INTERNATIONAL LABOUR ORGANIZATION

Sectoral Activities Programme

Social dialogue in the health services: Institutions, capacity and effectiveness

Geneva, 2002

INTERNATIONAL LABOUR OFFICE   GENEVA

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**Report for discussion at the
Joint Meeting on Social Dialogue in the Health Services:
Institutions, Capacity and Effectiveness**

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Contents

Acknowledgements

Introduction

This report has been prepared by the International Labour Office as the basis for discussions at the Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness to be held from 21 to 25 October 2002 in Geneva.

Background to the Meeting

At its 279th Session (November 2000), the Governing Body of the International Labour Office decided that a Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness would be included in the programme of sectoral meetings for 2002-03. At its 282nd Session (November 2001) the Governing Body decided that the purpose of the Meeting would be to exchange views on new structures and approaches in health services and how they affect the capacity and effectiveness of the social partners in social dialogue. The Meeting would also identify a framework for how social dialogue could be strengthened, using a report prepared by the Office as a basis for its discussions. Furthermore, the Meeting would adopt conclusions that include practical guidance for the strengthening of social dialogue and proposals for action by governments, by employers' and workers' organizations at the national level and by the ILO and adopt a report on its discussion. In addition, the Meeting may also adopt resolutions. The Governing Body also decided that the Meeting should be joint (governments as public employers and workers' representatives) with the participation of some private employers' representatives. On the same occasion, it was decided to invite the Governments of 18 selected countries. The Governing Body also decided that nine Employer representatives from the private sector and 27 Worker representatives would be appointed on the basis of nominations made by the respective groups of the Governing Body. At its 283rd Session (March 2002), the Governing Body decided to invite all interested Governments to the Meeting.

The Joint Meeting is part of the ILO's Sectoral Activities Programme, the purpose of which is to facilitate the exchange of information between constituents on labour and social developments relevant to particular economic sectors, complemented by practically oriented research on topical sectoral issues. This objective is being pursued, inter alia, by holding international tripartite or joint sectoral meetings with a view to: fostering a broader understanding of sector-specific issues and problems; promoting an international tripartite consensus on sectoral concerns and providing guidance for national and international policies and measures to deal with related issues and problems; promoting the harmonization of all ILO activities of a sectoral character and acting as focal point between the Office and its constituents; and providing technical advice, practical assistance and support for the latter to facilitate the application of international labour standards in various economic sectors.

Background to the report

Concern about public health and the increasing cost of health care have for many years now made this sector one of the most debated political issues in many countries. The vital role of the social partners, the State, employers' and workers' organizations and of social dialogue among them in this context has only been recognized recently. In 1998, the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms concluded that: "In the health-care reform process, policies should be developed for social dialogue since the best reforms are developed through such a dialogue. In

accordance with ILO Conventions Nos. 87, 98 and 151, health workers have the same right to organize and to bargain collectively as workers in other sectors". [1] Earlier, the ILO Nursing Personnel Convention, 1977 (No. 149), had already stipulated that "a policy concerning nursing services and nursing personnel designed, within the framework of a general health programme, ... shall be formulated in consultation with the employers' and workers' organizations concerned" (Article 2).

There is now wide recognition of the need for social dialogue in advancing and sustaining reform processes in many areas of the health sector and hence improving health care and the impact on public health. However, with regard to health services, the institutions and the capacity for social dialogue still need to be strengthened.

Structure of the report

Chapter 1 gives an overview of some of the critical issues in the health sector which affect social dialogue in many countries. The chapter specifically refers to changes and reforms of institutions in the health services, new forms of management in the sector, national and international trends of employment in the health services and issues related to the financing of health-care delivery. Chapter 2 describes various approaches to social dialogue and the institutions necessary for social dialogue to unfold. The role of the social partners (governments and employers' and workers' organizations) and the challenges for social dialogue are illustrated by reference to some national examples. Certain prerequisites for improving the capacity for social dialogue are described, as well as indicators for assessing the effectiveness of social dialogue in the health services. The chapter concludes with detailed examples of good practice of social dialogue in health services in Brazil, Canada, Chile and the United Kingdom. Chapter 3 introduces the ILO approach to strengthening social dialogue in general and in the health services in particular, and suggests questions for discussion with a view to designing a framework to strengthen social dialogue in health services.

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[1] ILO: *Note on the proceedings*, Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, Geneva, 1998, p. 26.

1. Recent developments in the health sector: Setting the context for social dialogue

Given the complexity of the issues and the limitations on the length of this report, this chapter cannot endeavour to give a detailed account of current developments in the health sector which have an impact on social dialogue. Nevertheless, the following paragraphs will highlight some of the areas which constitute priority issues for social dialogue in order to give an impression of the environment in which social dialogue takes place.

1.1. Institutions and structures in health services

In many countries, the often monolithic structures of public national health services with branches at regional and local levels have evolved over the past two decades into more varied and complex national health systems. Decentralization in public health systems has resulted in greater autonomy of decision-making and increased responsibility of local governments for providing health-care services. However, in many cases the devolution of responsibility has not gone hand in hand with a transfer of budgetary resources. Privatization has generally been introduced with the intention of achieving more efficient delivery of quality health services or simply solving the financial problems of local governments, which are often unable to provide the necessary funds to health service institutions. There are also countries which have a long tradition of private health-care institutions, often in the non-profit sector. At the same time, globalized health-care markets have developed, which has resulted in mergers and acquisitions by international health or other service companies (of the for-profit sector) as well as by health insurance companies. The challenge to the social partners is to develop structures which can deliver efficient, high-quality health services to the public and at the same time offer decent employment and working conditions to personnel – which in turn have an impact on the quality of services.

1.1.1. The public sector in health services

In the public health sector, decentralization has been a prominent trend in all geographical regions and can be traced back to the Declaration of Alma Ata of 1978 [1] on primary health care and the follow-up activities aimed at moving towards more primary care-led health services. A further impetus was provided by the process of democratization in Latin America and Africa in the early 1990s and the transfer of political authority to lower tiers of government. In the industrialized countries, decentralization has been more focused on devolution of managerial responsibilities and increasing the role of users in service delivery. In general, in larger countries with dispersed centres of population an important role for provincial and local government has emerged. This pattern is also prevalent in countries with a federal structure of governance. [2] A variety of political, social and economic reasons can prompt decentralization in the health sector, which is often combined with more general reform of the public service. The devolution of administrative

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[1] Adopted by the International Conference on Primary Health Care, jointly sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

[2] ILO: *The impact of decentralization and privatization on municipal services*, report for discussion at the Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services, Geneva, 2001, pp. 16-17.

responsibilities to lower tiers of government includes, in most cases, human resources in the health services and hence has an impact on issues of social dialogue.

In recent years, decentralization in health services has often been implemented as an integral part of health sector reforms. The transfer of human resources to decentralized levels involves a very complex process which requires adequate information on staff and cooperation between the various government levels, health workers' organizations and registration bodies for health-care professionals.[3] The most critical issues for social dialogue are differences in pay and benefits of staff at different government levels. Successful decentralization requires clear definition of new organizational structures and their roles and responsibilities. Decentralization is often carried out in haste and not adequately communicated to the various institutions involved. In New Zealand, where the decentralization of responsibility for health services to the district health boards (DHBs) is being introduced, the process is being carried out through social dialogue and led recently to a tripartite agreement on working conditions for nurses in three DHBs in Auckland. This has involved a high degree of commitment from all the social partners.

Box 1.1.

Commitment to cooperative industrial relations in the Waitemata District Health Board in New Zealand

All parties are very committed to this process and are hopeful of some significant, noticeable and durable outcomes for nurses with regard to workload, staffing levels, career progression, stress management and agreed wage paths. The Minister of Health is so committed to it that she has recently got the Ministry of Health to advertise a position for an Industrial Relations Specialist Adviser to advance initiatives like this on a nationwide basis. This action indicates the willingness of this Government to engage with unions and employers in the health sector to achieve some predictability of workforce supply and cooperative industrial relations in the public health sector. The Public Service Association has been at the forefront of such partnership arrangements in New Zealand, but the New Zealand Nurses' Organisation in the Auckland region has taken this up with alacrity because of the potential importance of the outcomes for their members both in Auckland and in the rest of the country.

