirec, remains essential if we want to guarantee the future of the institution. Following the numerous medical-technical examinations still carried out outside the institution, we have analysed the avenues that would make it possible to increase the availability and accessibility of medical imaging in order to offer a service that is as fast and flexible as that provided by small private structures. In order to offer this service, we have extended, in perfect collaboration with radiologists, the time slots in all our imaging departments, whether for ultrasounds, scans or magnetic resonance. For these, we have organized ourselves to offer appointment possibilities at night and on weekends."* [23]

Like everywhere, competition between hospitals becomes apparent in the fall of the price of the service, whether it is reducing the variable part of capital or by making labour more productive of new value. The individual capital is thus constrained and forced to grow ceaselessly on pain of being overtaken by its competitors in so far as a selection between various hospital establishments is made on the basis of the commodity which they provide and, obviously, the costs of production in the face of market prices fixed by the institutional partners. Going back to our car industry analogy, the marques which work the best are those which produce cars in which the final profit is highest, which correspond to vehicles at the top of the range.

But these massive expenditures on constant capital[24] have an almost mechanical effect of causing their rate of profit to be smaller. This fall can be compensated for in various ways. By increasing the mass of profits (therefore by continuing to enlarge the scale of operations that the hospital is involved in); also by playing in a situation of "technological rent" created by the

[22] Indicating that radiology labs, principally those which need a significant initial capital, and which are efficient, do not have any difficulty financing themselves through the banks and paying off their loans.

[23] Source: *Rapport annuel Chirec 2018, vision 2019.*

[24] A major element in the growth of capital accumulation, investments in constant capital allow the hospital that makes them to achieve a level of capitalist efficiency which its less efficient competitors are not capable of achieving. This necessity to invest in constant capital is the direct result of competition between hospitals – the other "potential" determinant being class struggle.

mastery of technical means that competitors don't have (which allows them to fix prices at a higher level or simply to temporarily pocket super-profits); by an increased centralisation of capital. This can happen by a fusion between hospitals or by a hospital taking more profitable services from another one. The hospitals with the less efficient departments will be absorbed or will perish, mostly those with a weak technical composition and high labour composition, like maternity wards.

"Centralisation completes the work of accumulation by enabling industrial capitalists to extend the scale of their operations. Whether this latter result is the consequence of accumulation or centralisation, whether centralisation is accomplished by the violent method of annexation — when certain capitals become such preponderant centres of attraction for others that they shatter the individual cohesion of the latter and then draw the separate fragments to themselves — or whether the fusion of a number of capitals already formed or in process of formation takes place by the smoother process of organising joint-stock companies — the economic effect remains the same. Everywhere the increased scale of industrial establishments is the starting point for a more comprehensive organisation of the collective work of many, for a wider development of their material motive forces — in other words, for the progressive transformation of isolated processes of production, carried on by customary methods, into processes of production socially combined and scientifically arranged. But accumulation, the gradual increase of capital by reproduction as it passes from the circular to the spiral form, is clearly a very slow procedure compared with centralisation, which has only to change the quantitative groupings of the constituent parts of social capital. The world would still be without railways if it had had to wait until accumulation had got a few individual capitals far enough to be adequate for the construction of a railway. Centralisation, on the contrary, accomplished this in the twinkling of an eye, by means of joint-stock companies. And whilst centralisation thus intensifies and accelerates the effects of accumulation, it simultaneously extends and speeds those revolutions in the technical composition of capital which raise its constant portion at the expense of its variable portion, thus diminishing the relative demand for labour. The masses of capital fused together overnight by centralisation reproduce and multiply as the others do, only more rapidly, thereby becoming new and powerful levers in social accumulation. Therefore, when we speak of the progress of social accumulation we tacitly include — today — the effects of centralisation." [25]

Sometimes, for reasons of capitalist rationality, it is the state itself which manoeuvres to make hospitals share expensive equipment and to work together by enacting laws for this purpose[26]. The problematic is the same as in car manufacturing groups who need to achieve a certain volume of production to survive and so are forced to group together technical resources and production sites between them.

[25] Karl Marx, *Capital.* Volume I, section VII, chapter 25: "The General Law of Capitalist Accumulation", 1866. See: https://www.marxists.org/archive/marx/works/1867-c1/ch25.htm

[26] See below the example of the health reforms in Belgium.

Finally, from the point of view of the mass of labour power employed, the comparisons between hospitals and car industry are pertinent here too. The quantity of labour employed in a big hospital is similar to that of a car factory (a few thousand people). In both cases it is a question of mass production.

Industrial workers: cars and hospitals

- Renault factory at Flins (France), approx. 2,000 staff
- Audi factory at Forest (Belgium), approx. 3,000 staff
- Mercedes factory at Rastatt (Germany), approx. 6,500 staff
- Technocentre de Guyancourt (France), approx. 12,000 staff
- Chirec hospital (Belgium), approx. 4,500 staff
- Pitié-Salpêtrière hospital (France), approx. 7,800 staff
- Prague Motol hospital (Czechia), approx. 9,000 staff

Competition, costs of production and surplus value

In general, all hospitals receive from the state a minimal allocation based on their healthcare specialities and proportionate to the volume of their procedures, an allocation which is they hope is sufficient for the survival of the enterprise. Where this is not so, the state will most likely close it, as in the case of small provincial hospitals. The capacity of the hospital to make money depends on its productivity.

The new value extracted from the activity of productive health workers is realised, through the competitive movement of capital in this sector, by the selection of individual capitals capable, at constant market prices for services, of squeezing the costs of production below those recognised and financed by the single state buyer-shareholder. To put it another way, the profitability of a hospital depends on its capacity to "make savings" on services compared to the standardised prices for each one decided by the state and the various organisations involved (social security and mutual insurance funds).

Prices are fixed annually in a scale of fees negotiated between all parties. It rests on a standardisation of the labour process suitable to squeeze the average cost of procedures and care (by grouping them according to pathology, hospital stay etc.). It also includes medicines[27]. For the latter, the state fixes the price (which matters to the drug companies) and the rates of reimbursement (which matter to the users).

For exchanges of commodities to realise the new value produced in the process of concrete health labour, it is still necessary that the prices of commodities contain the costs of reproduction of capital **and** the surplus-value created by the workers. Given how prices are calculated, certain activities are more profitable than others. This is why, in the health sector, the state-boss disinvests from some specialities and overinvests in others.

Collective capital pays relatively "well" for health overall but not enough for less profitable functions like emergency services and establishments providing first-aid, particularly in "secondary" productive territories. These are not profitable because the state fixes the price of some procedures too low, and consequently there is little or no competition possible in these markets which are too restricted or too ruled by administrative frameworks and regulations.

