ANGRY WORKERS OF THE WORLD

London Bulletin - Issue #2 angryworkersworld@gmail.com » angryworkersworld.wordpress.com

GET IN TOUCH

If you want to circulate your experience, get in touch. If you want to organise stuff at your work or in area and are looking for support, get in touch. We meet once a month and check website for date and place - but we can meet whenever necessary in between.

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(HEALTH) WORK IS SICK

STRUGGLES IN THE HEALTH SECTOR

CONTENTS

Working longer hours, more stress at work due to 'under-staffing', more worries about losing the job or not finding one, pressure from the job centre or housing benefit office, lower wages or benefits and therefore less money to spend on quality food, general social atmosphere of uncertainty and 'all against all', cuts in health care... the impact of the crisis on our minds and bodies is direct. In the US, five million people have lost their health insurance since 2008. In Greece, suicide rates increased by 20 per cent during the first two years of the crisis, new HIV infections by 200 per cent due to more people shooting heroin, tuberculosis and malaria has seen a comeback after the government cut prevention schemes and at the same time cut spending on public health by 23 per cent between 2009 and 2011.

We have this reality on one side. On the other side we have a medical system, which announces that they can now breed new organs, that they have cracked the 'ageing gene' and could connect our brains directly to our smart-phone. We see a sharpening contrast between the deterioration of the living and health conditions of most people and the seeming progress of a detached 'science'. We have to ask ourselves why this contrast sharpens. The politicians say that 'there is not enough money', while at the same time there is an over-production of food and playstations and a growing mass of an unemployed 'workforce', which has been expelled from production due to productivity increases. This contrast between 'lack of money' (meaning lack of profits and incentive to invest) and decreased wages on the one side and the abundance of 'human productive possibilities' (available technology, knowledge, (wo-)man power) on the other, is becoming more acute. Even though the pharmaceutical industry runs into over-production, the state helps to keep up prices of medication through patent laws: millions of people cannot afford the abundance of medication because companies and states are more interested in 'property rights' than making medicine available to the people that need it. All this can't be healthy! This is why there is a social crisis...

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For this reason we spoke with friends who work in the health sector: nurses, hospital cleaners, office workers. We think that their conditions symbolise the absurdity: the restructuring of the health sector deteriorates the conditions and therefore the health of those who are supposed to 'make us healthy'. The current crisis of the Accident and Emergency departments and NHS Direct 111 is another symbol: the rest of the health system is in such a crisis that patients are piled up in A&E, while the state plans to shut down A&E units and/or to replace qualified paramedics with 6-weeks-trained health assistants. We asked our friends about their conditions and about the possibilities they see to resist further attacks on them - because in the end the state of our health will depend more on whether we can fight back against unpaid overtime, lower entry wages, hospital closures and hassle from the authorities than on 'ground-breaking' discoveries from the DNA-crack-heads. Before we get to the reports from our friends, some more thoughts about the history and current restructuring of the health sector. Enjoy!

Looking Back in Anger...

Why look back into history? Because what we take as 'natural', a separate 'health system', is a relatively new thing. Hospitals emerged together with factories and large-scale warfare. This was no coincidence. When masses of poor people were expelled from the land and forced to migrate to cities to get a job, the urban upper class was suddenly surrounded with poverty-related epidemics. The first hospitals were places to contain the poor and keep the sick amongst the sick. Industrial life became dominant and bodies had to keep up with the rhythms of machines. The bodies of the first generations of industrial workers collapsed fairly early, if they did not revolt. The interest of the state in workers' health therefore always had this double side: maintain or select productive bodies as cheaply as possible and keep things under control. The 'health system' allowed the state to turn the social problem of poor living conditions into the (individual) health problems of workers and families. Workers - and in particular female workers - were confronted with a medical system, which destroyed former knowledge about health, contraception and childbirth and demanded respect to the 'new specialists'. We had to sell the time and energy of our bodies and we were separated from the knowledge about our bodies: bosses and 'scientists' declared themselves to be the necessary managers of life. In times of crisis, the relation between state politics and the medical system becomes clearer, from mass health checks for the army to mass sterilisation campaigns to 'curb the growth of the poor population'.

Hospitals became part of a vicious circle. Once we accept that we are human cogs of machines at work, victims of rush-hour accidents and of poverty in urban areas (drugs, crime), no one can deny that hospitals are a life-saving necessity. But hospitals also became part of our acceptance and thereby 'make the daily massacre possible'. Maimed and exhausted bodies are carried away, out of sight, after work- or traffic-accidents, otherwise we'd hardly accept being victims of a relentless sped-up profit machine. Organised in similar ways to factories, hospitals concentrate ill people in one place and try to fix them with as little labour input as possible. Up to today this causes a lot of 'hospital related illnesses'. Last year over 3,000 people died in UK hospitals due to 'mistakes' - these are not personal failures, but 'inbuilt'. Catching hospital related infections and wrong medication is the fourth most likely way to die in the US. This contradiction of 'health vs. wage work' is not only symbolised in the concrete buildings of factories and hospitals, they have planted the contradiction right into our head: how we see our own bodies.

If we have to sell our labour power on the market to survive, then we have to see our body as an apparatus, which has to be maintained. As a body in competition with others, hunting for the same jobs. We hate our body if it can't keep up. Once this separation between 'us' and 'our bodies' is established whole industries emerge on the background of this separation: fitness centres, food supplements, beauty products - and increasingly parts of our bodies actually become commodities: organ trade, surrogate mothers. We sell the energy of our bodies on the labour market and we extend this relation to the market of love. In particular women workers are forced to compare their bodies with the high-investment bodies on the catwalks. We start to see our bodies as assets or investments - like the rest of nature, which becomes a 'resource'. The state encourages this view.

While cutting down public health care we are supposed to be 'responsible for ourselves', for our bodies. It is not asbestos, the beauty terror, the stress at work, the threat of nuclear disasters and stock-market crashes which make us ill, but our 'wrong habits' (eating the wrong stuff, having a fag). We are supposed to 'manage' our bodies well and be in control, while around us the social chaos increases - to 'choose' a healthy diet is ironic when you are not able to tell if the can of corned beef you just opened is actually horse or not. Within ourselves the separation between a fearful and stressed mind, which tries to force and mould a non-complying body, is increasing. Depression, eating- and anxiety disorders, chronic fatigue syndromes are the results and they are mass phenomena and become investment opportunities for the 'healing' industry. If our mind or bodies go on strike, we should not treat it as an individual failure, but as 'healthy' reactions towards an ill society. The main treatment will be to break out of isolation.

We can only overcome these widening gaps between us and nature, between ourselves as competitors and between mind and body if we find a way to produce our living in a more conscious and collective way, which put the means and knowledge of production and health care in the hands of all. If wage, price and profit prevail as the main measurement of whether and how things are produced, we are fucked and the generations to come are properly fucked. But it is not about waiting for the 'big change'. In daily life and daily struggles against the attack on our living conditions we can and have to change our relationships. Changing from anonymous colleagues and neighbours to people who struggle together and take care of each other.

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Current Restructuring of the Health Sector

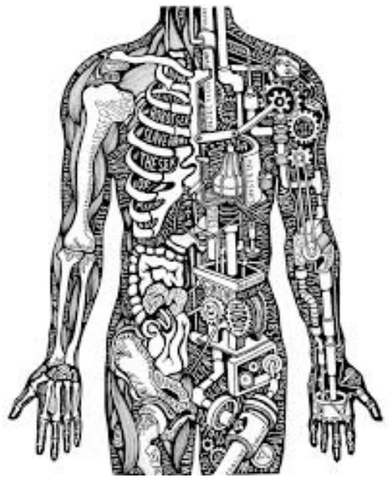
So much about the general character of the 'health system', now to the current changes. The main aim of the restructuring of the NHS is obvious: cutting costs, 20 billion pounds by 2015. Cutting costs often means to sell things off: 'privatisation'. The state has to sell its assets in order to keep its debts in check. Ironically one of the main reasons why the state debt accumulated is because the state had to bail out banks, which were close to collapse due to bad debt from the 'private sector'. In this sense privatisation is another desperate attempt to blow up another bubble and to grease the profit-machinery. Part of the privatisation process is the systematic underfunding of certain hospitals or departments in order to demonstrate their inefficiency to then justify selling them off or closing them down completely. We can see the contradictions in this shifting around of money and the scope for corruption. Some people find this scandalous, we find it not very surprising. Some recent examples.