Source: Maryan Street, Employee Relations Manager, Waitemata District Health Board, Auckland, New Zealand, Mar. 2002.

Decentralization to relatively small operational units of health services at local government levels raises another challenge: the loss of economies of scale in delivering or purchasing services. In industrialized countries this has prompted establishments to contract out certain services, such as cleaning, catering and information technology. At the same time, public health facilities have formed groups, networks or cooperatives in order to achieve economies of scale for purchasing goods and services. In Germany, for example, a group of 25 municipal hospitals with about 17,000 beds founded a cooperative for medical supply in 1999. Already in the first year of its existence, framework contracts were concluded with 56 supplier companies.[4] Both contracting out and network arrangements have an impact on relations between the social partners and hence such arrangements become issues of social dialogue.

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[3] R.-L. Kolehmainen-Aitken: "Decentralization and human resources: Implications and impact", in *Human Resources for Health Development Journal* (Bangkok), Vol. 2(1), Jan.-Apr. 1998, pp. 1-16.

[4] B. Simmler: "Der Bedarf kooperativer Neugründungen", in H.-H. Münkner (ed.): *Innovative Kraft organisierter Selbsthilfe: Fachgespräch zwischen Theorie und Praxis* (Marburg, Marburg Consult für Selbsthilfeförderung, 2001), pp. 107-108.

1.1.2. The private sector in health services

The private provision of health services is frequently associated with big national and multinational health-care companies. For example, in 1997 Columbia/HCA Healthcare Corp. was the seventh largest private sector employer in the United States, with $20 billion in annual revenues. [5] However, the institutional picture in the private health sector is as diverse as in the public health services, and in fact comprises both for-profit and non-profit organizations. Traditionally, non-profit organizations [6] are very widespread in the private sector, and this applies both to industrialized and to developing countries. In addition, primary health-care services are often dispensed by self-employed health professionals. These various providers of the private health sector also cooperate with each other as well as with the public sector.

In the for-profit sector of private health services, large national and transnational health companies have existed for a long time. In the United States, for example, Kaiser Permanente, founded in 1945, today employs over 100,000 persons. The United Kingdom, which has the largest public national health system, has also for many years had large private health companies with international outreach. For example, BUPA, founded in 1947 as the British United Provident Association, today employs about 40,000 staff in the United Kingdom and some 1,500 abroad. Another company, PPP Healthcare, was founded in 1940 and is now a member of the global AXA Group. Other partnerships have been created among health facilities and insurance companies, sometimes resulting in the establishment of hospital chains and networks.

Since the 1990s, the non-profit sector in general has been the subject of research by Johns Hopkins University at its Center for Civil Society Studies. In cooperation with partner institutions in 40 countries, the Center carries out the Comparative Nonprofit Sector Project [7] to document the scope, structure, financing and role of the non-profit sector. According to research results for 22 countries, non-profit sector expenditures account for an average of 4.6 per cent of these countries' gross domestic product (GDP) and 10 per cent of total employment in all service sectors. [8] For the extent to which non-profit organizations contribute to total health sector employment in selected countries, see table 1.3 in section 1.3 of this report.

Health organizations in the non-profit sector today face problems arising out of their relatively small size. Accordingly, some non-profit organizations are joining together to form networks or even joint-stock companies. In Germany, for example, Agaplesion-AG

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[5] S. Lutz; E. Preston Gee: Columbia/HCA: *Health care on overdrive* (New York, McGraw-Hill, 1998).

[6] Non-profit organizations are defined in this context as organizations which are private, not profit distributing, self-governing and voluntary. See L. Salamon; H. Anheier; R. List; S. Toepler; W. Sokolowski et al.: *Global civil society: Dimensions of the nonprofit sector* (Baltimore, Johns Hopkins Center for Civil Society Studies, 1999), pp. 3-4.

[7] Initially focusing on 13 countries, by 2001 research covered some 40 countries; http://www.jhu.edu/~cnp

[8] L. Salamon et al., op. cit., p. 8.

was established by a group of Protestant church hospitals and other health facilities in the Frankfurt area. [9] Such major restructuring is becoming an issue for social dialogue.

The share of the private sector in health services has increased through privatization of public health facilities, public-private partnerships and contracting out. The most important component of privatization has been the contracting out of specific services. Although this practice has been strongly associated in the past with particular countries (especially New Zealand, the United Kingdom and the United States), the process has left few countries untouched. Despite criticism from various stakeholders, such as service users, trade unions and international agencies, contracting out is being considered seriously even in countries that have so far hesitated to embark fully on privatization (for example, Denmark and Sweden). Nevertheless, public opinion still seems reluctant to endorse these developments. Although the geographical reach of contracting out is extensive, its volume as a proportion of public sector budgets has been relatively small. [10]

Self-employed, independent private health professionals are still a very important part of the private sector in many industrialized countries. However, here too the pressure towards greater rationalization has prompted practitioners to form networks and other group arrangements in order to achieve economies of scale, especially for management functions and supply. All institutional arrangements in the health services may be more sustainable and more successfully adjusted if the stakeholders in these institutions are continuously involved in social dialogue on institutional policies and their impact.

1.2. Management of health services

Owing to continuous financial pressure, health systems are exploring approaches to private and commercial management with the intention of improving or at least maintaining high-quality services while containing costs. Since the sector is highly labour intensive, the major challenge for management lies in the area of human resources management. This includes performance management and pay or non-pay incentives to retain and further qualify existing staff and attract newcomers into the profession.

The demand for performance management has emerged with the institutional changes described in section 1.1, mainly decentralization and privatization. Performance management is a concept of private sector management which has only recently been adapted to health services and its use is largely limited to some national health systems in Western Europe and managed care companies in the United States and Canada. The separation made in earlier studies between management approaches focusing on quality (a service outcome) and those targeting performance (a human resource outcome) proved not to be practical. All management approaches in health services ultimately rely on the skills, motivation and performance of health workers. [11] Nevertheless, performance management can be seen from the perspective of the performance of the individual health worker and

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[9] Ver.di: *Infodienst Krankenhäuser*, No. 15, Mar. 2002, pp. 40-41.

[10] S. Bach: *Decentralization and privatization in municipal services: The case of health services*, Sectoral Activities Programme Working Paper (Geneva, ILO, 2000), p. 18.

[11] For an overview, see J. Martinez: *Assessing quality, outcome and performance management*, working paper presented at the WHO Workshop on Global Health Workforce Strategy, Annecy, 2000.

from that of overall organizational performance.[12] At the organizational level, performance management focuses on achieving targets and goals as expressed in business and operational plans and measured by performance indicators. Performance is the result of a number of factors which provide input into the operations of health organizations, such as human and financial resources and work organization. For this purpose, organizations wishing to apply this management approach need to be independent in their decision-making processes. Top management needs to be trained in and committed to this approach and has to be accountable for the results. Performance management has been introduced predominantly in the private sector of health services, but decentralized public institutions may, in principle, apply this approach. However, depending on the general situation of the national health system, the introduction of performance management may come up against a number of obstacles or not be possible at all. An essential prerequisite is the existence of a basic public health sector with adequate financial resources to enable performance management to produce public health outcomes.[13] Moreover, the necessary management, planning and evaluation capacity also has to be available, as well as training opportunities to enable staff to acquire such skills.

Performance management is closely related to quality management, which means that in the health services performance indicators have to refer to outcomes for public health and to publicly regulated quality standards (such as laboratory and hygienic standards). A number of countries have been able to introduce such quality standards, some of which are even internationally comparable (such as the ISO standards set by the International Organization for Standardization). Some developing countries, however, face constraints in this respect, since health outcomes and quality standards may be affected by infrastructural, climatic or communication factors which are beyond the control of the individual health professional or the organizational structure.[14]

A results-oriented approach to performance management in the labour-intensive health sector is dependent on the motivation of the staff and their individual performance. This may require that employees be treated as resource assets rather than as cost-creating factors. Individual performance appraisal would take place within the framework of awarding incentives to perform the agreed tasks based on high-quality standards which contribute to organizational performance. Financial and material incentives, provided through salaries and other benefits, have often been considered an important instrument in making the performance appraisal attractive. This may be particularly valid in situations where health workers do not earn adequate remuneration. However, the practicability and fairness of individual performance pay are called into question today, and modern performance management puts more emphasis on promoting teamwork and staff development and on establishing planning review processes.[15] Therefore, other types of incentive are gaining importance, such as employment security, improved working conditions, career advancement, participation in decision-making and in overall work processes, training and skills mix. Where the performance appraisal is being used as a tool of performance management, it may be linked to incentives, but there must also be adequate safeguards against potential abuse by those who use this instrument.