[27] For France, see: solidarites-sante.gouv.fr/soins-et-maladies/medicaments/le-circuit-du-medicament/article/la-fixation-des-prix-et-du-taux-de-remboursement

The movement of capital pushes the hospitals which are not competitive structures (in France, Belgium and other countries with a health system managed by the state, as opposed to the US or Switzerland, for example) to become such[28]. Hospital entities financed by the state are more and more in competition with private hospitals and those often have a head start in the most profitable segments of the market.

Different costs of production translate into values of different services between hospital establishments. In this difference resides – for those among them whose value is less than those financed by clients and fixed upstream – the capacity to accumulate capital. Conversely, the establishments which produce "health" at values equal to or greater than those recognised by paying clients, will prove to be unproductive of new value despite the exploitation of the workers that they employ. This simple fact determines if they are exposed to restructuring measures or closure by their shareholders (the state or private capitals, juridical property relations are not important).

The whole problem, for capital, is constituted by a situation where the market is rigged (fixed prices), which does not allow the commodity "health" to be sold at a market price which can realise all or part of the surplus-value created. A stay at the hospital whose cost is less than the fee agreed by the payer organisations and by the patient will be profitable. The problem comes when the level of the fee doesn't cover the cost involved. Thus, the tendency to take on a patient according to the price of their care – including when it is officially "free of charge" according to the social contract in force between the various institutional parties of the healthcare system – becomes paradoxically the main argument for the survival of unprofitable hospitals. The introduction of all-inclusive tickets, the payment of part of the expenses of a stay, the reduction in the days of hospitalisation, the segmentation pushed by care which takes less and less account of comorbidities… all these elements move in this same direction.

PRODUCTION AND REPRODUCTION

What does the hospital do for capital? The use value of the commodity health

If human activity in the field of health has always been primarily concerned with the necessity of the reproduction of life, in societies divided into classes, and thus in the capitalist mode of production, health work responds to the vital imperative of the reproduction of labour power.

It is obvious from the start that capital needs a workforce capable of continuing to work efficiently. For this reason, work done in the reproductive sphere is a necessary condition for the reproduction of capital. Exploitation leads to the wear and tear and exhaustion of labour-power, and therefore it needs to be "repaired" in order to continue to operate in the relations of production. The hospital is thus an essential link in the cycle of reproduction of labour power. Its "social reason" is to repair and to put back into work labour-power which is impaired and diminished. This is the primary explanation for the financing by the state – as the representative of the general interest of collective capital – of healthcare.

Let's note that a growing part of the labour of reproduction is socialised within the capitalist mode of production. The hospital is a cornerstone of the historically determined system for providing capital with the labour-power necessary for its valorisation. In the same way, the education of children and work training of proletarians are partly delegated to the state. For all that, the keystone of this reproduction remains – even today when capital dominates – the family, which is anchored in the private relation of domination of men over women, in which the woman bears most of the tasks outside of the social relation founded on wages (education of children, domestic work, as the sexual and affectionate object of a man etc.).

[28] A specificity of the healthcare market is the strong distortion of competition because of interference from professional clientelism, and territorial, political, and trade union factors.

With the increase in life expectancy, the hospital also takes charge of more and more elderly patients. On one side, the present reforms in the labour market concerning the lengthening of working life, a necessary adjustment so that capital can make use of this windfall of available labour power, also lead to an increase in the costs of reproduction of that segment of the workforce relative to the young. This is one more reason and an additional opportunity for productive labour in the health sector to generate profit for individual capitals. On the other side, elderly and retired proletarians, in other words those who have left the active workforce employed by capital, are also taken in hand by the hospital and this does not contradict its social reason from the point of view of its utility for capital. In effect, caring for the elderly maintains the availability for work of working people who would otherwise have to take care of their elders, a responsibility that is in practice taken on by women outside the workforce. This aspect of reproductive work was more than visible during the lockdown to slow down the circulation of the Covid-19 in the daily management of children: without school, no flexible work force.

The roles of the hospital

From the Middle Ages, the Church organised Maisons Dieu (later called hôtels-Dieu in France) in various European countries. These were the asylums/old people's homes where the poor and sick were kept. Starting in 1656 in Paris, the general hospital took over social control. The archery brigades at the hospital acted as a militia responsible for capturing and locking up beggars and vagabonds. After 1789, the influence of the Church declined and the public health role of the hospital developed more than its welfare role. After a time of completely free exercise of medicine, only doctors of medicine were authorised to practice (monopoly of the profession linked to training). In the twentieth century, the birth of the clinic went hand in hand with the emergence of modern medicine. The hospital became the centre of production of knowledge and the reproduction of the medical corps. Clinicians passed a competitive examination after appointment as a house officer (*internat*) to practice at the hospital and, also, in private practice. The discovery of micro-organisms profoundly altered the understanding of the causes of infection (contagion/immunisation) and responses to it (vaccination, disinfection). At the end of the twentieth century, innovation moved to the laboratories (notably in Germany and the US). In the twentieth century, after World War II, the hospital came to be at the heart of the health system. It combines treatment, teaching and research, and still holds on to a welfare mission. Finally, the creation of social security organises a mechanism of investment by the state in hospital equipment.

To return to labour power, this is at the heart of the concrete labour process under the domination and for the benefit of capital.

- In the first place, it has a particular and unique use value for the valorisation of capital. In the whole capitalist process of production, the creation of additional new value is the exclusive property of labour power, contrary to machines which only transmit all or part (according to their value which is absorbed at once or in part throughout the process of production) of their own value to that of the commodities which they help to produce under human direction.
- Consequently, labour power is not in itself a commodity. It is a prerogative of the individual and it exists independently of the organisation of societies into classes. Only the "location" of labour power, its use during the labour process by the capitalist, makes it a commodity.

"The use of labour-power, labour, can be materialised only in the labour-process. The capitalist cannot resell the labourer as a commodity because he is not his chattel slave and the capitalist has not bought anything except the right to use his labour-power for a certain time." [29]

- The value of labour power thus "rendered" is expressed by the intermediary of wages which represent, in the form of price, the equivalent of the labour time socially necessary to the production of the commodities which help to maintain and look after labour power. It's a price which in addition is most often less than this value because of the existence of a permanent reserve army which tends to press it down below its value.
- What's more, there is something else that ensures that labour power is never paid for at its value. This is the fact that the capitalist never monetises the *general intellect* of proletarians – their capacity to collaborate in the concrete process of labour – while claiming that productive cooperation is the exclusive fruit of the social relation of capital.