*** Rotherham National Health Service Trust, in South Yorkshire has spent £3 million between 2010-13 on private management consultants. While these advisers and consultants are making good money, the 3,800 staff at the hospital are being told they must accept 750 job losses and cuts to their wages and conditions.

*** GSTS Pathology, the joint venture between Serco and two London hospital trusts forged in 2010. The hospital had actually lost money in the first six months of the partnership. While the hospitals have provided labs, equipment, staff and over £3m in capital between them, Serco has provided no capital and is actually being paid by GSTS - £8.4m in the first two years - to send its management consultants to "transform" the service. Serco's "transformation programme" is mainly concerned with achieving the 30 per cent cuts in the cost of pathology tests to meet targets set by the government report and to make a profit. GSTS tries to replace "experienced and costly staff" with less qualified Medical Laboratory Assistants. Staff complain that the £8m paid to Serco consultants has created an extra layer of managers and no productive investment. http://www.corporatewatch.org/?lid=4105

*** The private company Atos was given the contract to do the disability assessment for the governmental Department for Work and Pensions. The contract runs for five years, it is worth Â£400 million, covers 75 per cent of disability benefit claimants, around 11,000 claimants are supposed to be tested per week. The government announced the aim to cut the number of disability claimants by 20 per cent by 2015 and someone has to do the dirty job - there have been several suicides of claimants already. But Atos is not able to do the job due to lack of staff and skills, so they in turn outsource assessment work to 14 subcontractors of charities, private companies and... back to NHS trusts.

On a social level, all this wheeling-and-dealing creates a huge amount of extra work (new recruitment, company logos, extra admin work for coordination between different companies, extra work for the tax office etc.). If we don't only assume that all this is a big conspiracy to siphon off money into the hands of middlemen and consultants (many of them ex-politicians!), then what is the aim behind all this? Let's put it bluntly: the political class hopes that by 'privatising' they can put more pressure on workers and their wages and enforce the lowering of standards for patients unless they pay for extra services - what they call 'more choice' (why not get your hip replaced in India?! - see report). The state itself has introduced 'market rules' within the NHS (bonuses, targets, penalties) and with the introduction of Foundation Trusts under Labour, hospitals could act as 'independent players' opting out of national pay and conditions. Meaning, for workers and patients, it does not really matter whether the management are state bureaucrats or private pen-pushers, the struggle for better conditions and care is on either way. To appeal to the state that it should take care of 'human needs' is delusional: in times of crisis an increasing number of us are just unproductive costs from the bosses and state's point of view. And what do we hear from a state (and its media), which systematically pushes money into the hands of management middlemen and cuts workers wages (many of them with a 'migrant background)? We are supposed to hunt down the 'non-eligible immigrants' who are blamed for draining the NHS...



A Whole Load of Bullshit...

Nurses under the NHS are told that 'as public servants and good (motherly) carers they have to be frugal and willing to self-sacrifice, while the patients are told that they should not be 'a drain on taxpayers money'. In the private sector the ideology is now that the nurses, as service providers, should 'create a great care experience' for their clients. Both ideologies are bullshit, they keep us separated. The senior bastards know how to blackmail the hospital workers into worse conditions by declaring it as a necessity for the well-being of the patients. In a Financial Times article Mr Bown, chief executive of Poole Hospital NHS Foundation Trust, says that the announced pay cuts are necessary, otherwise 6,000 jobs would be at risk and he continues that: "the proposals were not simply aimed at saving money but also using terms and conditions as a lever to raise productivity and standards, which have been under the spotlight since the publication of Robert Francis's report into up to 1,200 avoidable deaths at Mid Staffordshire Foundation Trust". He's basically saying that if workers don't accept the attack on conditions they put patients' lives at risk. We repeat: bastards.

Within the current restructuring of the NHS you can see two tendencies: centralisation and separation. Centralisation is the closure of departments or hospitals and the merger into mega-hospitals. This is the usual concentration process in order to reduce the workforce in relation to the turnover of patients. On the other hand there is a decentralisation in the form of GP-led groups. In April 2013, GP-led groups took control of local NHS budgets. What is behind that move? Basically the GP who sees the patient will not only have to assess what's wrong with you, but also whether the transferal to a specialist or other 'provider' will be economically viable for the general budget. They want to force the GP to have the price tag in mind when checking your gall bladder. It is also an easy way out for the political class to outsource the management of austerity to 'specialists' like doctors - who themselves are put under pressure by public 'performance tables'.

By chopping things into smaller units they hope that the 'fear of going bankrupt' or the 'motivation to make profits' enforces itself more easily on lower management's mind. In the balance-sheet of single companies you don't see how much unproductive extra work is generated in order to coordinate work between different companies.
While the individual companies might be able to display a profit, this does not equate to greater efficiency, i.e. on an individual company level, time is increasingly spent on meaningless, business tasks.

At the same time, if workers see themselves only as part of a small workforce, either in a GP's surgery or as outsourced cleaners in a hospital, they are less likely to feel self-confident. The pressure on wages and conditions starts from within the NHS, while at the same time the NHS is 'surrounded' by private companies where conditions have already been lowered. More 'competition' therefore in the end is more competition between workers: who works the hardest for the lowest pay wins. And for those who have 'lost the competition' and are out of job, there is more cheap labour around the corner: With the ideology of the 'Big Society' a lot of work is not supposed to be paid at all: women who used to have a permanent care job are now supposed to rediscover their 'family feelings' and 'caring nature' and look after the sick at home or as 'volunteers' in the 'community'. Another ideological attack.

Massive Attack on Wages and Conditions...

Since the mid-2000s over 24,000 NHS jobs in hospitals have gone. The main attack therefore is systematic understaffing in order to force workers to work more. This is not a management failure, it is a strategy. On the background of growing unemployment and fear of job losses the actual wages and conditions can be attacked. Agency work is increasing - see report by NHS Bank worker. The pay freeze since 2010 has resulted in severe real wage losses. Then there have been attempts by individual trusts to opt out of the 'Agenda for Change' (national pay agreement), especially those burdened with crippling PFI debt repayments. A consortium of 20 healthcare trusts in the South West, dubbed the 'pay cartel', got together and planned to slash workers' terms and conditions. This would have resulted in a 15 per cent wage cut (two days less holiday, one hour extra work per week, reducing maternity and paternity pay, cut of unsocial hours bonus, drop of wages of lower-rank pay grades). After heavy protests from the workers and unions the plan was dropped (for now...).

Another way to justify pay cuts is the formal 'de-skilling' of workers. Some more examples...

*** At Salford Royal Hospital management has forced through pay cuts of up to £6,000 a year against 60 pathology staff. National Health Trust Laboratory and the union leaders agreed to it. In 2012 biomedical staff who typically earn between £21,000 and £35,000 had already suffered a three-year pay freeze. Using the union's refusal to call strike action, Trust management approached staff between August 2012 and February 2013 on an individual basis, asking them to sign an agreement to settle the dispute. In a related dispute, 30 biochemists at Milton Keynes Hospital Foundation Trust in the East Midlands have been working to rule since February 19 in opposition to a new contract. Under this contract, a previously voluntary agreement for "secondary cover" at nights and weekends would be compulsory. Staff would receive £25 as a 12-hour standby payment on top of their 37.5 hour week. Under the old agreement, work during unsocial hours was paid at £25 per hour.
*** Ambulance staff in Yorkshire began an overtime ban in March 2013 in response to management's plan to replace medical technicians with emergency care assistants (ECAs). According to Unite, ECAs receive only six weeks' training while a paramedic undergoes a two-year degree course. In 2011, the Daily Telegraph noted that, "trusts are now relying on ECAs, who earn £12,000 less than qualified paramedics, to perform frontline roles as they axe paramedics to cut costs. Six out of 12 ambulance trusts in England now send two ECAs on 999 calls without paramedics." Another example is government's announced plans to force all would-be nurses to spend a year working as healthcare assistants - helping to feed, wash and turn patients. A year of low-paid qualified work.

*** The company TQtwentyone was launched in December 2010 by Southern Health NHS Foundation Trust (SHFT), a big NHS service provider with more than 8,000 workers. In spring 2013 TQtwentyone, which provides social care services to people with learning difficulties and mental health needs, forced its workers to sign new contracts including a restructured pay system (some workers could see more than 20 per cent cut from their salary), an end to unsocial hours payments (by setting up an internal bank of staff with zero hour contracts to stop overtime payments), and a drastic reduction in annual leave. The justification is that without lower wages and worse conditions they wouldn't be able to compete with other private social care providers.