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[12] D. Bandaranayake: *Assessing performance management of human resources for health in South-East Asian countries: Aspects of quality and outcome*, working paper presented at the WHO Workshop on Global Health Workforce Strategy, Annecy, 2000.

[13] ibid., p. 16.

[14] ibid., pp. 14-15.

[15] J. Martinez, op. cit., pp. 9-13.

Accountability of management is an essential requirement for performance management in the health services, and it must be consistent with the overall vision, objectives, operational plans and indicators of the health organizations or institutions concerned.

Performance management may therefore be more sustainable if the formulation of organizational visions, goals and operational plans and the development of performance indicators, as well as their implementation, become an issue of social dialogue.

1.3. Labour market development in health services

Labour markets have developed rapidly in the health services at national and international levels. Their development is complex, however, owing to the extensive regulatory needs of these services (for example, with respect to professional education and licensing of personnel) and frequent imbalances between supply and demand, which are normally slow to adjust. Such imbalances occur between public and private health services, between occupational groups and between geographical areas both within and between countries.

1.3.1. National employment trends

Statistics on trends in employment in health services are only available for a limited number of years and for selected countries. Frequently, statistics can only be obtained for health services together with social services, or in combination with education and other social services, or for the service sector in general. The closest approximation to statistics of employment in health services is currently to be found in the ILO compilation of national statistics on employment by type of economic activity, in which one of the main categories is "health and social work". [16] However, since 1995 a few countries report statistics separately for this sector. "Social work" accounts for only a minor share of this category. The figures in tables 1.1 and 1.2 reflect general trends in health sector employment.

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[16] The ILO compiles statistics according to the International Standard Industrial Classification of all Economic Activities (ISIC, Rev.3, 1990), tabulation category N of which ("Health and social work") includes the provision of health care by diagnosis and treatment, the provision of residential care for medical and social reasons, as well as the provision of social assistance, such as counselling, welfare, child protection, community housing and food services, vocational rehabilitation and childcare to those requiring such assistance. Also included is the provision of veterinary services. For full details see Statistical Office of the United Nations: *International Standard Industrial Classification of all Economic Activities, Third Revision*, Statistical Papers, Series M, No. 4, Rev.3 (New York, 1990).

Table 1.1.   Total employment and health and social work employment by sex, 1995-2000

Country (or territory)	Total employment ('000)				Health and social work employment ('000)			
	1995*		2000**		1995*		2000**	
	Total	Women	Total	Women	Total	Women	Total	Women
Developed (industrialized) economies								
Australia	8 218.2	3 540.8	9 009.6	3 947.4	744.4	570.3	849.3	665.3
Austria	3 758.8	1 596.0	3 776.5	1 631.0	279.4	210.8	299.9	224.9
Belgium	3 712.3	1 538.0	3 847.6	1 645.9	368.4	268.1	413.0	298.9
Canada	13 505.5	6 109.0	14 909.7	6 860.4	1 396.2	1 119.0	1 526.4	1 237.7
Cyprus	–	–	288.6	112.5	–	–	10.4	7.2
Denmark	2 609.7	1 161.1	2 692.4	1 232.3	433.0	361.7	458.8	388.3
Finland	2 128.0	1 003.0	2 356.0	1 108.0	298.0	263.0	326.0	289.0
Germany	36 048.0	15 109.0	36 604.0	15 924.0	3 151.0	2 356.0	3 696.0	2 757.0
Greece	3 823.8	1 371.6	3 946.3	1 489.0	163.1	103.5	183.7	119.8
Iceland	141.8	66.2	156.4	72.8	21.0	18.5	20.6	17.9
Ireland	1 281.7	482.9	1 591.1	643.9	103.8	78.4	119.9	95.1
Italy	20 233.0	7 007.0	21 225.0	7 764.0	1 234.0	672.0	1 288.0	770.0
Luxembourg	214.1	–	237.0	–	13.0	–	14.4	–
Netherlands	6 835.0	2 787.0	7 731.0	3 311.0	929.0	723.0	1 071.0	841.0
New Zealand	1 735.9	777.9	1 779.0	806.3	126.3	104.2	142.4	117.2
Norway	2 131.0	977.0	2 269.0	1 057.0	372.0	307.0	402.0	335.0
Portugal	4 441.7	1 968.4	4 921.1	2 213.8	200.4	147.1	243.1	193.1
San Marino	16.3	6.2	18.7	7.3	0.9	0.6	1.0	0.7
Spain	12 041.9	4 152.8	14 473.7	5 387.1	618.1	432.9	789.3	561.5
Sweden	3 986.0	1 925.0	4 159.0	1 992.0	820.0	716.0	770.0	670.0
Switzerland	3 800.0	1 542.0	3 908.0	1 649.0	358.0	268.0	398.0	299.0
United Kingdom	26 026.0	11 628.6	27 442.3	12 303.9	2 754.0	2 240.7	3 014.6	2 413.1
United States	117 191.0	56 643.0	131 418.0	63 654.0	11 566.0	9 384.1	13 102.2	10 641.2
Transition economies								
Azerbaijan	–	–	3 704.5	1 767.0	–	–	168.4	95.0
Bulgaria	3 285.9	–	3 072.0		187.2	–	165.1	
Croatia	1 540.3	701.9	1 553.0	704.3	85.0	65.2	91.3	70.1
Czech Republic	4 995.0	2 187.0	4 751.0	2 064.0	285.0	227.0	294.0	232.0
Estonia	656.1	313.8	608.6	294.8	36.5	30.7	29.8	26.2
Georgia	–	–	1 748.8	814.0	–	–	85.2	58.7
Hungary	3 678.8	1 629.2	3 849.1	1 726.7	231.4	175.2	241.7	182.0
Kazakhstan	–	–	6 127.0		–	–	325.9	–
Kyrgyzstan	1 641.7	754.4	1 764.3	792.7	85.1	62.3	85.2	62.9
Latvia	973.0	457.8	966.8	474.8	59.6	47.4	49.7	42.0
Lithuania	1 570.7	742.0	1 517.9	758.1	100.3	79.2	102.1	87.3
Moldova, Rep. of			1 514.6	767.2			74.2	60.0
Poland	14 791.0	6 696.0	14 526.0	6 522.0	975.0	798.0	938.0	773.0
Romania	11 152.3	5 125.7	10 763.8	4 991.6	345.2	261.2	345.8	280.1
Russian Federation	60 021.0	28 467.0	60 408.0	28 884.0	4 176.0	3 416.0	4 333.0	3 555.0
Slovakia	2 146.8	953.5	2 101.7	964.4	141.6	113.0	147.9	121.5
Slovenia	882.0	409.0	892.0	410.0	47.0	37.0	45.0	36.0
Tajikistan	1 853.0	815.0	–	–	88.0	–	–	–

Country (or territory)	Total employment ('000)				Health and social work employment ('000)			
	1995*		2000**		1995*		2000**	
	Total	Women	Total	Women	Total	Women	Total	Women
Selected countries and territories of Africa, Asia and Latin America								
Argentina	7 369.8	2 765.5	8 261.7	3 319.8	434.3	285.4	474.5	320.6
Bolivia	1 848.5	841.6	2 096.0	924.9	55.8	33.5	48.8	27.7
Costa Rica	1 145.0	336.9	1 318.6	416.1	52.8	31.2	51.9	28.2
Egypt	15 830.0	3 017.0	16 750.2	3 139.2	410.4	181.5	531.1	275.9
Israel	1 965.0	834.4	2 221.2	1 009.5	172.4	129.9	213.6	162.5
Korea, Rep. of	20 432.0	8 256.0	21 061.0	8 707.0	303.0	202.0	412.0	289.0
Macau, China	–	–	200.1	96.2	–	–	5.3	3.7
Mexico	33 881.1	10 854.3	38 983.8	13 311.2	786.9	506.1	1 062.6	699.8
Netherlands Antilles	54.1	23.6	52.2	24.9	4.2	3.1	4.3	3.5
Panama	866.7	279.6	961.4	323.4	28.0	18.4	30.8	19.1
Peru	6 130.5	2 508.0	7 128.4	3 060.7	169.7	111.6	169.7	112.6
United Arab Emirates	1 311.8	152.1	1 779.0	226.0	23.6	10.9	33.3	16.2

Notes: * Or year close 1995.   ** Or year close 2000.   – Not available.
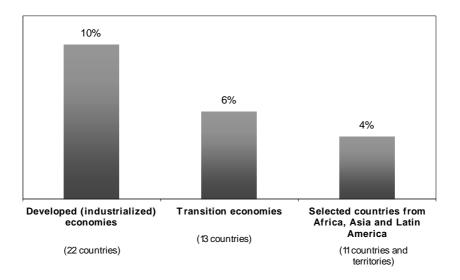
Source: ILO database on labour statistics (LABORSTA), 2002.