"The average price of wage-labour is the minimum wage, i.e.*, that quantum of the means of subsistence which is absolutely requisite to keep the labourer in bare existence as a labourer. What, therefore, the wage-labourer appropriates by means of his labour, merely suffices to prolong and reproduce a bare existence. We by no means intend to abolish this personal appropriation of the products of labour, an appropriation that is made for the maintenance and reproduction of human life, and that leaves no surplus wherewith to command the labour of others. All that we want to do away with is the miserable character of this appropriation, under which the labourer lives merely to increase capital, and is allowed to live only in so far as the interest of the ruling class requires it. In bourgeois society, living labour is but a means to increase accumulated labour. In Communist society, accumulated labour is but a means to widen, to enrich, to promote the existence of the labourer."* [30]

- Finally, the capitalists try, whenever possible, to reduce the level of wages below the value of labour power and to lower the price of the elements making up constant capital. This, in the case of hospitals, consists in lowering the prices of healthcare and, certainly, the price of labour power.

"What, then, is the cost of production of labour-power? It is the cost required for the maintenance of the labourer as a labourer, and for his education and training as a labourer. Therefore, the shorter the time required for training up to a particular sort of work, the smaller is the cost of production of the worker, the lower is the price of his labour-power, his wages. In those branches of industry in which hardly any period of apprenticeship is necessary and the mere bodily existence of the worker is sufficient, the cost of his production is limited almost exclusively to the commodities necessary for keeping him in working condition. The price of his work will therefore be determined by the price of the necessary means of subsistence." [31]

A productive activity in the sphere of reproduction of labour power

Capitalism requires hospitals to be profitable in order to sustain their activity. Continuing the comparison with the car factory, for which the characterisation of productive activity clearly makes sense, as does commercial activity (dealerships for the sale of the vehicles produced) and financial activity (loans granted for purchase of the vehicles), what do we find for the hospital?

In broad outline, in hospitals, the performance of medical procedures is a matter of productive capital and commercial capital. Care is carried out and sold in the same place. The hospital also has a more strictly commercial activity, such as the pharmacy, for example, which

[29] Karl Marx, *Capital.* Volume II, Chapter 1, II, "Second Stage. Function of Productive Capital", 1885. See: https://www.marxists.org/archive/marx/works/1885-c2/ch01.htm#2
[30] Karl Marx and Friedrich Engels, *Manifesto of the Communist Party.* Chapter 2: "Proletarians and Communists", 1848. See: https://www.marxists.org/archive/marx/works/1848/communist-manifesto/ch02.htm
[31] Karl Marx, *Wage labour and capital*, 1847. See: https://www.marxists.org/archive/marx/works/1847/wage-labour/

accounts for a large part of its turnover. The hospital then acts as a dealer by bringing the goods closer to the customer. However, to date, the hospital does not take on the role of a bank or insurer.

The productive sphere of capital designates the sectors of activity that create new value which encapsulates surplus value. With regard to the hospital as individual capital, apart from the fact that the particular commodity of the hospital is care of the human being - a living body which represents for the hospital the use value on which its activity is based - the productive process is identical to the example chosen of the car industry.

In both cases, use values enter into the concrete labour process which transforms them into new commodities in which not only is the value put to work retained (the part of the constant capital used for the manufacture of the commodities and the variable part of the capital), but a new additional value (the surplus value) is also incorporated.

It is very much a matter of the figure envisaged by Marx who, while speaking of the modern commodity (that is to say the form of commodity which corresponds to developed capitalism), stated that beyond its attributes of use value and exchange value, it must still, to contain the surplus-value extracted from wage labour, be the result of a material transformation in the process of concrete labour. This is certainly the case for the patient during their stay at the hospital. The example of the surgical procedure is very clear. That of psychological care, notably but not only in a psychiatric unit, is no different.

"In considering the labour-process, we began (see Chapter VII.) by treating it in the abstract, apart from its historical forms, as a process between man and Nature. We there stated, "If we examine the whole labour-process, from the point of view of its result, it is plain that both the instruments and the subject of labour are means of production, and that the labour itself is productive labour." … A single man cannot operate upon Nature without calling his own muscles into play under the control of his own brain. As in the natural body head and hand wait upon each other, so the labour-process unites the labour of the hand with that of the head. Later on, they part company and even become deadly foes. The product ceases to be the direct product of the individual, and becomes a social product, produced in common by a collective labourer, i.e.*, by a combination of workmen, each of whom takes only a part, greater or less, in the manipulation of the subject of their labour. As the co-operative character of the labour-process becomes more and more marked, so, as a necessary consequence, does our notion of productive labour, and of its agent the productive labourer, become extended. In order to labour productively, it is no longer necessary for you to do manual work yourself; enough, if you are an organ of the collective labourer, and perform one of its subordinate functions. The first definition given above of productive labour, a definition deduced from the very nature of the production of material objects, still remains correct for the collective labourer, considered as a whole. But it no longer holds good for each member taken individually. On the other hand, however, our notion of productive labour becomes narrowed. Capitalist production is not merely the production of commodities, it is essentially the production of surplus-value. The labourer produces, not for himself, but for capital. It no longer suffices, therefore, that he should simply produce. He must produce surplus-value. That labourer alone is productive, who produces surplus-value for the capitalist, and thus works for the self-expansion of capital. If we may take an example from outside the sphere of production of material objects, a schoolmaster is a productive labourer when, in addition to belabouring the heads of his scholars, he works like a horse to enrich the school proprietor. That the latter has laid out his capital in a teaching factory, instead of in a sausage factory, does not alter the relation. Hence the notion of a productive labourer implies not merely a relation between work and useful effect, between labourer and product of labour, but also a specific, social relation of production, a relation that has sprung up historically and stamps the labourer as the direct means of creating surplus-value."* [32]

When we analyse the hospital as an individual capital, the raw material to which all the medical engineering is applied in the course of its industrial cycle is the human body – in its quality as labour power potentially needing care. The hospital's technical labour process will

[32] Karl Marx, *Capital.* Volume 1, Chapter 16: "Absolute and Relative Surplus-Value", 1867. See: https://www.marxists.org/archive/marx/works/1867-c1/ch16.htm

ensure that the patients who entrust themselves to it will be able to function again. In order to do this, it is necessary to "modify" this raw material in order to make it operational again. The patient, if they are treated, come out transformed like a car whose parts are changed or whose engine is adjusted.