'Deterioration of conditions' do not always come with new contracts: on a daily level we are forced to work a bit longer, do a few more tasks, tick off patients a bit faster. As reported by our friend who works as a cleaner: bit by bit they add tasks, cleaners have to prepare food or hand out tea and coffee to patients etc. 'Individualised responsibilities', ward targets and computerised administration work are meant to ensure that the additional tasks are taken on - see report by nurse from Germany.

Patients Are Sick Workers...

The increasing pressure on health workers deteriorates the conditions for the patients. Department and hospital closures result in longer journeys. The cuts in workforce has led to an A&E crisis: there have been 1,200 jobs cut at NHS Direct (call centre telephone health advice) since 2010, resulting in 120,000 more hospital referrals in the past year. This and cuts to social care support mean more people are being seen in A&E. But there are too few staff to cope. The number of 'A&E diverts' in England -when ambulances are turned away from one A&E department with no space and sent to another hospital- rose from 287 in 2011-12 to 357 in 2012-13. The crisis impacts also on 'scheduled treatment': more than 220 operations a day were cancelled within the NHS with less than 24 hours' notice during the first three months of 2013, a ten year high. How does the state deal with the A&E crisis? By putting more pressure on it. Present funding arrangements designed to encourage a reduction in A&E admissions mean hospitals are only paid 30 per cent of the normal fee when numbers rise above levels seen five years ago. That means a rise in patients is costing some hospitals millions of pounds a year. If that does not help, just close down the whole department (in the end it was in debt, wasn't it?!): There are currently plans to close four A&E departments across north-west London alone (Ealing, Central Middlesex, Charing Cross and Hammersmith). Recent 'scandals' show that things are unlikely to get better if things are outsourced: the private healthcare firms Serco and Harmoni were recently accused of covering up serious cases of neglect in their private GP services, e.g. employing 'underqualified' staff.

What Can Be Done?

We don't have a bulletproof plan, but we can raise some points for discussion. The main necessity will be a (self-) critical exchange about our own experiences: what did we try? what went well? what went badly? why? Things are happening, and we can learn from them. Here is just a short list of recent struggles in the health sector in London. The hospital domestics at Whipps Cross struggle against the contractor Initial. On 21st of January 2013 the company announced to these mainly migrant workers a 30-day consultation with plans to cut working hours by 30 minutes per shift. The women workers were on part-time of three-hour shifts. After meetings and rallies Initial withdrew the hour cuts. Workers at the drug charity Equinox in London are in dispute. Equinox wants to cut workers' pay by up to 25 percent. Workers balloted for strike action at the end of May 2013. Cleaning workers at the British Medical Association are struggling to be paid more than £6.19 an hour. Let's go and visit these workers and discuss how to take small, but effective steps where we work:

* Start where we are: Coordinate small steps together with those around us, according to strength. Don't blame each other for work stress. Refuse working through breaks or extra tasks etc.
* Before we take a step understand the different fears people have. This could be because of: having different contracts, personal debts, being a single parent, having more problems to find jobs due to age etc. Take these problems into account and organise support.
* Relate to patients as co-workers: explain our situation as workers and encourage patients to make their situation known. Try to coordinate common activities.
* Make sure our steps do not require 'individual heroes': no one should have to stick their neck out alone. If management wants to talk, they can talk to all of us.
* Find ways to put pressure on management, which have the least harm for us: 'official' action often results in pay cuts; there is no need for official action, there are other ways to put pressure on management (work-to-rule etc.)
* Know our (or rather: their) rights, but don't rely on them: avoid getting entangled in legal battles which make us dependent on older expert men in suits
* Address other workers around us: from volunteers to cleaning staff to outsourced departments to caff workers at the hospital corners; explain our situation and encourage them to coordinate together; find places to meet
* Do our homework: in order to find adequate answer to the attacks we should know about management plans at our workplace and others, about conditions of workers in companies which cooperate with our hospital, about struggles close by
* Create a coordination: once we manage to get some collective steps going, try to make them public and spread the word (social media, posters etc.) - inviting discussion and coordination with other group of workers; don't think that 'getting into the media' actually creates pressure or solidarity
* Avoid tiring symbolic actions: lobbying politicians, collecting random signatures, organising ritualistic placard-whistle rallies in front of management buildings etc. These are usually not much fun and do not create direct contacts with other workers
* Discuss the role of the unions: we should avoid being dependent on the apparatus and its formal rules, because in the end it is stifling; it turns wider problems into company or 'professional' issues; no one will organise things for us; if we are strong enough and the unions want to support us we can discuss the concrete conditions.

DIE WORKING OR LIVE FIGHTING: REPORTS FROM FRIENDS IN THE HEALTH SECTOR

Cleaner - Royal London Hospital

I started working as a cleaner in the NHS in 2005. In 2007 the cleaning work was outsourced to Carillion. Now you have three different kinds of cleaners: the workers with old NHS contracts; the people hired by Carillion since 2007; and workers hired through temporary agencies - more or less equally one third of each category. For 37.5 hours week, working the weekend instead of Monday and Tuesday, I get around 1,500 quid per month, this includes 300 pound London weighting. We get around £7.60 an hour, the Carillion cleaners £7.42 and the agency workers the minimum wage, I think £6.19 per hour.

In 2011 they closed down the department where I used to work. I was shifted to the new building of the Royal London hospital in Whitechapel. They hired a lot of new people during that time, some directly for Carillion, many through various temp agencies e.g. Blue Sky Solutions. These workers are employed at Royal London for three months, they are then shifted somewhere else, I assume in order to avoid having to give them certain entitlements. Some of them come back after a while. In total there are about 400 cleaners at Royal London hospital, if not more, around 60 per cent of them women. Their backgrounds are from Philippines, South Asia, Africa, West Indies and the remaining fifth from South America and (Eastern) Europe. On each floor you find all kinds of cleaners, old NHS, Carillion and agency workers - it is mixed, all do all tasks.

Working conditions have changed a lot since I was hired in 2005. The main problem is workload increase. They give people a general job description, but they add tasks bit by bit and sometimes, when other workers are off sick or on holiday, they send you to their floors, so you have double-work. If you want to clean things according to their own quality standards, you would need about 50 per cent more time for each task. This is why they bring in some extra-workers before they have their monthly audit, to get things spick and span for a day.

00:05 - 01:00 clean the pantry and eating room
01:00 - 01:30 dust beds
01:30 - 02:00 clean all sinks
02:00 - 02:15 re-fill all soap dispensers
02:15 - 03:00 check and empty all bins
03:00 - 03:45 break
03:45 - 04:30 re-fill water-stations / hand out water to patients
04:30 - 05:00 put food for patients in oven and check trays
05:00 - 05:30 hand out coffee to patients
05:30 - 06:00 get food out oven and put on plates
06:00 - 06:30 serve food to patients, on trolley
06:30 - 06:50 clean food area and utensils
06:50 - 07:10 clean food trays
07:10 - 07:30 clean plates and dry them
07:30 - 07:50 clean kitchen area
07:50 - 08:05 check toilets and clean if necessary
08:05 - 08:20 clean pantry area
08:20 - 09:20 make and hand out tea and coffee
09:20 - 09:50 clean fridge, cleaner store etc.
09:50 - 10:00 check toilets again and clean if necessary
10:00 - 10:25 fill in paperwork

On top of this you are supposed to squeeze in certain other tasks over the week, e.g. cleaning the hoover, polishing metal fittings of the kitchen, wash out bins. There are about 30 beds per ward, so you can imagine the workload. Cleaners would not accuse other cleaners to 'go off sick', but they are angry about having to do double work. The work pace also leaves little time for the relationship with patients. They mainly ask us for tea and coffee, there is little time to talk about their situation or worries.

Everyone has a long way to and back from work. Most cleaners take buses, in order to save money. That adds at least two hours travel time to their work-day, some have four hours daily travel time. According to our contract we have the right to get out of our working clothes during the official working-time, but management says that they don't want to see anyone in their casual clothes before punching out. So what many people do is putting their casual clothes quickly over their working clothes after end of shift, which is a health hazard.