Table 1.2.   Trends in total employment and health and social work employment, 1995-2000 (percentages)

Country (or territory)	Share of health and social work employment in total employment		Share of women in health and social work employment		Annual growth rates			
					Total employment		Health and social work employment	
	1995*	2000**	1995*	2000**	Total	Women	Total	Women
Developed (industrialized) economies								
Australia	9.1	9.4	76.6	78.3	1.9	2.2	2.7	3.1
Austria	7.4	7.9	75.4	75.0	0.1	0.4	1.4	1.3
Belgium	9.9	10.7	72.8	72.4	0.7	1.4	2.3	2.2
Canada	10.3	10.2	80.1	81.1	2.0	2.3	1.8	2.0
Cyprus	–	3.6	–	69.7	–	–	–	–
Denmark	16.6	17.0	83.5	84.6	0.6	1.2	1.2	1.4
Finland	14.0	13.8	88.3	88.7	2.1	2.0	1.8	1.9
Germany	8.7	10.1	74.8	74.6	0.3	1.1	3.2	3.2
Greece	4.3	4.7	63.5	65.2	0.6	1.7	2.4	3.0
Iceland	14.8	13.2	88.1	86.9	2.0	1.9	–0.4	–0.7
Ireland	8.1	7.5	75.5	79.3	4.4	5.9	2.9	3.9
Italy	6.1	6.1	54.5	59.8	1.0	2.1	0.9	2.8
Luxembourg	6.1	6.1	–	–	2.1	–	2.1	–
Netherlands	13.6	13.9	77.8	78.5	2.5	3.5	2.9	3.1
New Zealand	7.3	8.0	82.5	82.3	0.5	0.7	2.4	2.4
Norway	17.5	17.7	82.5	83.3	1.3	1.6	1.6	1.8
Portugal	4.5	4.9	73.4	79.5	2.1	2.4	3.9	5.6
San Marino	5.5	5.5	68.0	71.6	2.7	3.3	2.6	3.6
Spain	5.1	5.5	70.0	71.1	3.7	5.3	5.0	5.3
Sweden	20.6	18.5	87.3	87.0	0.9	0.7	–1.3	–1.3
Switzerland	9.4	10.2	74.9	75.1	0.6	1.4	2.1	2.2
United Kingdom	10.6	11.0	81.4	80.0	1.1	1.1	1.8	1.5

Country (or territory)	Share of health and social work employment in total employment		Share of women in health and social work employment		Annual growth rates			
					Total employment		Health and social work employment	
	1995*	2000**	1995*	2000**	Total	Women	Total	Women
United States	9.9	10.0	81.1	81.2	2.3	2.4	2.5	2.5
Transition economies								
Azerbaijan	–	4.5	–	56.4	–	–	–	–
Bulgaria	5.7	5.4	–	–	–1.3	–	–2.5	–
Croatia	5.5	5.9	76.6	76.8	0.2	0.1	1.4	1.5
Czech Republic	5.7	6.2	79.6	78.9	–1.0	–1.2	0.6	0.4
Estonia	5.6	4.9	84.1	87.9	–1.5	–1.2	–4.0	–3.1
Georgia	–	4.9	–	68.9	–	–	–	–
Hungary	6.3	6.3	75.7	75.3	0.9	1.2	0.9	0.8
Kazakhstan	–	5.3	–	–	–	–	–	–
Kyrgyzstan	5.2	4.8	73.2	73.8	1.5	1.0	0.0	0.2
Latvia	6.1	5.1	79.5	84.5	–0.1	0.7	–3.6	–2.4
Lithuania	6.4	6.7	79.0	85.5	–0.7	0.4	0.4	2.0
Moldova, Rep. of	–	4.9	–	80.9	–	–	–	–
Poland	6.6	6.5	81.8	82.4	–0.4	–0.5	–0.8	–0.6
Romania	3.1	3.2	75.6	81.0	–0.7	–0.5	0.0	1.4
Russian Federation	7.0	7.2	81.8	82.0	0.1	0.3	0.7	0.8
Slovakia	6.6	7.0	79.8	82.2	–0.4	0.2	0.9	1.5
Slovenia	5.3	5.0	78.7	80.0	0.2	0.0	–0.9	–0.5
Tajikistan	4.7	–	–	–	–	–	–	–
Selected countries and territories of Africa, Asia and Latin America								
Argentina	5.9	5.7	65.7	67.6	2.3	3.7	1.8	2.4
Bolivia	3.0	2.3	59.9	56.7	2.5	1.9	–2.7	–3.7
Costa Rica	4.6	3.9	59.2	54.4	2.9	4.3	–0.3	–2.0
Egypt	2.6	3.2	44.2	51.9	1.1	0.8	5.3	8.7
Israel	8.8	9.6	75.3	76.1	2.5	3.9	4.4	4.6
Korea, Rep. of	1.5	2.0	66.7	70.1	0.6	1.1	6.3	7.4
Macau, China	–	2.6	–	69.8	–	–	–	–
Mexico	2.3	2.7	64.3	65.9	2.8	4.2	6.2	6.7
Netherlands Antilles	7.7	8.1	74.4	81.4	–0.7	1.0	0.4	2.3
Panama	3.2	3.2	65.7	62.0	2.1	3.0	2.0	0.8
Peru	2.8	2.4	65.8	66.4	3.1	4.1	0.0	0.2
United Arab Emirates	1.8	1.9	46.3	48.8	6.3	8.2	7.1	8.2

Notes: * Or year close 1995.   ** Or year close 2000.   – Not available.

Source: ibid.

Subject to these limitations, the average share of health services employment in total employment, according to recent ILO estimates, varies between countries but lies at 10 per cent for selected industrialized countries, 6 per cent for transition countries and 4 per cent for selected developing countries (figure 1.1).
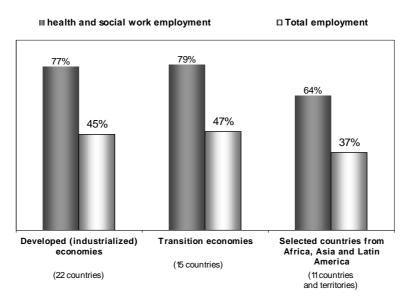
Figure 1.1. Share of health and social work employment in total employment, 2000 (average percentage)

The proportion of women in this workforce is very high and substantially exceeds their share in total employment: in industrialized countries 77 per cent in health services compared to 45 per cent in total employment, in transition countries 79 per cent compared to 47 per cent, and in developing countries 64 per cent compared to 37 per cent (figure 1.2).