In his or herself, the patient is not a raw material, they become one when they are the object of an organic exchange to produce new value. The patient is then the basis on which the individual productive capital of health is applied in order to transform it (healing) and thus extract surplus value from the productive health workers. In other words, the human being is the use value that enters into the hospital labour process and on which the hospital valorisation process is founded.

The hospital and the state – public health as an unproductive expense

In all the advanced capitalist countries with a state-run health system, the state is the key actor and the main organiser of this reproductive function of capital. The state is at the same time the legal owner of public hospitals (a sort of holding company), the principal of the hospitals, the hegemonic client which fixes the market prices of care upstream (no possible determination on the market of the market value or, even more so, of the production price), which partly finances the infrastructure and constant capital, which pays the wages of the public health sector and which is the guarantor of the social contract around health with and through its intermediary bodies (trade unions, mutual insurance societies).

This situation naturally generates internal conflicts within the state between all these qualities and functions. Ensuring that health structures are in good working order by curbing unproductive expenditure is the main contradiction it faces. It is a moving contradiction that is not resolved by purely budgetary choices, as is shown by the investments made in the wake of the health crisis.

By contributing to the financing of health care and by owning the public health system, the state intervenes in its full capacity as the representative of collective capital (the capitalist class). From the point of view of public health, the state buys care from the hospital (here as an individual capitalist health enterprise with public or private capital). This client-provider relationship is relatively independent of the patient, whose contribution[33] covers only a limited or even minimal part, although it is generally increasing due to the fiscal crisis of states and the evolution of the model of health financing and the production costs of care.

[33] The "ticket moderator" is so called because of its role in "moderating" consumption of healthcare by patients, thus limiting public expenditure.

Bismarck and Beveridge

The Bismarckian model of social insurance, which is in force in Belgium and France (notably), is based on co-management by employers and representatives of employees (the "social partners") and its financing is guaranteed by state allocations. These cover rights which are not proportional to risks – as in pure insurance logic – but based on wages (socialisation of risk). The motivations which were at the origin of social insurance, starting in the 1880s in Germany, were curbing the workers' movement[34] by integrating the management of social relations while improving the conditions of life of the proletariat.

The other model, sometimes called Beveridgian, rests on a logic of assistance organised by the state and financed by taxes. The protection is universal and covers all risks. This model is based on the Beveridge Report, published in November 1942, at the request of the British government, with a view to remaking the system of sickness insurance[35] and putting in place the "Welfare State"[36]. Consequently, the NHS (National Health Service) was created in July 1948.

In practice, compulsory health insurance provides for (partial) reimbursement of consultations, examinations, treatments, medicines and hospitalisation costs. Sick or disabled employees are also "entitled" under specific conditions, to a guaranteed income. The problem for the state is that its health care budget generates no return on investment and is strictly unproductive expenditure.

However, changing health needs, linked mainly, but not only, to greater life expectancy (at the cost of co-morbidities and chronic diseases), and the rising cost of fixed capital and intermediate goods needed for care - coupled with the extension of examinations on a large scale to prevent higher health expenditure otherwise - are pushing up health care expenditure.

At the same time, the structure of financing of social security[37] rests on labour (deduction from the contributions of workers and employers), and this source is contracting with later entry into the labour market, more "atypical" working lives (read: a string of casual jobs) and a growing demographic weight of retirees.

To top it all, the crisis of 2008 has drastically reduced the borrowing capacity of states, which are now in a situation of lasting fiscal crisis. This implies, among other things, the continuation and deepening of the restructuring of the financing and rationalisation of hospital organisation, already well underway before the crisis. The hospitals are pressed to finance their own equipment, while knowing that labour is still paid for by the state. These cuts in spending also increase the proportion spent by patients, no longer on social security contributions, but now on insurance premiums and contributions to complementary mutual insurance companies.

Payment by the state of the wages of the hospital workforce is an important difficulty for its plans to restructure healthcare. The state is in effect paying a tribute to the particular framework of the section of the labour market occupied by public healthcare (which has civil servant status in France). One of the conditions for good functioning of the competitive movement of capital is the possibility of putting proletarians into competition with each other at the moment they get hired, and this condition is not fulfilled in the public hospital because the staff all have an equal wage for an equal qualification. Competition between workers in public

[34] And also facing the destruction – in a context of industrial revolution – of the "protections" previously provided by the family and community (notably religious ones).

[35] Source: lemonde.fr/financement-de-la-sante/article/2014/09/04/la-securite-sociale-entre-deux-philosophies_4482297_1655421.html

[36] Source: https://en.wikipedia.org/wiki/Beveridge_Report

[37] The "social partners" sit on the Social Security Board of Directors. In France, eight State representatives are appointed by decree on the proposal of the government authorities concerned; one for the Prime Minister's office; two for the Minister for Employment; one representative for the ministries responsible for finance, health, the civil service, agriculture, trade, industry and artisans; eight workers' representatives; eight employers' representatives.

healthcare can only be infiltrated into the state in this sector by calling on contract staff, who don't have the status of civil servants or similar and, for medical staff, making use of the famous interns. Interns are, as we shall see later on in the analysis of reforms in the health sector in France, the outcasts of the hospital and an essential (low-priced labour power) on which the state restructuring plan rests.

SOME THINGS FOR COMBATTIVE WORKERS TO THINK ABOUT

This text is dedicated to important structural changes at work over the last few years in the healthcare sector – more precisely in the hospitals – mostly in a few advanced countries, Belgium, France and Czechia.

Starting with a few basic questions – concerning the function of the hospital in a capitalist society, relations between the hospital and the state, and the process of capital accumulation in the hospitals – we have tried to explain that les transformations of the hospital set in motion by states are dominant tendencies and that they suck in everything to make the economic model of the hospital converge towards that of modern industry. These changes are in perfect continuity with the constant need for capital to take over all areas of economic activity, whatever they are, so as to try to "commodify"[38] them to the maximum, with the aim of allowing value to continue to valorise itself – with all the consequences which that involves for health workers.

It is not only through this concrete reality – hospitals as an industry – that the conditions of exploitation of the labour power of health workers are revealed: just like all workers of any capitalist enterprise. It is also necessary to understand that despite the manifest difference of the raw material processed in hospitals (the body of the human being) and all the "understandable" mystifications which accompany it, the place of the hospital in the productive process is in line with the workers of this sector being in a similar situation to that of other workers in capitalist enterprises and indicates to them how to struggle against their exploitation.