I always work on the same ward. During my working-day I might meet five to six other cleaners, but there is little time to talk. We have a staff room on the ward, everyone uses it, also the nurses. The atmosphere is alright, nurses would not look down on cleaners. But nevertheless, I know little about the problems of the nurses, about how the restructuring of the NHS affects them. Nurses mainly talk amongst themselves. During the whole time since 2005 I never experienced a strike or collective walk-out. There might have been one or two, but probably when I was off work. The union is not present at work. I asked a shop-steward, who is also a supervisor, about branch meetings, but never got a proper answer. Another time I asked a union official about the 'changing work dress during shift' he said that we are supposed to change after shift-times. So what to do about it all?

Midwife - hospital, London

I started working as a midwife in a Hospital in London. The maternity ward was under a lot of pressure: on the post-natal ward there were 32 women with their babies and three midwives and one or two support workers to look after them. Often you would come to work and there were only one or two other midwives. So the level of care was poor. You ticked boxes, that was all. There was a lot of discontent about it, but more than the management, the midwives and nurses blamed each other for not working hard enough. Management reacted by putting one or two more people on the ward, but only support workers, not skilled midwives. This is mainly about money, a midwife earns about £13 an hour, a health care assistant £7. This meant that at the end it was the midwives who did most of the administrative work and paperwork and the support workers the actual hands-on work. Because of the stress, a lot of the administrative work didn't get done, so the ward was sometimes without a shift rota or other essentials. The women complained about not receiving good care, for example about being left in dirty sheets, but they hardly ever blamed the midwives, because they saw how much we worked. The whole NHS only runs because of the good-will of the front staff. There is a shortage of midwives, but that has something to do with conditions. For example at Redbridge hospital there is a chronic shortage because the hospital is situated just outside the zone of the London weighting, which means around £5,000 less annual pay.

For the women and their newborn, things change with the restructuring of the NHS. Whoever can afford it can now pay more to get a private room and one-to-one care. They offer this, for example at Chelsea and Westminster Hospital or Kings College. Then there is a tendency towards the merger of hospitals towards mega-hospitals. In December 2012 this caused a crisis on the maternity ward in our hospital - the catchment area of our hospital got much bigger. Women about to give birth had to wait in the corridors. It also means that the number of women who opt for a home-birth will very likely shrink further if the hospital available in case of emergency is further away. Women have less choice. We can criticise a high-tech and medicalised approach towards birth, but if they cut the hospital back-up then 'midwife-led' care only disguises underfunding and the midwives will feel even more under pressure. The complimentary tendency to the mega-hospitals are the GP-led trusts, which basically means that the first person who sees you and who has to assess your medical needs has at the same time to decide about the financial aspects of your care. If the GP decides to transfer you to a specialist, the money for that is paid out of the GP surgery budget. This will impact on medical decisions. Many patients don't understand what impact gradual changes of the NHS restructuring have, like with the NHS staff, things often only move when closures are announced.

In the hospital where I worked before, nothing happened about these conditions until they announced that they might close the consultant-led units. People were scared to lose their jobs. Local residents supported demonstrations against the closures. UNISON did not do anything about the conditions, had only the annual AGMs and didn't involve members. They only supported the demonstrations at the last minute. In the hospital where I work now, things are slightly better, it is not so understaffed, which might also have something to do with the fact that the union is more active. Currently there are some mobilisations of cleaners who have been outsourced to Medirest, they got organised and asked for better conditions. I sometimes meet midwives from my previous hospital when they come over on NHS-agency shifts. We work three or four regular 12-hours shifts per week, many midwives then work extra shifts through the NHS-Bank agency in other hospitals. They still hope that things keep on running.

Office worker - health NGO, London

I used to work in a big cancer charity as a policy officer, meaning that my job was to try and persuade the government to make policies benefiting people with breast cancer. You generally need to have had policy experience to get this job and a university degree, usually in a relevant specialist area. Annual pay ranges from about £28-32,000.

Breast cancer gets more publicity and funding than other cancers not just because it is one of the most common cancers, but also because it has a great marketing and fundraising strategy. The focus remains on middle-class white women on the whole because that is where the main sources of money come from. Tackling issues like racism, homophobia and class within the health system is a big challenge and one that is often stepped around by big charities who don't want to seem too radical. Because you all have your special group of people to represent (breast cancer patients or bowel cancer patients or people with diabetes), you often end up in a situation where you are pitted against one another, scrabbling around for the same pot of money and resources. If you can make the economic argument, you might have a chance at justifying your demand e.g. employing more specialist nurses.

Because the NHS is being opened up to service providers, charities sniff the opportunity to win lucrative NHS contracts, which would pay them for the services they currently offer for free. So I found myself having to 'tone down' my analysis and recommendations so as to keep civil servants on our side. But censorship also happens in more subtle ways, for example, the increasing professionalisation of meetings (lots of older white men in suits and formal atmospheres) that made it difficult to speak out about what patients actually need. So it was a depressing time, writing

all these policy documents knowing that they probably wouldn't even get read and if they did, it wouldn't make any difference anyway. The NHS was being sold down the river because these big health charities, and eventually everyone else, believed in the idea that it was inevitable.

Health charities also get money from pharmaceutical companies. When NICE, the organisation that decides what drugs can be made available on the NHS, rejected a breast cancer drug and I wrote a press release saying the pharmaceutical company should improve either its research data or lower its price, I was not allowed to release it. Why? Because the pharmaceutical company in question had just given us Â£20,000. This was written in an email to me. When I raised the issue with my manager, I was told 'it was just a joke'. It is not a coincidence that these big charities are never heard slagging off the extortionate prices of drugs and their relative inefficacy. The pharmaceutical companies have a deservedly bad reputation and so need to use charities as mediators to ensure that their interests are promoted without having to do it explicitly themselves, where their profit motives are plain for all to see.

And then one day they announced that, despite the millions we got every year from people fundraising, they were 'restructuring' our team. Looking back on it, it was all carefully planned. The new Head of the team did one-on-one interviews with us, trying to find out what (who) was working well and what (who) wasn't. They had just hired a HR vampire, no doubt on an inflated salary, whose sole job was to fire us in the quickest, most efficient way - the whole process from telling us to leaving lasted about 3-4 weeks giving us little chance to formulate a plan or organise amongst ourselves. They had restructured another team a year before and we strongly suspected more were in the pipeline, but they chose to always fire less than 19 people at a time so that they wouldn't have to adhere to the 3-month statutory minimum notice. They had amended their previously 'generous' (more than statutory) redundancy package to the bare minimum a year before. And they didn't need a policy team anymore whose objectives were at odds with the charities strategy to make money off its services. Looking back on it, it seems obvious that this strategy was an attempt to neutralise the anger we felt at how we were being treated.

They also tried to place us in the position of being responsible for our dismissals and actively trying to pit us against each other. There were only 2 part-time job openings that we had to re-apply for, essentially meaning that we would have to compete with each other to get the jobs. So like any other business with an annual budget of millions of pounds and a public profile to protect, they threw us on the scrapheap and monitored our emails because they didn't want us to tell anyone that they had fired us. While there were lots of people that worked there that genuinely cared about women with breast cancer and worked to support their needs and best interests, it was frustrating to work in an environment where the bigger picture stuff was ignored, like the state of the NHS and welfare cuts that would leave patients getting over their treatment with no money to support themselves. There was never any attempt at questioning the structures that made the whole cancer experience an industry.

NHS Bank worker, Bristol

The bank service functions as a kind of NHS temp work 'agency'. It is casual labour with no job guarantee. Each bank worker receives emails or phone calls with temp job offers from the Bank office. Their length varies from a few days (covering sickness absence) up to a few years (this changed recently). Because there is no guarantee of work, no paid sick leave or holiday leave, we get 12 per cent compensation on top of our wage. So our take home money is actually slightly better than those on permanent contracts in the same band (I get £8.69/hr when I am posted on band 2 and £9.13/hr when on band 3, however this pay varies depending on the primary care trust and region). I usually work about 20-25 hours/week, some bank staff work only one day a week but many do full time.

Everybody knows that this service was introduced to save labour costs and promote flexible work. Once I worked in an out-of-hours patient service handling the calls, where the bank workers were called in to fill the gap after many staff had left the job because they had disagreed with the new flexible shift system. It can also save labour costs in a direct way: I met an office worker who was on the bank for five years before she was given an interview and a permanent contract. My longest post took 1.5 years. This was changed recently when the management decided that bank working needs to be brought in line with the directive on agency work, so now we are not allowed to work in the same post for more than three months.