Figure 1.2. Share of women in total employment and health and social work employment, 2000 (average percentage)

As already stated, the share of health services employment in total employment varies from one country to another. In the selected countries, it ranges between a low of 1.9 per cent (United Arab Emirates) and a high of 18.5 per cent (Sweden) for the year 2000 (figures 1.3 to 1.5).
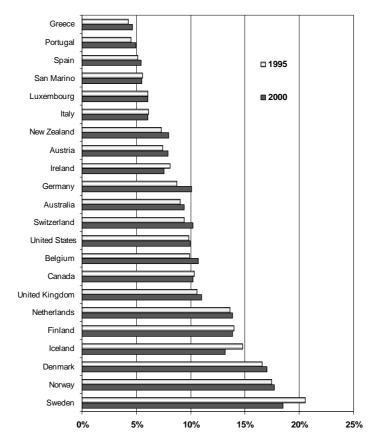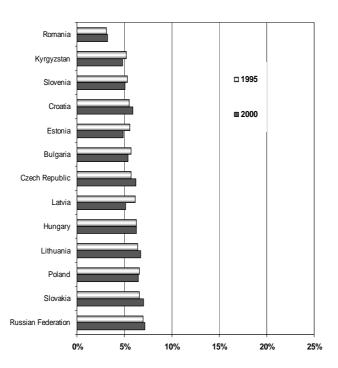
Figure 1.3.   Share of health and social work in total employment in 22 developed economies [1]
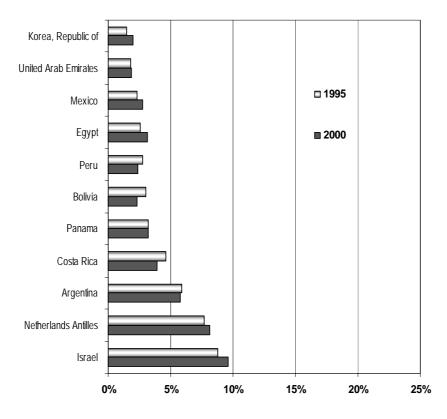

¹ In order of increasing percentage for 1995.
Source: ibid.

Figure 1.4.   Share of health and social work in total employment in 13 transition economies [1]

¹ In order of increasing percentage for 1995.
Source: ibid.

Figure 1.5. Share of health and social work in total employment in 11 selected countries and territories of Africa, Asia and Latin America [1]
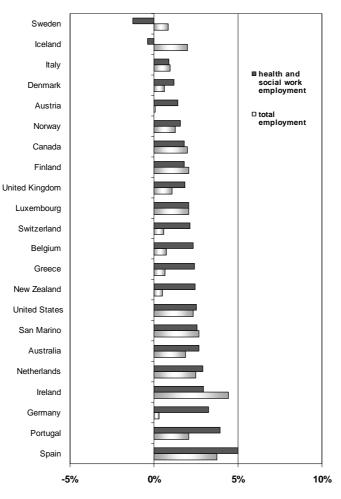

¹ In order of increasing percentage for 1995.
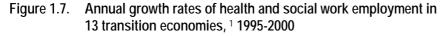Source: ibid.

A comparison of the changes in employment in health services between 1995 and 2000 shows relatively small variations in industrialized countries (figure 1.6). Only in Sweden and Iceland was there a decline in health services employment of 1.3 and 0.4 per cent, respectively, as an annual average during the five-year period. In other industrialized European countries, one can note an increase in the workforce in health services, the highest being annual average growth rates of 3.9 per cent in Portugal and 5 per cent in Spain.
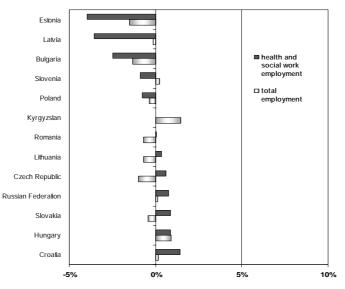
The situation looks different in some transition countries, where the decline in health services employment has been quite pronounced (figure 1.7): in Estonia, Latvia and Bulgaria the average annual declines between 1995 and 2000 were 4, 3.6 and 2.5 per cent, respectively. The share of health services in total employment has also declined in the same countries, by 0.7, 1 and 0.3 percentage points, respectively (figure 1.4). In some other transition countries, there were small increases over the same period. Among the few developing countries for which statistics on employment in health services are available, Bolivia and Costa Rica registered an annual decline of 2.7 and 0.3 per cent, respectively, over the same five-year period (figure 1.8). It appears that in the majority of these countries, health services employment is rising, both in absolute numbers and as a share of total employment (figures 1.5 and 1.8).

Figure 1.6.   Annual growth rates of total employment and health and social work
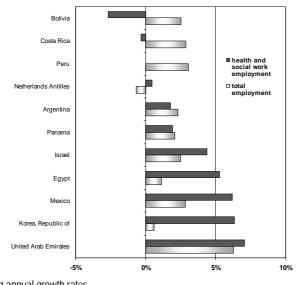employment in 22 developed economies,[1] 1995-2000

[1] In order of increasing annual growth rates.
Source: ibid.

Figure 1.7.   Annual growth rates of health and social work employment in
13 transition economies,[1] 1995-2000

[1] In order of increasing annual growth rates.
Source: ibid.

Figure 1.8. Annual growth rates of health and social work in total employment in 11 selected countries and territories of Africa, Asia and Latin America, [1] 1995-2000

[1] In order of increasing annual growth rates.
Source: ibid.

There are no consistent data on the share of the public and private sectors in national health sector employment. Nevertheless, a certain distribution of employment among the public and private sectors is reflected in the employment share of private non-profit organizations in health services, as shown for selected countries in table 1.3.

As the general trend in health services employment is rising, it is not surprising that there are countries which report staff shortages in the sector. In a number of industrialized countries, staff shortages have already reached high levels in certain health sector professions. Long training periods and often relatively short periods of employment only allow very slow adjustment of labour supply to demand. Forecasts of staff shortages are therefore often alarming. In other countries, in particular transition and developing countries, certain types of jobs in the health sector are being eliminated or health facilities are being closed owing to cost containment measures and lack of finance through health insurance.

It is frequently recognized that the particularities of the health services do not allow market mechanisms alone to achieve an adequate balance between labour demand and supply. The World Health Organization (WHO) carried out a specific consultation in March 2002 in Ottawa, Canada, in order to discuss recent research work on imbalances in the health services workforce. Only a few of the ideas that emerged can be mentioned in the context of this report. Market mechanisms fail in the health sector mainly as a result of institutional and regulatory arrangements on the demand side and slow response on the supply side, which in turn is largely due to the long and strictly regulated education for health professions. Other limitations on the demand side result from budgetary restrictions on the mainly public health sector.

Table 1.3. Share of non-profit organizations in health sector employment, selected countries

Country	Share of non-profit organizations in health sector employment (%)
Argentina	16.0
Australia	17.3
Austria	15.0

Country	Share of non-profit organizations in health sector employment (%)
Brazil	12.8
Czech Republic	4.2
Finland	12.4
France	12.4
Germany	23.1
Hungary	0.8
Ireland	40.9
Israel	43.7
Italy (1991)	6.0
Japan	59.7
Mexico	1.1
Netherlands	70.4
Romania	2.0
Slovakia	0.3
Spain	9.5
Sweden (1992)	0.7
United Kingdom	4.2
United States	46.6

Source: Johns Hopkins Comparative Nonprofit Sector Project.

Therefore human resources planning is often required to correct such labour market difficulties. In practice, however, it is difficult to identify imbalances and several indicators have been used to estimate the extent of shortages and surpluses. [17] These indicators have been classified in four categories: employment indicators (such as vacancies, growth of the workforce, occupational unemployment rate, staff turnover rates), activity indicators (such as overtime), monetary indicators (such as real wage rate, rate of return on investment in the education of the individual) and normative population-based indicators (such as doctor/population ratio, nurse/population ratio). Each of these indicators has advantages and disadvantages, and this list of categories is not exhaustive. In any event, it appears to be insufficient to rely on only one indicator for measuring imbalances in the health services labour market. Apart from the difficulty of identifying imbalances, the collection of statistical data itself poses problems. It is clear, however, that human resource planning has not always achieved the desired results, since staff shortages in the health services often arise in a cyclical pattern. Even if national demand and supply can be balanced, the challenge still remains to correct imbalances between various occupational groups and skills and between geographical areas within a country (for example, between urban and rural areas).

Furthermore, a variety of stakeholders with an interest in health services have an impact on the demand and supply side through regulatory mechanisms, which makes forecasting for human resource planning in the health services extremely difficult. Dialogue between the social partners to identify indicators, to measure imbalances and to

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[17] P. Zurn; M. Dal Poz; B. Stilwell; O. Adams: *Imbalances in the health workforce*, briefing paper (Geneva, WHO, Mar. 2002), pp. 32-41.

discuss the impact of regulation, education and training may contribute to overcoming the various labour market difficulties.

