astray. There are some who are more market-oriented than benevolent, and so we have to see to it that in our own domain, our ethics prevail and not those exceptions that are mammon-oriented. We do that as well as we can. The classical example are the so-called Individual Health Benefits [IgeL—care which is not paid by insurance, but by the patient privately—ed.]; here the limit of merely selling benefits is sometimes exceeded; our job is to put a curb on that, and we hope that we do a pretty good job.

Zepp-LaRouche: Thank you for letting us speak with you.

EU Countries Take The Ax to Health Care

by Elke Fimmen and Rene Noack

This article appeared in Neue Solidarität *of May 27, and was translated from German.*

The discussion at the 112th German Medical Assembly on May 19-22 set into motion a long overdue public debate about the "shortage of care" and "secret rationing of medical services." The delegates expressed their astonishment at the "speed and political facility with which billions are spent to bail out a failed financial policy, and to consolidate banks and corporations, while patients, physicians, and citizens of our country have had to struggle mightily for years for comparatively small increases in the financing of statutory health insurance."

For years in Germany, in hospitals for example, this situation has led to drastic underfunding and worse patient care. Due to austerity policies in the delivery of health care, the number of hospitals sank to 307, a drop of 12.7%, from 1991 to 2006. Since 1991, it has been the declared policy to remove an ostensible "overcapacity" in the hospital system.

According to a study produced for ver.di[2] in the Summer of 2008, from 1995 through 2006, 95,650 full time hospital positions were cut, or 10.8% of the total, causing, above all, a sharp reduction in the scope of care. And that, despite rising numbers of patients, as between 1995 and 2006, the number of inpatient admissions rose by 12.2%. Between 2002 and 2006 alone, the number of partial hospitalizations increased by 66%, the number of pre-admission cases by 94%, and the number of outpatient surgeries by 162%. The ver.di study points to the sharp decline of the very foundation of health-care financing, namely the development of taxable revenue of members of the Statutory Health Fund (GKV) as a proportion of Gross Domestic Product (GDP), and stresses that the principal problem is with income, not with distribution. Primarily the high unemployment, which has been persistent and climbing since 1980, as well as the very insignificant growth of wages and salaries, and an increasing gap between higher and lower income levels, have made this foundation shrink more and more.

Declining Revenues

The GKV members' income that is subject to taxation, which amounted to 47.387% of GNP in 1996, had sunk by 2005 to 43.255%. The solution to this problem on the income side can be shown with a simple computational model: Had the basis for the GKV's revenue not shrunk over this period, the Health Fund would have had 10% more funds at its disposal, even without increasing premiums.

Thankfully—contrary to all the balanced budget-fixated monetarists—this study points out, moreover, the absurdity of setting up monetarist accounting criteria to measure health care. Until now, there has been "no generally accepted definition of 'profitability' in social law." Back in 1991, the Council of Experts for Concerted Action in Health Care had determined: "Owing to the heterogeneity of cases, the medical benefit of a hospital can be no more defined from available global data, than its social benefit: It is impossible to compare the total expenditures with all the efforts used to bring about the results, and to conclusively determine the benefits of inpatient care as a whole." Therefore, it is just as impossible to arrive at a verdict concerning profitability, "whereby profitability is understood as the quotient of medical and social benefit (yield) and general expenditure."