I have worked in various NHS venues: administrative office block, out-of-hours call centre, a sexual health screening programme within hospital premises, small community-based services, etc. The pace of work is usually OK and the workload easy. I am usually stressed when starting a new post which I have never done before, because there is never any training provided other than 'on the job'. So, for example, although I was officially hired as a receptionist, I was expected to share office administration with my colleague (printing, scanning, uploading documents, working with patient database, checking the presence of staff at work, dealing with petty cash and stationery, etc.) I was lucky that the staff was very nice and helped me to get through the first weeks without any training.

What I really hate is the constant separation between us, the bank staff, and other workers with permanent contracts. We are never allowed to join team meetings, not even when the issues around our role have been discussed. With one exception, I've never been invited for a meal or a drink, when the rest of the staff went out.

My worst workplace so far has been an NHS support agency. This

organisation only narrowly escaped a fatal outsourcing to India and the uncertain future deeply marked the way the whole thing had been (non-) managed as well as the relationships at work. Even the permanent staff rarely spoke to each other: a completely sterile environment, where your boss was constantly watching you. A young colleague who had been there for five years told me that in his time the training period for newbies went down from two weeks to three days and that more and more staff had been replaced by bank staff and private agency staff (they were getting over a pound less per hour than me).The staff turnover was very high: 'It's not about saving costs, it's about creating more chaos', he laughed.
I think my young colleague was quite right! The absurd split between commissioners and providers, permanent and bank, now the private agencies, outsourcing and subcontractors are jumping in... The fragmentation and competition between sections of workforce is growing and so are the costs, while the management tell us about savings.

I heard Left activists speak about growing anger in the ranks of NHS staff. I am afraid this is not my experience. What I noticed could be best described as a resignation among older workers. They have seen many governments in their career and each government came in with some health care reforms. Who the hell has got time to follow all this and even get the grip on it? Young workers, in my experience, don't talk about these things at all. The only people who are interested in these 'big issues', or who seem to know what's going on, are trade union officials.

I am a member of Unison, however my experience with unions is largely negative. An example of this was our attempt to stop the transformation of our workplace into a social enterprise. This would mean not only our separation from the rest of the NHS workers, but even a direct competition with them for the provision of community health services. We were just four ordinary workers, but we launched our campaign and managed to get verbal support and promise of material support from 'our' Unison branch committee. But when we dared to show our own independent initiative and intelligence, e.g. printing leaflets or holding a public meeting, without the agreement and supervision of our union daddies, the branch officials turned against us and ordered to stop our activity. In the end we stopped the campaign, not so much because of the union pressure but rather because we didn't feel that workers were up for a fight and the deadline of the switch to social enterprise was very close. Only four people came to our public meeting, after we handed out hundreds of leaflets across many health care venues in town. I could go on listing more examples, e.g. when the branch committee denied solidarity to a grassroots strike of hospital cleaners from Swindon "because they were members of another union", or the completely unprepared picket on N30 public sector strike in the hospital where I worked at that time.

Report from Germany: What has changed - working in hospitals in the 1980s and today

I work in Freiburg, in a hospital with nearly 10,000 staff. In the mid 1980s in many western-European countries nurses - and in some cases other groups of hospital workers - started to mobilise themselves. There were chain reactions: at the beginning of 1988 nurses went on strike in England, in autumn 1988 in France, in December in Holland, then in Italy. We received a new organisational impulse from nurses in France, which crossed the borders to Germany - the 'co-ordinations'. Within half a year a network of rank-and-file groups managed to mobilise up to 20,000 workmates to take the streets and (in parts) to go on strike.

There were two main reasons for the emergence of these struggles: first of all a new generation of women had entered the hospitals. They did not see the work with patients as a 'female fulfilment', but as a full-time job, which had to pay enough in order to live independently, which expressed itself in wage demands. Secondly, the workers struggled against what they called 'the white factory', meaning a more and more 'industrial' commando over workers and patients. There was an idea of more 'humane' care-work.

Hardly any of the young colleagues today carry this myth of 'better care'. There is something like professional ethos, but the type of ethos has changed. It is the ethos of a skilled worker who wants to apply the skills she has learnt, under good working conditions. This 'skilled workers' consciousness leads some colleagues to apply for or accept the new 'responsible' professional positions, called 'care worker with responsibility for the care process' (PV). There are not many of these posts, may be one out of ten nurses. The introduction of the PVs was a sort of rupture, given that a new level of hierarchy was imposed, running between workers of the same formal qualification. This is a palpable hierarchy on the job, basically a division into planning and performance. Some of the PVs are more or less permanently in front of the computer, others still notice when there is a lot of stress and still react to patients pressing the bell-button. The PV position has been introduced without hiring new staff. They also do administrative work, which hasn't been done in this form before, mainly optimising admissions and dismissals of patients. The turnover of patients increases, but there are less nurses actually working with patients. The bosses say that in turn we don't have to do that much paperwork anymore, but given the general stress, this is rather cynical.

During the last decade the number of private hospitals has increased, they account for nearly one third now and have around 17 per cent of all hospital beds (in 2000 only 20 per cent of hospitals were private, they had 10 per cent of all beds). Since the beginning of the 1990s the total amount of hospital beds has been reduced by 25 per cent, the average time a patient remains in the hospital

has been reduced by 50 per cent. The turnover has been increased. The state has enforced that the health insurances pay for 'certain cases', not for each day in hospital. Under this pressure hospitals try to 'optimise their processes', they outsource services, close down unprofitable departments or hospitals.

An example. In 2012 around 1,000 hospital workers of the ZSG service-subsidiary of the 'Damp' group in Kiel were sacked after demanding a new collective contract. In March 2012 the Damp-group had been bought by the private hospital chain, Helios (Fresenius). In July 2012 the trade union 'ver.di' and the Helios management came to an agreement: 800 workers will be rehired and keep their terms and conditions for 18 months, the others will be offered a retraining course. The wider collective contract for hospital workers in the public sector, which the 800 former Damp-workers used to belong to, were given a 1.4 per cent pay raise for August 2013, but with the new agreement the 800 workers were excluded from the increment. This was a typical conflict - during the process of outsourcing the union wants to enforce a collective contract, but factually accepts the new divisions or co-manages the establishment of divisions.

Back to the shop-floor. During the 1980s and 1990s we still coordinated amongst each other on the ward how we divide up the general work. Today you have an individual documentation for certain areas and tasks, which are your individual responsibility. Mutual support has become difficult. The increased workload then results in a feeling of competition. The division of labour has been extended to the 'bottom'. Most of the logistical work, such as handing out food, has been outsourced in our hospital. There is a 'service-assistant', hired through temp agencies, working on three wards, handing out food, making tea and coffee and so on.

Most of the younger nurse colleagues start with time-limited contracts, often half a year, up to two years. This contractual situation instills a certain insecurity. They only know the conditions that prevailed during recent years, and they accept them as given. And while earlier generations of nurses often married when they were 35 and were then replaced by the next generation, today many work till retirement. So you have a third of workers who are over 50 years old, doing a job you can hardly do when you are over 45, but they know that they have to stay. Another third is younger, but they try to stay on the job. The other third are workers who drop in and out, often hired through temp agencies. There is such a high turnover, it causes stress on the wards. The colleagues are often quite rough with the temp workers. They don't join up against the general stress, so they expect the temps to get to grips with the work quickly. In this hospital of nearly 10,000 workers you only find few who want to do something collectively - but many crumble under the pressure individually (illness, burnouts, depression). The older workers wait until they reach the mandatory age go on 'part-time scheme', while the younger ones cannot remember that it is possible to do get together with some people in order to rock and enforce things.

We should just try things out, make small steps. And this will have to cross 'company-boundaries' right from the start. Today single wards are handled like separate companies. This is an important lesson from the 1980s. Back then our leaflets always addressed workers of other care units and hospital units, and that was fruitful. Due to time-limited contracts, the individual fear seems bigger, at the same time the actual work has often become more similar. The 'industrial commando' has often standardised 'manual work with patients', be it 'skilled' or unskilled. In the 1980s no one had thought that people would become active themselves that quickly. Leaflets, in a first step, have to reflect our situation and behaviour and those of our co-workers and address the atmosphere. In a second step the mass-complaining has to turn into practical initiatives. This is what is difficult to find today, courage for initiative...