1.3.2. Globalized labour markets and migration

International migration has become the most apparent feature of globalized labour markets in health care. The impact of international migration is very complex both for health workers and for the countries involved. From the individual standpoint, migration is mostly motivated by the desire to find employment and/or better remuneration and working conditions, although there are also other motivating factors. The incentive of pay and other material benefits might not be enough to generate internal migration, for example, between urban and rural areas, but given the striking differences in pay between developing and transition countries, on the one hand, and industrialized countries, on the other, this seems to be the main driving force behind international migration. Industrialized countries thus become "recipient countries", while the "donor countries" face major investment losses as a result of this "brain drain", particularly in terms of the education provided to health workers. Even more importantly, emigration of qualified health workers may further undermine the functioning of weak national health systems in developing countries, which are often the losers in the struggle to retain the workforce, while recipient countries face the challenge of integrating health workers into their own workforce while avoiding social dumping in internal labour markets.

The United States is one of the biggest recipient countries. In the early 1990s, it was estimated that about 80,000 immigrant nurses were employed in the country, [18] and this trend seems to be rising. Another big recipient is the National Health Service (NHS) in the United Kingdom. In February 1999, over 29,000 registered nurses in that country (nearly 30 per cent of all registered nurses) came from abroad. [19] The countries of origin are quite varied. Emigrating health workers from the Philippines and other Asian countries supply the United Kingdom and the United States. Other countries "exporting" health workers to the United Kingdom include Australia, South Africa, New Zealand and Finland, while Central and Eastern European countries send health workers to Germany and other Western and Northern European countries.

There has been concern about international migration in health services for some years now, but recently the situation has become more acute. The migration of health workers is generally left to the motivation of the individual workers, prompted by a legitimate desire for employment, higher income or better jobs. At the same time, however, employers in recipient countries are actively recruiting health personnel abroad and facilitating their temporary or long-term immigration to their countries. The costs of recruiting abroad vary, depending on the country of origin. In the United Kingdom, recruitment costs were estimated in 1999 at £3,200 for a nurse from Australia, at £1,700 from the Philippines and at £1,150 from Scandinavia. [20] At the same time, sending countries are training their citizens in health professions knowing that they will not be absorbed into the national health services workforce. They are thus preparing these

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[18] ILO: *Terms of employment and working conditions in health sector reforms*, report for discussion at the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, Geneva, 1998, pp. 37-38.

[19] J. Buchan; F. O'May: "Globalisation and health-care labour markets: A case study from the United Kingdom", in *Human Resources for Health Development Journal*, Vol. 3(3), Sep.-Dec. 1999.

[20] ibid.

workers for "export" in order to achieve an inflow of foreign exchange through the remittances of their citizens working abroad.

Box. 1.2.

United States recruits nurses abroad to cope with shortage

An acute shortage of health-care workers is driving Washington area hospitals overseas to recruit hundreds of nurses critical to patient care. The shortage is especially severe at the Washington Hospital Center, which is paying temporary-staffing agencies up to $70 an hour to hire freelance nurses, including some from out of the Washington area, to fill more than a third of its 1,236 nursing positions. That provides a powerful incentive to recruit full-time nurses who are paid, on average, less than $25 an hour – and to recruit in places such as Manila, where nurses are paid less than $1 an hour. For five days in spring 2001, Hospital Center recruiters held a job fair in London's posh Le Meridien Grosvenor House Hotel, signing up 90 nurses, most of them immigrants from developing nations. The program was run by a recruiter who charges up to $5,000 for each new hire she delivers.

A review by the *Washington Post* found that the Hospital Center offered these nurses and others from overseas salaries which are substantially lower than those paid to their US counterparts. In determining pay, hospital executives said they credited overseas nurses for only half their years of experience. Foreign nurses require more training, said Joanne Gucciardo, who oversees the hospital's nurse recruiting. Local nurses' union officials said the half-credit practice violates their contract with the hospital; hospital officials say it does not. Washington Hospital Center executives said they were doing plenty to retain their current nurses – offering them, for example, bonuses of $2,000 if they remain on staff for one year, another $2,000 if they stay for two years and $3,000 for three years.

There have been nursing shortages at American hospitals before, but never this severe, hospital executives say. This shortage is mostly from declining enrolment in nursing schools as women, still the mainstay of the profession, take advantage of new and less stressful career options. Over a five-year period, the number of nursing school graduates dropped by 20 per cent. There were 2.7 million registered nurses in the United States in 2000, a 5 per cent increase since 1996, according to the American Nurses Association. But today's demand for nurses is greater as baby boomers age and require more medical care. A survey of 715 of the 5,000 US hospitals found 126,000 job openings for nurses, the American Hospital Association reported.

With many nurses retiring – the average age is about 45 – hospital executives say that they have no choice but to look overseas. For US hospitals, the hunt for nurses often begins in the Philippines, which graduates more nurses than its hospitals can employ. Filipino nurses are widely coveted in the United States because they are trained in English at nursing schools that use the same curriculum as US universities. Though Manila hospitals have plenty of new graduates to choose from, thousands of their most experienced nurses have taken jobs in London, Washington, Los Angeles and other Western cities.

Source: B. Brubaker: "Hospitals go abroad to fill slots for nurses", in *Washington Post*, 11 June 2001.

Regional integration, for example in the European Union (EU) or the North American Free Trade Agreement (NAFTA), and mutual recognition of health-care qualifications, coupled with skill and staff shortages in many countries, have given further impetus to migration. International agreements such as the General Agreement on Trade in Services (GATS) may be another contributing factor to cross-border flows of health professionals.

Social dialogue is critical in finding a balanced approach to cross-border migration. Immigrating health workers have to be represented in social dialogue. They need to be informed of their rights as workers and their terms and conditions of employment. The principle of equal opportunity and treatment must also apply to immigrant workers. At the same time, the existing workforce needs to feel assured that their own position and acquired rights are not undermined by the arrival of migrant workers who might be willing to accept poorer conditions of employment and work. And although this might not be a priority concern at a time of staff and skill shortages, health services might find themselves accused of social dumping when employers actively recruit abroad.

1.4. Financing of health-care delivery

Despite long-term and often drastic policies of cost containment in the health sector, health expenditure is increasing in both absolute figures and as a share of GDP. There is thus a need for policies and strategies to improve the efficiency of health systems. This applies not only to private and public schemes of financing, but also to the allocation of human resources in this highly labour-intensive sector. The remuneration of the workforce accounts for up to 70 per cent of total costs. Dialogue among the social partners is increasingly seen as an asset and not an obstacle in addressing efficiency and cost containment concerns.

The basis for any reflection on health-care financing is a country's GDP. The share of GDP which countries actually spend on health care differs considerably; it is the performance of the national economy which largely determines what a country is able to spend on health services. However, the amount of financial resources allocated to health services does not necessarily give an indication of equity in access to these services, of their quality or of their impact on health outcomes. Therefore, unsatisfactory situations may exist in countries that spend a large share of GDP on health services. For example:

- the high expenditures on health care may be concentrated only on part of the population;

- high investments may be made in curative rather than preventive health care;

- prices, fees and incomes in health services may be very high, but the quality of care may be similar to that in other countries where health expenditures are lower. [21]

In 2000, WHO published a set of indicators for the performance of national health systems which together give more refined information than individual indicators such as the share of health-care expenditure of GDP or health professional/population ratios. [22]

Health-care financing is a highly political issue, and there is strong competition with other social and economic priorities which need to be financed out of public budgets. Private contributors to health-care financing, employers, employees and users all have to weigh their contributions to health care against other expenditures. The financial capacity of tax and contribution payers may be limited by the economic environment, through low wages and incomes. The scope for raising social expenditure by the State is increasingly reduced as the globalization of markets results in taxes and social costs which add to labour costs of goods and services – determining factors for the international competitiveness of national economies. This development has led policy-makers to explore alternative means of financing health care other than through public expenditure alone. Such methods range from health insurance and co-payments to user charges and consumer taxes.

When introducing user co-payments it is essential to take into account individuals' ability to pay. This is often non-existent in countries with low income levels and a large

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[21] A. Weber: "Health-care financing and employment", in ILO/Public Services International (PSI): *Employment and working conditions in the health sector of Central Asian countries*, report of the ILO/PSI Central Asian Conference on Restructuring Health Services and the Role of Trade Unions in this Process, Almaty, 24-26 Mar. 1999 (Geneva, 2000), p. 42.