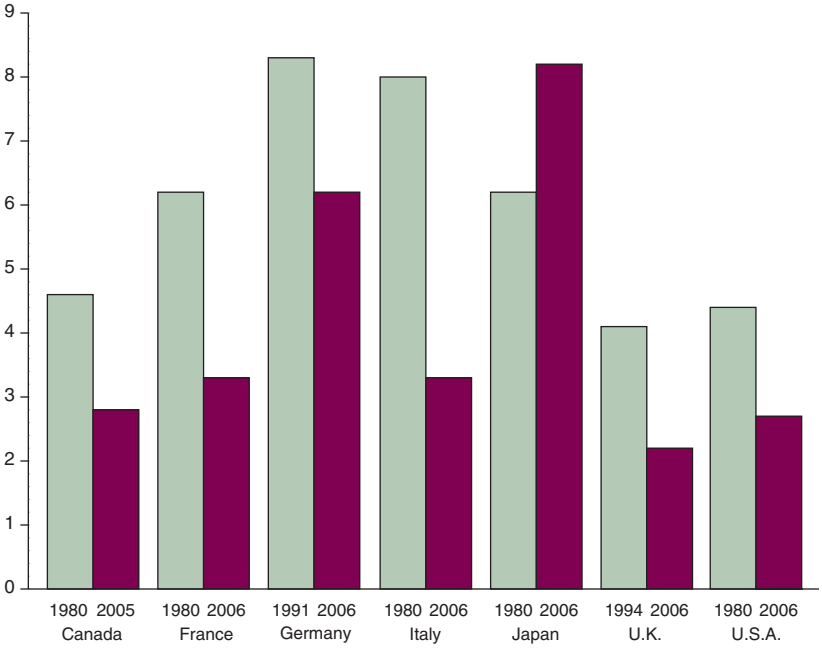
Instead of placing the primary accomplishment in

2. Citations and statistics from "Sixteen Year Cap on Hospital Budgets: a Critical Review," by Prof. Michael Simon, FH Hanover, for ver.di, June, 2008.

the center, namely the cure and treatment of diseases, quantifiable, monetary "operating figures" are employed (length of stay, number of cases and operations, diagnostic procedures, etc.), which then are instituted to determine ostensible yet-unrealized "further profitability reserves" in hospitals, with strict cost-cutting. Hence the care provided to the population is continually shrinking, and the central principle of the German public health-care system is blatantly violated—namely, that all insured will have an unrestricted claim to all necessary medical services, in case of need.

According to Eurostat, there has been a considerable decline in the overall number of hospital beds in most member states of the European Union (EU) since 1980. In the EU of 15 member states, this contraction from 1980 to 2000 was greater than 30%, owing to, among other things, the shorter and shorter inpatient stays, because of cost considerations. The average length of stay fell from 17.4 days in 1980 to under 11 days in 1997.

FIGURE 1
Ratio of Hospital Beds to 1,000 Population



Source OECD.

Note that not all the years are the same from country to country.

If now, through the new EU directives on the so-called "Application of Patient Rights in Cross-Border Provision of Health Care"—which was just sanctioned by the European Parliament—a new "Internal Health Market" is to be established based on Article 95, with dumping prices, we will see a new wave of privatization and destruction of the national health-care systems. In 2005, due to massive resistance by the trade unions, the inclusion of health-care delivery provisions had still been excluded from the EU's Bolkestein Directive on "free movement of service providers."

Still more "cost savings" under conditions of economic collapse, the massive decline of tax revenue, and in the face of the danger of global pandemics (such as swine flu), pose broader existential questions: For example, does the medical infrastructure actually exist on the scale anticipated in the German Federal pandemic plan adopted in 2007? If there were to be be a pandemic infecting around 30% of the population in eight weeks, this would lead to 13 million additional doctor visits and 370,000 additional hospital admissions, according to official calculations.

A look at the situation in leading OECD countries, after 20 years of privatization and cost-cutting, reveals that all the nations considered here have reduced their hospital beds for inpatient care. The figures come from the OECD:

Canada: 113,278 (1980) to 89,491 (2005)
France: 334,796 (1980) to 224.168 (2006)
Germany: 665,565 (1991) to 510,767 (2006)
Italy: 444,143 (1980) to 190,561 (2006)
Japan: 1,534,900 (1994) to 1,051,107 (2006)
U.K.: 237,500 (1995) to 135,380 (2006)
U.S.A.: 992,075 (1980) to 804,491 (2006)

These countries have reduced their hospital capacity by between 30 and 50%. Considered as a ratio of hospital beds to 1,000 population, the scope of the reduction becomes even clearer, as shown in **Figure 1**.

In several of the countries shown in the graph, the bed count was *halved*. It is doubtful whether the population is being protected—particularly under conditions of a very possible general medical emergency.[3]

3. OECD statistics published at www.gbe-bund.de.