At the beginning of 2013 management of the Freiburg Uniklinik, one of the biggest hospitals in Germany, started to announce job cuts in all departments. In protest unions and shop stewards organised protest actions and demonstrations. We distributed two leaflets and invited to meetings, in order to carry the protest to daily shop-floor reality. It is difficult to come to collective activities - also because management withdrew the redundancy plans fairly quickly and now threatens with wage cuts instead. Many people hope that 'the protests have done their bit' and halted the attacks. This might turn out to be an illusion. Some people opened a 'workers' centre', we try to get in touch with workers employed at other hospitals and in the wider health sector in town.
(friends from: www.wildcat-www.de)

Student nurses' struggle - boycott of graduate scheme in Ireland

As part of the austerity agenda, wages across the public sector are being cut in Ireland. These cuts are being aim in particular at those least able to resist: young workers and recent hires. However, a recent attempt by the Health Service Executive (HSE) to cut graduate nurses starting salaries by 20 per cent and reduce job security has received a strong response. Graduate nurses have boycotted the graduate recruitment scheme. They've demanded that they are given the same contracts as existing workers, where they're paid 100 per cent of their wages and have job security.

Hamada, a 2012 Mental Health Nursing graduate, explains, that at first a "cohort of 2012 graduates employed in Galway were effectively told their current contracts were null and void and that they would have to reapply for the same job under this new scheme. This scheme offered them and all other 2012 nursing graduates a two-year contract at a cripplingly reduced salary with no guarantee of further employment after the two-year term. The movement against the scheme arose through a collaboration between 2012 graduated nurses (i.e. nurses who have already completed their training and are registered with the Irish nurses professional regulatory body in 2012) and many of the student nurses around the country."

"The two nursing unions the Irish Nurses and Midwives Organisation (INMO) and the PNA (Psychiatric Nurses Association) were both very vocal in their support to the new graduates and opposition to the HSE. We were left with no option but to boycott this proposed scheme. Collectively we organised press conferences, a public rally and of course were part of the march against austerity. We also held a picket outside the HSE HQ."

He explains that although the unions have been supportive of the movement and much of it has been organised through them, "our relationship with the two nursing unions (actually, unions in general) has always been one of restrained trust. While my union the PNA has always been the more militant of the two, both unions have had a history of making un-agreed and unwanted compromises with the HSE." Further, he states that regretfully, "support from the colleges was somewhat lacking. Apart from letters of support written by a lecturer or two, the colleges were surprisingly silent, perhaps highlighting the disparity between academic and practical nursing education."

The support of established full-time workers for the graduate nurses has been strong. Hamada notes that "apart from a small number, nurses who are already in full time employment continue to be extremely vocal in their disgust of the proposed scheme." Unfortunately this support has not translated into action remaining "largely symbolic". "I cannot give a clear reason for this but perhaps it has something to do with the nature of our work, long working shifts, seemingly endless clinical interventions to be implemented and a duty of care to our patients." When asked if the nurses drew inspiration from anywhere, Hamada replied, "I think a major inspiration for Irish nurses was the solidarity and focus of purpose the Australian nurses exhibited when fighting for their rights of fairer pay and higher nurse:patient ratios. With a single-minded determination they collectively, opposed the Australian government. Their mantra of 'TOGETHER we can fight and change injustice' has been a rally cry for many of us."

Despite these problems, the boycott of the graduate scheme has been highly successful. The HSE admitted there had been a "very slow level of application" to the scheme and has decided to review the scheme. However, the scheme is not dead and the unions are now in the process of agreeing to a new national wage agreement called the Haddington Road Agreement, which is only marginally better than the proposed graduate scheme.

Struggles of hospital cleaners and workers in Italy

Sodexo, a French-based corporation providing cleaning services at the Cisanello hospital in Pisa, announced that 78 jobs out of 306 would have to go: a reduction in the workforce by 25 per cent. Sodexco said that the jobs have to go due to the cutbacks to healthcare spending announced by the government. In response the cleaners started organising demonstrations inside the building ("cortei interni," a very popular tactic in the 1970s), temporary strikes, rallies, and all sorts of informative action to call attention to their situation. They picketed their workplace for over three months, from October 2012 to January 2013. On December 4, they also occupied the information centre in front of the Emergency Department: the occupied office became both an information centre and a logistics office for the pickets. The workers' determination earned them the nickname of "lionesses".

They had several tensions with local high-ranking members of their union, Filcams CGIL, the left-wing union which represents a large proportion of healthcare workers. In fact, high-ranking CGIL members initially described the Cisanello picket as self-centred. CGIL cancelled the one-day strike called for November 14, a move that was criticised (and disobeyed) by the struggling workers at the Cisanello hospital. A new chapter began on March 7, when 70 cleaners publicly gave up their membership of CGIL, seeing the union as complicit with the status quo and the region's powers that be. However, instead of joining other, possibly more conservative unions, the workers formed an independent committee for the defence of workers. Eventually, the workers gained victory: no job cuts, but re-distribution of workers between different workplaces.

The fact that company and government backed down is not only due to the stamina of the cleaners, but the fact that other struggles in the health sector happened at the same time. Healthcare workers at the San Raffaele Hospital in Milan protested in April 2013 after receiving the first 40 (of 244) letters of redundancy. After a general assembly, the struggling workers blocked all 32 payment counters and occupied the hospital reception and the roof of the building, prompting the heavy-handed response by police. After this, the workers held a demonstration out on the street in front of the hospital, occupying a roundabout on a major ring road and blocking traffic. The struggle at San Raffaele has been organised by the workers themselves, mostly members of the base union USB and the anarcho-syndicalist USI-AIT. The major unions (CGIL, CISL and UIL) have had little influence on the struggle, arguing that, rather than scrapping the cuts entirely, the unions should be allowed to decide which cuts to make. Indeed, Friday's protest saw an attempted intervention by a CGIL full-timer interrupted by workers. An agreement was reached with unions early on the morning of Friday 10th May, after 16 hours of negotiation, and was finally accepted by workers on the 16th after a series of assemblies. As with

the previous agreement, which was rejected by workers earlier this year, all redundancies have been stopped in return for workers accepting a 9% cut in pay. The 66 workers who had already received redundancy notices will also be reinstated. However, unlike in the last agreement, hospital bosses have also agreed that no workers will be moved from the public healthcare national contract to the (much worse) private one.

http://libcom.org/blog/hospital-workers-fight-police-milan-21042013
http://en.labournet.tv/video/6535/lionesses-cisanello-workers-victory-times-austerity

Self-organised free hospital in Greece

Health care in Greece is provided by a national health insurance system. However, under the austerity regime, unemployed Greeks lose their health insurance after a year. Four major Health and Insurance Funds (those for civil servants/state workers, private sector workers, self-employed-both workers and small bosses- and farmers/peasants) have been merged into one, covering 9.5 million people. Only 5000 doctors are contracted with this new Fund, which means 1 doctor for 2000 insured patients. Plus, the maximum number of patients who are allowed to visit a doctor for free is 50 during a week and 200 during a month. After these numbers have been reached, the next patients have to pay. State compensation to doctors has fallen from 20 to 6.5 euros per visit. A centralisation process has led to mergers or closure of small hospital units and a deterioration of health care in general. On 17th of April 2013 workers in health care walked off the job leaving hospitals with skeleton staff to protest against the problems the sector is facing following government cutbacks. Civil servants also staged a work stoppage and joined the demonstration of hospital workers, after the government announced plans to fire 15,000 civil servants by next year.

The interview below is with a doctor of the social clinic for solidarity in Thessaloniki, which provides free medical care for people who need it and organises actions for general free medical support. As he states himself: under the current conditions 'unpaid self-management' in itself can hardly be more than self-management of poverty. It has to be part of a wider struggle, and it is.

"I'm Vasilis Tsapas. I'm from Greece. I'm a doctor. I work for the state-run health system in a big hospital in Thessaloniki. Our solidarity clinic is called KIR, which stands for Solidarity Medical Clinic. The thing is 'the crisis'. Unemployment is rising. We're talking about a current unemployment rate in Greece of over 27 per cent. That is the official figure but it's even higher. Unemployment amongst young people under 30 years old is 57 or 60%. These people aren't insured. There are lots of people that aren't unemployed, they have shops or small businesses, and they actually have to pay their health insurance themselves. But they don't have the money to pay it because it can cost 300 euros a month. So although they work they have no insurance. Over 30% of people are uninsured in Greece, which is over about 3 million people. These people can't even access the first level of healthcare and can't get treated in hospital.