For example, everywhere, the nursing profession is subjected to the same changes: modification of skills, increase in the pace of work, deterioration of working conditions etc., with a lack of staff for good measure. In Czechia, for example, many nurses have gone to work in Germany for better wages, and their departure is not sufficiently compensated by the arrival of Slovakian, Polish and even Russian nurses.

The conception that health workers need to follow from now on is that their fight is not to preserve the public hospital, service to patients etc., but that their fight is a class fight which must be carried out against the conditions of their exploitation. It is only by taking the struggle to this level – a struggle for higher wages, for better working conditions etc. – that they will succeed in establishing a balance of forces in their favour in the face of their real enemy. It's an enemy which does not come from outside the hospital, but which has always consisted of the state and the hospital management.

The objective of the reforms going on is to give the managers of the individual capitals of the hospital sector the tools for managing production which are used in other enterprises. Whether the hospital is private or public changes nothing for workers' struggles. The ideology of "public service", which always has a commercial purpose within capitalism, only has the aim to make the state and the general interest coincide. Whether it is state or private capitals (in reality they are often interlinked) which run the hospitals, does not need to concern the workers. What must concern them is their working conditions and wages. And to defend them the first step is to fight collectively against the divisions created between workers by the way work is organised.

For that we have to abandon any demand for recognition of the usefulness of caring activity "*which saves human lives*" (we don't demand these conditions of exploitation, we fight

[38] In capitalism everything becomes, at one time or another, a commodity with a use value and an exchange value and containing a surplus value extracted from wage labour through the productive process.

them). The fetishism of the concrete process of labour definitely exists and is all the more marked in professions where the raw material is the human being. In a capitalist world, such a demand for social recognition can only lead to more exploitation, because it is a world built to extract the maximum value from each worker and not for the flowering of human relations. This is the one major difficulty confronted by health workers. But this difficulty is not insurmountable.

This fight necessarily involves an understanding that the activity of the healthcare sector is a commercial activity (production of the commodity "health") on which the individual capital of the hospital relies to gather in its profits, and that the reforms and transformations going on will not "kill" the hospital, but, on the contrary, will develop a hospital which is more competitive, more productive for capital.

The old workers' demand for free care is more than ever an essential objective of present struggles. It is clearly an objective of the struggle for wages. In the same way that increasing the price of labour power for those who work in the hospital is a struggle against exploitation. The workers – whether they are nurses, doctors or other staff – who go on strike to have the means to work in safety are leading a fight for wages. This must be at the heart of struggles to come in the healthcare sector. And more generally, all workers, whether they are employed in the health sector or some other one, must be involved and must defend the idea that access to health is no more nor less than the indirect wage.

On the side of the patient, the purchase of the commodity "health" corresponds to a defence of income, usually the wage. Responsibility for healthcare by social security corresponds to the indirect wage, whose general increase is defined by the social contract specific to each country. A social contract which is itself the consequence, the historically variable mediation, between the needs of reproduction of capital and the class struggle.

This is precisely the reason why proletarians must treat health as an indirect wage by breaking through, so to speak, the relation between the collective capital (principal client of public healthcare) and individual capital (the hospital, provider of the commodity "health") without caring about the accumulation of capital in this sector. The struggle for health is first of all a struggle for the wage against the accumulation of capital.

Finally, it must be understood that the wage increases and adjustments to working conditions that were hard won in the wake of the Covid-19 crisis, although certainly worth something, will eventually be called into question by capital, and can only be preserved by maintaining maximum uninterrupted pressure on the state and hospital bosses. The process of commodification which has begun will only stop with the defeat of the capitalist system.

The aim of this text in the end is to bring health workers to the conviction that to struggle, it is necessary to look at the relations of exploitation which confront them and that this is the only means they have to avoid exhausting themselves in vain in struggles which are not theirs.

APPENDICES: NATIONAL SITUATIONS AND HEALTH REFORMS

In Belgium and France, reforms are under way which aim to make hospitals more profitable by rationalising work through centralisation and optimisation of healthcare production. The establishment of protocols focusing on the definition of a patient profile, medical procedures and the time required for the patient's treatment are key elements in this process. The production costs thus set, and tending to be reduced, push hospitals to compete with each other. Ultimately, this will lead to the creation of specialised care centres or units using Taylorism to carry out complex tasks. This will save time and therefore money for the hospital.

Belgium: the De Block reform

After the Second World War, the Belgian state opted for the Bismarckian model of social protection, even if the current result is rather hybrid, as in many other states. After the oil shock of 1973 and the beginning of the policy of "wage moderation", Belgium had more and more economically inactive people who did not enjoy rights derived from work. This led the state to universalise several areas of social security coverage. A milestone in the 1990s was the almost complete opening up of health care to anyone with a self-employed social status, followed in 2008 by the extension of cover for "small risks". For people without a residence status recognised by the state, access to care is in principle guaranteed by the mechanism of urgent medical assistance via the public social action centres.

To bring spending into line, in 2007-2008, the Verhofstadt III government initiated the first reduction in the "health care growth standard", reducing it from 4.5% to 2% of GDP. With the Di Rupo government, the norm rose to 3% and during the Michel government it fell to 1.5%. And this at a time when the Federal Planning Bureau estimated that the health budget should increase to 2.5% in view of changing needs (excluding indexation).

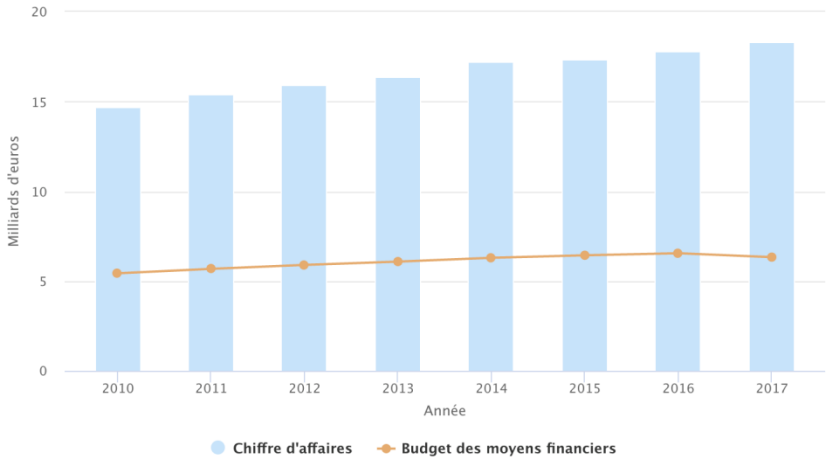
As the *Mutualité chrétienne* (the biggest mutual health insurance company in Belgium) wrote in 2013: "*The most striking developments in recent years have been mergers that have led to an increase in scale, the reorientation of hospital financing, the structuring of hospital activity through care programmes, and the reduction in the length of patients' hospital stays*[39]*.*"

The Financial Means Budget (BMF) is an allocation by the federal state[40] fixed annually and distributed among all the hospitals. It goes up to 98% of the hospital's general operating costs: nursing care, accommodation services, investments in medical equipment and hospital dispensaries. It does not cover 100% of the costs for each hospital.