[22] WHO: *The World Health Report 2000 – Health systems: Improving performance* (Geneva, 2000), table 8.

informal economy. Informal "co-payments", also termed "under-the-table payments", are very common in many transition and developing countries. Statistically, this type of financing is included in the category "out-of-pocket payments". According to WHO data on selected National Health Accounts indicators for 1997 and 1998, they can constitute up to 100 per cent of private health expenditures in some transition and developing countries, even if health care is officially free of charge. [23] In such countries, private health-care expenditure, which may amount to more than 50 per cent of total health expenditure, should therefore not lead to the conclusion that the country has an extended private sector of health services.

Health-care financing through insurance has certain features which make it different from financing through public funds. In particular, health insurance makes the cost of health care more transparent, even if the insurance organizations are often still dependent on payments out of public funds. Payments to health insurance raise the question of whether it is the employer or the employee who contributes to health-care financing. This debate often makes the financing of health care an issue for collective bargaining.

Since health services are a highly labour-intensive sector, decisions on health-care financing have a significant impact on the employment and working conditions of health workers. Health providers and health workers always find themselves caught between the financial contributors and the users. The financial contributors see the providers as generating excessive costs, while users see providers as providing inadequate services. This makes the situation of health workers difficult, especially when they are paid out of taxes and compulsory contributions to health-care finance. In addition, different forms of health-care financing may affect employment and working conditions of health workers in different ways, and any move towards greater efficiency and effectiveness has an impact on their day-to-day work. [24]

For example, pay systems are a major element in health sector reforms, since they address the quantity and the quality of health-care services. At the same time, they have an impact on performance and may be used as an instrument in performance management. Remuneration in the health-service professions is rather complex, particularly in view of the focus on "outcomes" in public health. Pay systems for physicians tend to be the most complicated and are often based on three elements: a salary, fee-for-service and capitation (fixed payment per beneficiary). Although these various pay systems have been under discussion, nurses and allied health professions are mainly paid by salary. The fact whether their pay is financed by the State (the taxpayer), the patient (out-of-pocket payments) or a third party (such as health insurance or the employer) also makes a difference for health workers and employers. Therefore the funding system is a major issue for social dialogue. The different options of financing and their impact on the workforce and employers should be carefully analysed. The choice of funding system is certainly guided by the overall goals pursued by the health system, but the impact on providers and their performance should be made transparent before that choice is made.

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[23] WHO: *The World Health Report 2001 – Mental health: New understanding, new hope* (Geneva, 2001), pp. 160-167.

[24] A. Weber, op. cit., pp. 47-48.

2. Institutions, capacity and effectiveness of social partners in social dialogue

The challenges facing the health sector described in Chapter 1 point to the wide range of tasks which need to be addressed in social dialogue. Because of their impact on the economy and society, the success of social dialogue may be more crucial in the health services than in other sectors. Since health services impact on every individual in society and every change in health services affects each person who is active in this sector, many stakeholders have to be involved in achieving improved outcomes for public health. Social dialogue offers a mechanism for such involvement. In establishing and strengthening social dialogue in health services, it is necessary to have a clear picture of the approach and the institutions in which social dialogue can unfold. The social partners have to identify their own role and challenges for social dialogue and recognize each other as partners in this dialogue. Participation in social dialogue has to be assured for all partners, and indicators have to be established to assess the effectiveness of social dialogue. Lastly, the evidence resulting from good practice may be the most convincing means of strengthening social dialogue.

2.1. Social dialogue as an approach to labour relations

Social dialogue is emerging as a cooperative approach to labour relations. It goes beyond traditional forms of collective bargaining and is mostly seen as a continuous process of participation of the social partners. In the context of this approach, social dialogue may be defined as "all types of negotiation, consultation or simply exchange of information between representatives of governments, employers and workers, on issues of common interest relating to economic and social policy".[1]

The ILO, based on its tripartite structure, supports social dialogue. Social dialogue is seen to have an instrumental role in the prevention and resolution of labour disputes and social problems. When used effectively, social dialogue can identify new opportunities for consensus building and cooperation to achieve vital economic and social development objectives. It also contributes to strengthening the social partners, reinforcing democratic governance and building effective labour market institutions. The Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services held in October 2001, which covered the health services among others, concluded that "social dialogue is not a single event but a continuous process of consultation and/or negotiation among employers both public and private and workers' representatives which does not end when the reform is implemented. This process may be time-consuming and long, but is rewarded by sustainable results and by ownership of all stakeholders in the decisions taken".[2]

In the specific case of social dialogue in health services, which in many countries belong mainly to the public sector, special attention has to be given to the issue of

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[1] ILO: *Programme and Budget proposals for 2000-01*, Vol. 3, Governing Body doc. GB.276/PFA/9, 276th Session, Geneva, Nov. 1999, para. 114.

[2] ILO: *Note on the Proceedings*, Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services, Geneva, 15-19 Oct. 2001, p. 32.

collective bargaining in the public service. [3] The exercise of the right of freedom of association by organizations of public officials and employees is now a reality in industrialized countries and in many developing countries. The Right to Organise and Collective Bargaining Convention, 1949 (No. 98), excluded from its scope public servants engaged in the administration of the State, but the Labour Relations (Public Service) Convention, 1978 (No. 151), took an important step forward in requiring member States to promote machinery for negotiation or other methods allowing representatives of public employees to participate in the determination of their terms and conditions of employment. Later, the Collective Bargaining Convention, 1981 (No. 154), which promotes collective bargaining in both the private sector and the public service, in the case of the public service only allows the fixing of special modalities of application of the Convention by national law or regulations or national practice. A State which ratifies the Convention cannot confine itself to consultations, but has to promote collective bargaining with the aim of determining working conditions and terms of employment.

The European Union (EU) has developed a concept of social dialogue and social partnership [4] which is set forth as follows in the Treaty of Amsterdam, 1997: "the Community and the Member States ... shall have as their objectives the promotion of ... dialogue between management and labour ..." (Article 136); "the Commission shall have the task of promoting the consultation of management and labour at Community level and shall take any relevant measure to facilitate their dialogue by ensuring balanced support for the parties" (Article 138(1)); and "should management and labour so desire, the dialogue between them at Community level may lead to contractual relations, including agreements" (Article 139(1)). [5] A Green Paper issued in 1997, entitled *Partnership for a new organisation of work*, set out conditions for social partnerships at work. [6] Some approaches to social dialogue also include wider dialogue involving all the stakeholders and their organizations. In the 1990s, this approach, termed "civil dialogue", was discussed in the EU as a complement to social dialogue; however, it was not included in the Treaty of Amsterdam. Nevertheless, declaration 38 appended to the Treaty referred to encouraging the "European dimension of voluntary organizations", and the Commission issued a communication on promoting the role of voluntary organizations and foundations in Europe, encouraging Member States to examine ways of strengthening the involvement of non-governmental organizations (NGOs).

At the EU level, a number of projects have been launched to develop sectoral and cross-sectoral social dialogue. Efforts have been undertaken to establish social dialogue in the health services sector, in particular through a formal framework for social dialogue in the hospital sector (box 2.1).

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[3] B. Gernigon; A. Odero; H. Guido: "ILO principles concerning collective bargaining", in *International Labour Review* (Geneva), Vol. 139, No. 1, 2000-01, pp. 47-48.

[4] "Social partnership" is a term which has been used with many different and sometimes conflicting meanings. For an overview and an attempt to classify these meanings, see E. Heery; J. Kelly; J. Waddington: *Union revitalization in the United Kingdom*, International Institute for Labour Studies, discussion paper series No. 133 (Geneva, ILO, 2002), pp. 15-16.