The whole story [behind the free clinic] began about 2 years ago, when some doctors came together to help undocumented immigrants who were on hunger strike, they came up with the idea of setting up a medical clinic in order to deal with the problem of people in Thessaloniki without health insurance. Lots of people are taking part in this attempt. All the people are volunteers. Nobody is paid. There are doctors and also lots of private individuals. There are different parts to the clinic: the medical part; general medicine; podiatrists; dentists; other specialist doctors. There is a big pharmacy where we collect medicines from private people. They collect medicines for us. 150-200 people work in the clinic. I don't know exactly, but there are a lot. There are 2 dentist chairs and patients are seen for 10 hours a day, every day.

We get money from civil society groups. We get money from unions. From other solidarity organisations. In Greece and also from other countries. We put on events and collect donations from people. We have absolutely nothing to do with the Greek state. We don't get any money from them. We don't get any money from the EU. We don't get money from companies. We don't have any sponsors. We don't take anything from anyone that has anything to do with the crisis situation we are in.

This solidarity clinic isn't just about health. We don't have the illusion that we will solve the health problem of Greece. We put on lots of events, we stage interventions in hospitals, in order to exert pressure, to say that all people, regardless of whether they have a job, regardless of whether they're insured, regardless of whether they're Greek or immigrants, regardless of whether they're immigrants without papers or with papers, that they're all able to go to a hospital. That they are all able to get medicines.

These are all political decisions that we make together when we meet in our assembly. When anything happens, then we react. We react with posters, we react through the press, we sent out texts. All of these are decisions, political decisions. And when we meet in our Assembly, we write the texts, or a group of 4-5

people draft a text that we discuss together in the Assembly. There are lots of people who aren't comfortable about speaking in a big circle of people. But we strongly believe that when we speak together in such a circle that helps the whole process by which one becomes political.

We don't have anything to do with charity. We talk about solidarity. We have to help each other. We're all on the same level. It is very important to ascertain that this is a problem in Greece, but this problem won't just remain in Greece. The crisis is not a crisis of lazy Greeks, bad Italians, of Spanish people that have borrowed too much money from the banks and so on. The crisis is coming to all countries in Europe. Sooner or later, the crisis will come knocking at every country's door.

http://solidarischgsund.org/2012/12/15/the-social-clinic-of-solidarity-thessaloniki-needs-your-support/
http://en.labournet.tv/video/6552/solidarity-clinic

Struggles against hospital privatization in Poland

Friends in Poland were supporting struggling hospital workers in Kostryzn. We asked them some questions about it...First some background:

Polish hospitals are permanently skint and chronically underfunded. Poland's healthcare is based on a general health insurance system, the National Health Fund (NFZ), which was created in 2003. Since its creation, this centralised but inefficient public health insurance fund has solved none of the fundamental problems underlying the health care crisis in Poland. The NFZ is paid for by all working people via a paycheck deduction, and works by contracting out a certain amount of treatment in Polish hospitals. These hospitals are in turn required to conduct this treatment "free of charge" for patients. The hospitals are in essence treated like private enterprises, however, responsible for their own budgets and economic output, and are frequently compelled to cut costs. Many have substantial debts on their books, and it is assumed that some will eventually be closed down altogether.
This was the case in Kostryzn. The debt agencies repeatedly blocked the local hospital's bank accounts, blocking wage payments to the workers. The consulting company Deloitte worked out a restructuring plan, which basically proposed to lay off workers. This is a similar scenario in many sectors in all countries, where chronic underfunding by the government leads to poor services, which then justify the road to privatisation for improved outcomes and efficiencies.

The struggle of the hospital workers from Kostrzyn lasted for 5 and a half years. 380 of the nurses and doctors had been working for half or no wages in the 4-5 months before the hospital was privatised and the ensuing struggle was to try and get these wages paid. The hospital was eventually privatised because of its huge debts. The hospital management declared bankruptcy and was then sold to a company called 'Know-How' who bought the building and the equipment for half price. Around 100 workers were re-hired, but on temporary contracts. The wages were much lower, and nurses were hired through job agencies rather than the hospital directly. And of course, the other effect of privatisation was the fact that patients had to now pay for their treatment.

Some of those workers who weren't re-employed at the privatised hospital, got a job at the nearby hospital (50 km away). But now there are plans to privatise that one as well and the whole story may repeat itself. Many of those who were fired went abroad or got employed in the nearby Special Economic Zone as production workers (1).

There was a nurses' union branch in the hospital, but they were criticised by many of the workers because they didn't arrange any protests or actions against the privatisation plans. People started to organise and become more

radical when they realised the union wouldn't protect their rank-and-file members who weren't protected against dismissals even after all those years of paying fees etc. Decisions on how to organise were made during neighbourhood meetings, outside of the hospital. Workers had exchanges with workers from other hospitals in the region that are also going to be privatised, some of those joined protests, but there was no formal cooperation or committee.

The main mobilisations were to get the outstanding wages paid to the workers. Workers did this by organising many pickets in front of the town hall, sending protest-letters, organising a blockade of the town hall and a demonstration through the city of Gorzow (local capital city). The town hall occupation was a spontaneous action of those workers and supporters who came to the town hall on the day of the vote by local politicians to decide whether or not they would pay the wages. They decided against paying back even a small portion of their money. They came to this decision after many years of talks and countless letters demanding that their money be paid back. The occupation was a result of the anger and lack of hope after local councillors, who have the power to reshape the budget, would not and will not support the workers. The vote was open to the public, so 50 people came (from old nurses to young punks) who blocked the door and didn't let they councillors continue their meeting. After 6 hours, they had their meeting in a small room, which the riot police barred to protesters. Then, a demonstration took place in April, with 250 people marching through

the city centre. It was a grass root demo, without big unions, with workers of a few hospitals.

Despite worker action, the outstanding wages have not been paid. Not a single penny. This is despite court verdicts that have said that the town hall who used to manage the hospital is responsible for paying the outstanding wages.

The workers were self-organised and aided by Workers' Initiative (IP), (2) which is an anarcho-syndicalist union that had a few activists in the region (local section) who kept in touch with those workers who were fired. Those who were re-employed by the privatised hospital are unionised by the big union that isn't very active. The big unions stay quiet, don't stand on the side of workers, and don't have a position on privatisation. IP's aims were to publicise the case, keep an eye what is going on with the legal proceedings, and keep up the contacts and network of solidarity with ex-hospital workers and those who still work. A few weeks ago, a doctor of another hospital in the same region in west Poland contacted IP and he said that the same company 'Know-how' wants to privatise their hospital as well. So now IP will do some research about that company and try to put in contact workers of those 3 big hospitals in that region.

For more information about struggles in Poland go to: http://ww.ozzip.pl/english-news

(1)
Workers in the Special Economic Zones get organised. Read about efforts of workers in a 'Chinese' electronics manufacturer in Poland http://www.gongchao.org/en/texts/2013/strike-in-chinese-company-in-polish-sez

(2)
The IP (Workers' Initiative) is a rank-and-file union organised according to principles of direct democracy and has no paid staff or bureaucrats.

Report from hospital workers in India: Medical tourism from the US and Europe

The following report is from friends in Gurgaon, a satellite town near Delhi and one of the global 'medical tourism hubs'. Wages and conditions of health workers become global - in order to avoid being played off against each other in a downward spiral we have to make efforts to globalise our struggle.

Medical tourism is a boom sector. Private clinics in India cooperate with NHS hospitals in the UK in order to reduce 'waiting-lists', labs in Gurgaon process material for the medical complex in the US, patients fly in for their final operation in Gurgaon due to lower local costs, 'illegal' organ trade is the scandalised warehouse of this boom sector.
On the bases of new technologies, oversupply of skilled labour in the global south, relatively cheap transport costs and dismantling of 'public health services' in the global north, we can see the establishment of a 'global body', which is worked upon in an international division of labour. According to mainstream statistics, medical tourism to India has witnessed an annual growth rate of 20 to 30 per cent during the last years. Treatment costs for e.g. hip replacement or heart surgery are said to be 20 per cent of the costs compared to US standards. Gurgaon has become one of the centres for medical tourism in India. Direct international flights to the nearby Delhi airport, special medical visa service, a sophisticated local service sector are the necessary infrastructural backbone for an assembly-line type of industry: in Apollo hospital in Delhi, doctors performed 4,200 heart operations in 2010.