The BMF has been growing very weakly since 2013 and has tended to decline since 2016; moreover, it accounts proportionally less and less for general hospital turnover (which is growing sharply: €18.2 billion in 2017, compared with €14.7 billion in 2010).

[39] Source: mc.be/media/mc-informations_253_fiche-info-hopitaux_tcm49-28968.pdf

[40] Investments (infrastructure, equipment) have been the responsibility of the communities and regions since the sixth state reform. Hospitals supplement these subsidies with their own resources and loans taken out on the financial markets.



Turnover and BMF in Belgium, 2010-2017[41]

Consequently, fee-based admissions are playing an increasingly important role in the budgetary sustainability of hospitals. In 2017, fees accounted for 40% of total turnover, BMF for 36.7%, and pharmaceuticals for 18.1%.

The number of admissions is also increasing. From 2008 to 2017, stays/contacts per 100,000 inhabitants increased by 13.9%. In particular, day hospitalisations (+9%) and outpatient contacts with the emergency services (+15.5%). From 2013 onwards, day hospitalisations exceeded conventional hospitalisations. Over the same period, the average length of stay decreased by one day in acute services (surgery, internal medicine, paediatrics and non-intensive care for new-borns) and maternity wards[42].

Medical fees are invoiced to the social security system and to the patient (a contribution of 22% of the total cost) but are ultimately only collected by (self-employed) doctors up to an average of two thirds (depending on the hospital, specialities, contracts), the remaining third being passed on to the hospital.

Turnover and cash flow are therefore highly dependent on services. Excluding constant capital investment in cutting-edge technologies (imaging, neurosurgery etc.) likely to increase labour productivity and return on capital, the role of doctors is crucial for hospitals. The more doctors an establishment has, in proportion to its basic capacity (number of beds, number of admissions, paramedical staff[43]), the more it will be able to generate admissions.

The Maha study indicates that in 2018, the yearly balance for the general hospitals was close to zero or even negative and corresponded to 0.2% of turnover (31.8 million euros). One out of three hospitals was in deficit at the end of the year (which incidentally means that two thirds of the hospitals were earning money) and 18% of the institutions had insufficient cash flow. Usually, large hospitals fare better, especially those that make the necessary investments in technology and infrastructure.

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[41] Source: belgiqueenbonnesante.be/fr/donnees-phares-dans-les-soins-de-sante/hopitaux-generaux/financement-des-hopitaux-generaux/sources-de-financement

[42] Source: belgiqueenbonnesante.be/fr/donnees-phares-dans-les-soins-de-sante/hopitaux-generaux/activite-de-soins-au-sein-des-hopitaux-generaux

[43] For the year 2017, the Maha study shows 95,000 full time equivalents (FTEs) in general hospitals. The paramedical personnel (nurses and orderlies) represent just over half (51.1%) for around 3 million care episodes per year in 2018-2019. Doctors represent only 5% of wages because a good number of them have an independent status.
Source: belgiqueenbonnesante.be/fr/donnees-phares-dans-les-soins-de-sante/hopitaux-generaux/organisation-du-paysage-hospitalier/evolution-de-l-emploi-dans-le-secteur-des-hopitaux-generaux

This fragile budgetary situation, or even deficit, of many hospitals is not new. It goes hand in hand with cost-saving measures relating to unproductive state expenditure, but also with an increase in health needs due, on the one hand, to demographic changes (new pathologies and new needs linked to ageing and chronic diseases) and, on the other hand, to innovations in medical technologies and therapeutic interventions.

Faced with this situation, in 2015 the Federal Minister of Public Health presented a reform plan. Its aim was to make healthcare more efficient, that is to say capable of "*creating more value with the budgets available*[44]*"*, opening the way to "*value-based care"* or *"pay for performance"*. Its three main pillars were:

- Centralisation of the supply of care by forcing the reorganisation of the hospital landscape in the form of networks defining the place and role of each one (base, reference and university hospitals; partner services). Expensive technologies, for example, would be allocated to a network rather than to several hospitals.
- Resizing the capacity of the care offered: reducing the number of acute beds and reassigning them as chronic beds; reducing the length of hospital stays.
- Pricing of care in a flat-rate form rather than fee-for-service financing. The latter leads to an increase in the volume of care (particularly for certain surgeries) in order to increase the volume of fees received. In 2019, for 57 procedures with low variability (care that is not very complex and varies little from one patient to another), global amounts according to pathologies and treatments were decided upon, independently of the actual care process for the patient considered individually. All hospitals lost money and had to adapt their cost structure.

Ahead of the Minister, as an "informed" manager of public spending, the *Mutualité chrétienne* wrote in 2013: *"Various factors encourage hospitals to collaborate more. Medical technology, which is becoming more and more efficient, is also becoming more expensive, even though the budget is limited. In addition, authorities are setting minimum size or activity standards for certain services or care programmes. In this context, cooperation leads to greater efficiency. Furthermore, the exchange of medical data helps to avoid double examinations, which are uncomfortable or even harmful for the patient and place a heavy burden on the social security budget. To encourage closer links between hospitals, the authorities recognise three forms of collaboration: grouping, association and merger. In addition, they support certain forms of electronic data exchange*[45]*."*

[44] Source: inami.fgov.be/SiteCollectionDocuments/plan_approche_financement_hopitaux.pdf
[45] Source: mc.be/media/mc-informations_253_fiche-info-hopitaux_tcm49-28968.pdf

France: "Ségur de la santé[46]" agreements

Reforms of the French health system have been a continuous work in progress for the various governments that have succeeded each other for the last forty years or so. The "health crisis" created by the coronavirus has given a boost to attempts by the present government to reform the hospital, its organisation and its financing. In France, as elsewhere, the final objectives are the same: make productive the services which aren't or which are not productive enough, even if sometimes the details differ from one country to another.

The government has granted certain concessions to healthcare staff. But these do not call into question the pursuit of health reform. It will be done with a different rhythm and with other priorities, but without deviating from its aim: "*To be able to adapt the workforce and the productive apparatus to the needs of the market, that is the central objective of the reform"*[47]. This is what has happened recently in the SNCF and what is being applied perfectly to healthcare (just as has already happened, to a lesser extent, in public education).