While the public focuses on price comparison for services of expert doctors, they often neglect the low-wage service regime, which provides the material foundation for the hospitals. One of the centres of local medical industrial complex is Medanta Medicity, according to the company website "one of India's largest multi-super specialty institutes located in Gurgaon". Spread across 43 acres, the institute includes a research centre, medical and nursing school, and 45 operating theatres catering to over 20 specialties. We met a housekeeping worker employed at The Medicity. http://www.medanta.org/

Medanta / The Medicity Worker (Jharsa Road, Rajiv Chowk)

The building has four underground floors, it is 16 floors high and has 1250 beds. The housekeeping workers, general duty assistants, security guards, drivers, barbers, washing workers are all hired through contractors. They say that housekeeping is done in three 8 hours shifts, but most housekeeping workers work 16 hours shifts, they receive 4,348 Rs per month (around 75 pounds). The general duty assistants and the security guards work two 12 hours shifts. There are about 500 general duty assistants - they are paid 7,500 Rs for 30 days of 12 hours shifts. There are two canteens - the workers hired through contractors have a hard time there. For 20 Rs you get hardly enough to fill your stomach. Even if you work 12 hours shifts you won't get a free cup of tea. The doctors, technicians and nurses are hired directly by the company. The nurses are paid 14,000 Rs, the technicians 22,000 Rs and the junior doctors get 50,000 Rs. They

work on two 6-hours day shifts and one 12 hour night-shift. One nurse cares for three patients during a shift. The patient fees for a single-room is 5,000 Rs a day, for a double-room 3,000 Rs.

http://gurgaonworkersnews.wordpress.com/gurgaonworkersnews-no-936/#fn3

Conditions are harsh and wages low - but that doesn't mean that workers don't try to do something about it. On 7th of May 2012 around 330 nurses employed at Asian Institute of Medical Sciences and 130 nurses at QRG Central Hospital in Faridabad (close to Gurgaon) went on strike for higher wages and workplace related improvements.

http://gurgaonworkersnews.wordpress.com/gurgaonworkersnews-no-956/#fn6

Summer Revolts: Turkey, Brazil, Greece...

In June we saw hundreds of thousands of people confronting the state force in the streets in Turkey and Brazil, we saw a general strike in Portugal and the occupation of the state television in Greece after the government shut it down, followed by demonstrations against austerity. Below some thoughts on the uprisings in Turkey and Brazil.

* The protests spread in a similar form. In Istanbul it started with people trying to save some trees on a central square (Gezi Park), against the construction of yet another shopping mall. The violent police response bought many thousands more to the streets, first in Istanbul, in the following days in nearly every bigger town in Turkey. In Brazil the movement started in Sao Paulo after the government announced an increase in bus fares, it then spread to other towns. Both governments were gob-smacked: it cannot be because of some scrawny trees or 20p more for a bus ride?!
* The brutal repression - in Turkey the police fired off 130,000 tear gas cartridges and injured over 7,900 people - showed that 'the right to peaceful protest' is not worth the paper it is written on. The protest had the support of the majority, but this did not deter the 'democratic state' to oppose the protest.
* The protests spread without any major political or other organisation calling for it. Millions took to the streets because others did. Streets and squares became the main spaces to make decisions about what to do next - similar to the square occupations in Spain and the occupation of Tahrir Square in Cairo shortly before the fall of Mubarak. There were no calls to get any of the opposition parties in.
* People who were thought to be opposed to each other (Turkish nationalists, Alevis and Kurds; or hostile fans of different football clubs) fought together against the state force.
* Both in Turkey and Brazil the protests were not about cuts or austerity. as both countries' GDP had grown in recent years. So if the governments in the EU now tell us that with some years of 'tightening our belts' GDP will perk up again and things will be fine, we should question that.
* The growth of recent years increased the gap between rich and poor. But more importantly, in the boom people saw that without the right connections to the 'new elite' of real estate developers, political parties, administration etc., you won't have a chance, even as a 'qualified person'. The boom creates money and displays of wealth, while 'public infrastructure' is 'sold off'.
* Therefore the spirit was 'we are the people' against 'this corrupted and authoritarian elite'. A revolt against the arrogance of power and the discovery of a 'we' after decades of all-against-all for the crumbs of the neoliberal boom - an atmosphere we could easily imagine emerging in the streets of London, too. The spirit was that this movement is an expression 'of everyone for everyone'. People appealed to a democracy, without appealing to the parliament.
* The focus on 'corruption' might turn out to become a middle class illusion: if we only had all fair chances to get jobs. But corruption is a result of the fact that the boom did not and could not create enough jobs, posts, profit share for all - so the market-rat-race of competition would continue, equality of chances or not.
* The protests showed that people can oppose the state and create for a short while 'a different social community' on the squares (self-organised food kitchen and hospitals, neighbourhood assemblies etc.). It also showed that this has limits in at least two ways:

1) There is only so much POWER in the streets. The state force can push people off a square, but it would have difficulties to push people to work if they decided not to. There was a one day 'general strike' in Turkey, but only around 200,000 people took part. In the current environment people seem to rather risk losing an eye by tear gas shells than losing their job. But in the end only a general halt of the profit machine could minimise the bloodshed (the army was on call) and put pressure on the state. Peoples' main fear of going on strike is to lose money and their job, given the high rate of unemployment. The protests like in Brazil and Turkey can help to come together as people who currently have a job and those who don't in order to form organisations of mutual support. In Istanbul striking textile workers and airline workers arrived on the square as a group, making their struggle public.

2) There is only so much you can do in and with the streets. It still remains a fact that the money and profit system decides if and what we produce (if we get a job at all) and the fact remains that officially the product does not belong to us. The next step after the occupation of a town square would be to take back what we have produced, to take over the idle or uselessly/exclusively used buildings (bank buildings, shopping malls) and means of production (factories, offices, universities) and decide together what to use them for, cutting out money and middlemen as the main precondition of corruption. This seems a big step, but some smaller steps towards this direction are happening every day, somewhere. Stay tuned!

http://en.labournet.tv/video/6566/taksim-square-open-mic

... and Brighton!

Refuse Collectors Refuse to Collect

The attack on public sector workers is entering a new round. Another 10 per cent cuts for council budgets were announced in June, resulting in a further 900,000 job losses by 2017. Some workers show that you don't have to take these cuts as facts: Bin workers in Brighton and Hove have taken two days of unofficial, 'wildcat' strike action, occupying their depot after the city's Green-led council announced it would be imposing a £4,000 per year pay cut on them. One street cleaner's description of the Greens as "fucking Tories on bikes" is very appropriate. Later on 96 per cent of the bin men and street cleaners voted for industrial action. Brighton is no exception. In Camden street cleaning has been outsourced to the company Enterprise which threatened street cleaners with new contracts introducing an additional working day per week - unpaid. We have to kick up shit...

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PO POLSKU

W czasach cięć nie jest łatwo być pracownikiem/pracownicą. Celem tej gazety jest wymiana doświadczeń i zastanowienie się, co możemy razem zrobić, by poprawić nasze życie. Będziemy polegać na naszych własnych siłach i na solidarności z innymi pracownikami/pracownicami, znajdującymi się w podobnej sytuacji.

… czy nie otrzymaliśmy pensji za naszą pracę lub jest ona za niska, aby godnie żyć?

… czy aby związać koniec z końcem jesteśmy zmuszeni pracować na nadgodziny lub dorabiać?

… czy mamy problem z urzędem pracy, bo nie możemy znaleźć pracy, której i tak nie ma?

… czy właściciele mieszkania lub władze grożą nam eksmisją, bo nie stać nas na rosnący czynsz?

… czy policja nęka nas, bo zamiast siedzieć samemu w domu czy w przepełnionych mieszkaniach, wolimy spędzać czas na ulicy?

… czy policja imigracyjna siedzi nam na karku, bo według nich człowiekiem jest się tylko wtedy, gdy ma się papiery?

… czy mamy dość wyścigu szczurów o pieniądze i posady, z powodu którego nie mamy czasu wolnego i który tworzy podziały między nami?

W innych państwach Europy, gdzie bardziej odczuwa się kryzys, ludzie szukają nowych sposobów walki. Od tworzenia grup przeciwko eksmisjom w Hiszpanii, po okupacje i samorządne zarządzanie zamykanymi szpitalami i fabrykami w Grecji. To od nas zależy, czy będziemy gotowi zrobić to samo.
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