The context of the health system reforms

<u>The state of things before…</u>

- First of all, wages: nurses get €1,500 gross per month at the start of their career, one of the lowest rates in the OECD countries. According to the unions, the difference from the average is around €300 per month.
- Then, under-staffing: the hospitals struggle to recruit and keep their staff because of the working conditions. *"The main medical desert in France is the hospital: almost 30% of posts are not filled"* (Frédéric Valletoux, President of the Hospital Federation of France[48]). Among the nurses, "*30% of those newly-qualified abandon the profession within five years"* (Thierry Amouroux, spokesman of SNPI[49]).
- More generally, the degradation of working conditions in public sector hospitals has led to the expression of a dual sentiment of the impoverishment of team working and the loss of the notion of a "labour collective". The effects of the Hospital, Patients, Health and Territories (HPST) law of 2009[50] are also called into question concerning, for example, models of governance.
- In the course of twenty years, almost 100,000 beds have gone from the clinics and hospitals, of which 4,700 beds closed between 2017 and 2020, across France, and 12,000 for APHP (Paris region) between 1992 and 2020.
- Finally, the financing of hospitals. *Tarification à l'activité* (T2A), installed in 2003, fixes the resources of hospitals according to procedures carried out. It is often accused of pushing the "race for volume", generating unsupportable costs for the state. At the same time, the total debt

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46 From the name of the street where one of the entrances to the Ministry of Health is located. The "Ségur de la santé" began on 25 May and lasted seven weeks during which the consultation was coordinated by the ex-General Secretary of the CFDT, Nicole Notat. The negotiations ended up with an agreement on 13 July, signed by all three of the big union confederations involved (CFDT, FO and UNSA). It concerned wages, hiring and working conditions. The total financial package announced was €8.2 billion, including 7.6 billion for non-medical staff. Other proposals have been put forward since by the government to recast the healthcare system. In addition, 33 measures were announced on 21 July. Source: solidarites-sante.gouv.fr/systeme-de-sante-et-medico-social/segur-de-la-sante-les-conclusions/

47 See Letter no. 46: "*SNCF: A balance sheet of the defeat of a conservative strike"*: https://mouvement-communiste.com/documents/MC/Letters/LTMC1946%20ENvF.pdf

48 Source: lejdd.fr/Societe/le-president-de-la-federation-hospitaliere-de-france-il-faut-replacer-lhumain-au-coeur-du-systeme-3970271

49 Source: bfmtv.com/economie/segur-de-la-sante-un-syndicat-alerte-sur-une-prochaine-penurie-d-infirmieres_AN-202007130218.html

50 See: legifrance.gouv.fr/jorf/id/JORFTEXT000020879475/

of hospitals, today close to €30 billion, is the subject of numerous discussions between the government and the hospital federations.

Content of the Ségur agreement

Point 1: Increased wages

- Wage increases will be in two stages: 1 September 2020 and 1 March 2021. The first will be 24 index points, which is €90 before tax, the second of 25 index points, making €93.

- Employees whose wages are not linked to indices will also see them increase by the same amounts.

- Revision of wage scales: pay more for the groups in categories B and A; move into category B the nursing auxiliaries and the childcare auxiliaries; integrate the nursing groups (nurses in general care, specialised nurses, paramedical health professionals, nurses in advanced practice) into the category A scale.

Point 2: Work organisation

- To allow a diversification of work organisation offered to care personnel (daytime-only activities, work schedules with no weekend), pilot projects will be developed in establishments so as to construct planning in "full autonomy" by the service agents with validation by management.

- An impact study will be carried out by regional health agencies with hospital managements concerning the situation of the staff (job vacancies, absenteeism, casual work, training needs with regard to capacity and activity structure).

- Also, systematise professional dialogue meetings, guarantee times of transfer between teams as working time, put in place tools for development of collective practices. And reinforce local negotiations (as opposed to on the national level) within the framework of the hierarchy of norms and the general status of the civil service.

An agreement for hospital doctors

- A collection of 16 measures, with a total allocation of €450 million. The allowance is today €490 gross per month for a full-timer and will be raised to €700 for those whose seniority is fifteen years' service or more. It will rise to €1,010 for all eligible general practitioners, with a first stage in September and a second in March 2021.

- In parallel, a revision of wage scales is planned to come in on 1 January 2021, with a fusion of the three levels and the creation of three additional levels for pre-retirement: €100m will be allocated.

- Interns, the future doctors employed in the hospital as part of their course, will gain from an allocation of €124m, while the measures are aimed at assuring *"better respect for working time"*.

Complementary Measures from 21 July[51]

- Put in place 4,000 beds to deal with seasonal peaks (€50m) from now until December 2020.

[51] See the article "Trente-trois mesures pour réformer le système de santé" ("33 measures to reform the health system"), *Le Monde,* 23 July 2020: lemonde.fr/societe/article/2020/07/22/investissement-financement-gouvernance-les-conclusions-du-dernier-acte-du-segur-de-la-sante_6046892_3224.html

- Invest €19 billion, including 13bn for hospital debt; 2.1bn over 5 years for the EHPADs (homes for the elderly) of all categories; 2.5bn priority hospital projects (links between community and hospital medicine); 1.4bn for investments in digital technology.

- Attenuate the effects of the 2009 HPST law, notably by setting up participatory governance in the hospitals.

- Experiment with mixed models of financing.

Summary of the reform which is in progress

For the incomes of employees, the increase (in two stages) of €183 is significant, even if it is not the demand of €300 for everybody expressed by health workers, such as on the demos of 16 June 2020. Promotions in category according to the Public Hospital Function (FPH) of 563,000 nursing auxiliaries (from C to B) and 210,000 nurses (from B to A), out of 1,173,000 employees covered by the FPH also translates in the short term into wage increases, and, in the medium term, by more rapid career progression and better bonuses. Longer term, it leads to better pensions (on the present basis).

It is a matter of a pay rise of roughly 10% in a period of weak inflation. To put this in perspective, the similar percentage gained in May-June 1968 took place in an era of high inflation[52]. Nevertheless, we must not forget the workers who were excluded: 370,000 contractors, temps and agency staff, and the 58,000 classed as "various", representing respectively 18.2% and 7.1% of the total employees of the sector. This reinforces the division between the "statutories" and the casual workers of the hospital. This is a strategy applied for a long time in other capitalist enterprises in the public services like the Post Office or the SNCF. These concessions from the state will not be without repercussions for the working conditions of health personnel.

Increasing the flexibility of the staff, its mobility between services (while respecting health regulations), optimising investments and better controlling the mass of wages, will be achieved by "loosening" the rules of FPH. All this while dealing with the experience of Covid-19, which tends to transform hospitals into military hospitals, practicing a form of "battlefield medicine"[53]. The condition for the good functioning of "battlefield hospitals" is the presence in sufficient numbers of a qualified workforce which is supple, adaptable, deployable to operate ephemeral healthcare structures, mobile and adjustable to the needs of the moment. This is the reason why a fundamental objective of the reform of the French hospital system is to demand from the staff, as a counterpart to the rise in wages and faster career progression, more flexibility, mobility and multi-functionality.

Covid-19 reveals itself to be a full-scale test for the restructuring of certain services which cannot be ignored and are very costly, often not very, or not at all, profitable, like intensive care services. The experience of the so-called "first wave" of Covid-19 saw these services completely overwhelmed by the influx of sick people, partly in terms of lack of beds, but also because of lack of personnel, and in particular of personnel trained to face this particular health crisis. In intensive care services, every bed occupied mobilises an average of eight healthcare staff. Thanks to the first lessons of the catastrophic management of the epidemic in spring, new methods seem to be emerging[54], less "greedy" for staff because they are based on faster rotation and increased

[52] The figures are taken from the annual report on the civil service, from 2019. See: fonction-publique.gouv.fr/files/files/statistiques/rapports_annuels/2019/Rapport_annuel_FP-2019.pdf

[53] An example, that of Mulhouse put in place during the Covid crisis. See: huffingtonpost.fr/entry/voila-a-quoi-ressemble-lhopital-de-campagne-de-mulhouse_fr_5e7a4f3ac5b63c3b64984943

[54] "Para-intensive care" services, whenever this is possible. These intensive care services function with lighter structures and less personnel, put in place following the first wave of Covid, or the contributors have learned lessons from the saturation of intensive care services and have introduced new methods of treatment. The new organisation

ductility of dedicated care workers. From this it is possible to manage greater numbers at lower cost.

Unlike the nurses and hospital doctors, other professions have yet to benefit from an improvement in the contractual terms of their statutory frameworks. We can mention dieticians, pharmacy assistants, lab technicians and, a second time, ambulance drivers and medical regulation assistants. On the other hand, those forgotten by Ségur are two categories of underpaid health personnel without which the public hospitals would not function: the students and, above all, the interns. And these are the two categories who will bear the weight of additional work coming from the promised reduction of casual staff. This reduction is, up to a point, perfectly compatible with the objective of squeezing the mass of wages, on condition that actions carried out by casualised health workers are performed by others at a lower cost, such as interns, nurses and trainee nurses. These serve, and will continue to serve, as an adjustable variable in hospital planning, skilled labour at very low cost and with schedules that can be extended at will. Along with the nurses, the interns were massively mobilised for the "first wave". It remains to be seen if they will be willing to work in the same conditions without reacting if and when there is a second shock on a similar scale.

The modernisation of the organisation of the hospital business

To transform the hospital into a business, the first stage is the transfer of decision making to a local level, the hospital director becoming head of the company in their own right:

1) For negotiations over wages, working conditions and investments. Arbitration over investments happens at a departmental level of the ARS (when the sum is over €100 million) but their criteria (not defined in Ségur) will be efficiency objectives;

2) For work organisation, on a team level as well as for individual salaries. The individual part of the wage will increase (including the management of overtime). Careers will also be more individualised. The "revalorisation" of team working will involve competition between different teams in the same hospital, in the same way that competition will increase between hospitals to attract skilled personnel.

   That will allow better rationalisation of territorial distribution of hospitals and services but will also authorise, inside each hospital structure, the temporary (or not so temporary) transfer of staff from one service to another and, to some extent, from one specialisation to another. The fall in the number of beds will continue but it will be planned on the basis of criteria which are standardised across the territory. Meanwhile, the government has announced the suspension of present closure plans, such as for the CHU in Nancy, which doesn't mean that they are definitely stopped[55].

"Health has no price. The government will mobilise all financial means necessary to bring assistance, to look after sick people, to save lives. No matter what it costs." "We must learn the lessons" and *"question the model of development to which our world has been committed over the decades",* said Emmanuel Macron on 18 May 2020[56]. Words which fool no one and certainly not health workers.

The precise timetable for Ségur is not fixed. Many elements of the reform are still to be defined. The greatest vigilance and the mobilisation of hospital workers are needed more than ever, not only to counter the plan to increase the intensity and mobility of labour, but also to

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and the new treatments applied to patients allow them to avoid, to some extent, going through the intubation stage and so clogging up the classical intensive care services. They also need fewer qualified staff per intensive care bed.

[55] See: actu.fr/grand-est/nancy_54395/le-plan-de-suppression-de-600-postes-au-chru-de-nancy-est-toujours-prevu_34418388.html

[56] See: francetvinfo.fr/sante/maladie/coronavirus/quoi-qu-il-en-coute-emmanuel-macron-lance-un-appel-general-a-la-mobilisation-contre-le-coronavirus_3863731.html

fight all the way against any new measure which will worsen working conditions in hospitals even more.

Already, faced with the second wave of Coronavirus, faced with the resignations of staff refusing to see their situation worsen[57] and to compensate for the militarisation of labour[58], the government has announced that it will bring foreword the payment of the second part of the wage increase (€93) from 1 March 2021 to before 31 December 2020[59].

Leaflets

We have distributed two leaflets about the situation in healthcare, one in Belgium[60], the other in France[61].

[57] For example, the 900 additional hires by APHP are not enough because 450 health workers in Paris have resigned in the meantime, sickened by the unbearable working conditions and the deception regarding their wage increases.
[58] APHP postponed or abolished the All Saints' Day holiday.
[59] https://www.francetvinfo.fr/sante/maladie/coronavirus/covid-19-la-deuxieme-hausse-des-salaires-pour-le-personnel-hospitalier-sera-finalement-versee-avant-la-fin-de-l-annee-annonce-jean-castex_4142941.html
[60] See: https://mouvement-communiste.com/documents/MC/Leaflets/TR200912%20Sante%C3%AC%20vGEN.pdf
[61] See: https://mouvement-communiste.com/documents/MC/Leaflets/TR201014%20Sante%20vF%20EN.pdf

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“By cowardly giving way in their everyday conflict with capital, they [the workers] would certainly disqualified themselves from the initiating of any larger movement”

Karl MARX,
Wages, Prices and Profit, 1865

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