[5] Treaty of Amsterdam amending the Treaty on European Union, the Treaties establishing the European Communities and certain related acts, signed at Amsterdam, 2 Oct. 1997, in *Official Journal of the European Communities*, C340, Vol. 40, 10 Nov. 1997; http://europa.eu.int/eur-lex/en/treaties/dat/ec_cons_treaty_en.pdf

[6] http://europa.eu.int/comm/employment_social/soc-dial/social/green_en.htm

Similar approaches are being taken in different countries. In the United Kingdom, the partnership approach has become widely used in the last two decades in the health sector. In health policy, the concept of partnership between different agencies working towards health improvement has been influential. This approach has been adopted in several countries in an effort to bring different agencies and sectors together to improve health and social development, as stipulated in the WHO Ottawa Charter for Health Promotion of 1986. [7]

Other examples of the partnership approach include New Zealand, where the Public Service Association launched the concept of "Partnership for Quality" in its Health Sector Bargaining Strategy of June 2001. In the United States, the idea of labour-management partnership has also been introduced in the private health sector, specifically through the national agreement concluded between Kaiser Permanente and a coalition of workers' organizations in 2000. This agreement promotes social dialogue and workers' participation as a continuous process going beyond traditional collective bargaining (see section 2.4). [8]

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[7] The Charter was adopted by the First International Conference on Health Promotion on 21 Nov. 1986; http://www.who.int/hpr/archive/docs/ottawa.html

[8] This case is an example of the "new generation" of labour-management partnerships in the United States, based on intensified competition and union revitalization efforts, and in which trade unions agree to support the company and in turn receive recognition as partners. For an overview, see R. Hurd; R. Milkman; L. Turner: *Reviving the American labour movement: Institutions and*

2.2. Categories and types of institutions in social dialogue

The existence of institutions for social dialogue is decisive, as can be seen from the experience of countries where they have only recently been established. Such institutions may be set up on a formal and legal basis or through informal arrangements, most recently, "virtual" institutions. Institutions of social dialogue may be located at the national, local or enterprise level, or indeed at the international level. They may be sectoral or cross-sectoral. Social dialogue may take the form of negotiations on labour issues resulting in formal agreements, or of consultations or information. The machinery for social dialogue may be established for a limited period or for a continuous process without limit of time.

A country may have a variety of tripartite bodies and mechanisms in which social dialogue takes place, in many forms and at many levels, ranging from national tripartite consultation and cooperation to plant-level collective bargaining. [9] In situations of significant economic and social change or crisis, tripartite structures have been created with strategic outreach for all stakeholders at national level (for example, national social pacts on health-care reforms); these go beyond collective bargaining but set the framework for collective bargaining at central and decentralized levels.

The EU has established a range of formal institutions for social dialogue at company level (European works councils), at interprofessional level (social dialogue committees) and at sectoral level (sectoral dialogue committees). Although there is not yet a sectoral committee for the health services, efforts are currently under way to create a formal framework for social dialogue in the hospital sector (see box 2.1). These efforts may culminate in a sectoral dialogue committee consisting of representatives of trade unions and employers' organizations, which would meet several times a year to negotiate a work programme and to participate in EU programmes. Possible outputs of such committees include projects, exchanges of experience, joint statements and opinions, common principles, codes of conduct and formal agreements. All of this would have to be consistent with the EU policy of promoting flexible and dynamic social dialogue structures.

The Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services held in 2001 concluded that "when designing and implementing social dialogue, it should be made clear to all stakeholders whether a process of negotiation or of consultation is intended. Where the negotiation process results in an agreement, it should be enforced under relevant legal provisions." [10]

Negotiations in health services have always been embedded in the development of wider health policy. In view of the specific nature of the sector, which affects the social conditions and health of the whole population, the inclusion of civil society in dialogue is often taken into consideration. In health services, as in other services in the public interest, the practice in many countries is to include others in addition to the traditional tripartite partners, in particular the users of services, in such wider dialogue. The Joint Meeting on the Impact of Structural Adjustment in the Public Services held in 1995 concluded that "Public service reforms are most likely to achieve their objectives of delivering efficient,

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mobilization, International Institute for Labour Studies, discussion paper 132 (Geneva, ILO, 2002) pp. 10-12.

[9] T. Fashoyin: "Promoting social dialogue: Issues and trends", in A.S. Oberai; A. Sivananthiran; C.S. Venkata Ratnam (eds.): *Promoting harmonious labour relations in India: Role of social dialogue* (New Delhi, ILO/SAAT, 2001), p. 36.

[10] ILO: *Note on the Proceedings*, loc. cit.

effective and high-quality services when planned and implemented with the full participation of public sector workers and their unions and consumers of public services at all stages of the decision-making process". [11]

In October 2001 the Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services concluded that in the context of decentralizing services in the public interest "the process [of social dialogue] may take place in several stages and should be supported by an external dialogue between the municipality, as the responsible government structure, and the citizens and users". [12] This in turn certainly also has an impact on tripartite social dialogue. The New Zealand Health Strategy document issued in December 2000 includes in the seven principles for health-care delivery the "active involvement of consumers and communities at all levels". [13] It is important, however, to distinguish between one aspect of social dialogue which deals with service development and policy and should involve as wide a range of stakeholders as possible, and another aspect which covers wages and terms and conditions of employment, and which should concern employers (public and private) and workers' organizations.

There is clearly a need at sectoral level to set up an agenda for social dialogue. This may occur in several steps, from informal networking and discussion to formal negotiations. In the EU, informal discussions first led to a Joint Declaration [14] in 1996 by employers' and workers' organizations, which since then have taken further steps towards forming a sectoral dialogue committee.

In formal social dialogue, the parties concerned need official recognition and certification. In Canada, this task is carried out by the Canada Industrial Relations Board, which implements the procedures for trade union recognition set out in the Canada Labour Code (1985). The Board determines the unit that is appropriate for collective bargaining. A "unit" means a group of two or more employees. For professional employees, the Board determines the unit appropriate for collective bargaining. It may decide on the inclusion of employees from more than one profession and of those performing functions without professional qualifications. In the United Kingdom, the Employment Relations Act 1999 introduced a new procedure for trade union recognition in units employing more than 20 persons and a model pattern for conducting collective bargaining. [15]

In times of structural change it may be necessary to set up structures such as committees and forums which monitor the representation of tripartite interests in social dialogue. These institutions may have general coverage or cover specific sectors. In Hungary, the general function was carried out by the tripartite Interest Reconciliation Council (IRC), set up in 1988. In 1992, the tripartite Interest Reconciliation Council for

[11] ILO: *Final report*, Joint Meeting on the Impact of Structural Adjustment in the Public Services (Efficiency, Quality Improvement and Working Conditions), Geneva, 24-30 May 1995, p. 20.

[12] ILO: *Note on the proceedings*, Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services, Geneva, 15-19 Oct. 2001, p. 32.

[13] R. Gauld: *Revolving doors: New Zealand's health reforms* (Wellington, Victoria, University of Wellington, 2001), p. 189.

[14] Joint Declaration of the CEMR Employers Platform and EPSU on Modernization of Public Services, Nov. 1996; http://www.ccre.org/sodmod_an.html

[15] J. Lethbridge: *Social dialogue in health services – Four case studies*, Sectoral Activities Programme Working Paper (Geneva, ILO forthcoming).

Budgetary Institutions (IRCBI) was established to cover primarily public services, including health services.

The IRCBI was the national consultative and negotiating forum for public services, including health services, financed out of the central state and municipal governments' budgets. [16] It dealt with labour relations issues and financial and regulatory aspects that determine the terms and conditions of employment for public service employees. Within the IRCBI framework the parties (central and municipal governments, trade unions for the public service) negotiated and concluded agreements on certain labour relations issues (such as job classification, salary scales), and held consultations on draft legislation of relevance to the public service and on general economic and social issues. The IRCBI had a leading role in setting criteria of national-level representiveness for trade unions. The assessment of representiveness was linked to the results achieved at the public servants' council elections (provided for in the Act of 1992 on the legal status of public servants) which were held in 1993, 1995 and 1998. In order to be qualified as representative, a union had to obtain at least 10 per cent of the votes at national or municipal government or institutional level. In November 1999, however, a decree stipulated that social dialogue would only take place at sectoral level within the public service, thus implicitly dissolving the IRCBI. The ICR was also dismantled but replaced by several other national bodies dealing with labour issues. In late 1999 negotiations took place between the Forum for the Cooperation of Trade Unions (SZEF), the biggest public sector trade union, and the Government, leading in March 2001 to a three-year agreement which provided for (a) the establishment of a special forum for social dialogue covering all public employees, including those in the health service; and (b) an average wage increase in the public sector equal to the rate of inflation plus half of the real growth of GDP.

In some countries, even though national tripartite institutions have been established by law, their use and performance have not always been very consistent, as was observed in the case of Kenya, where interest in using the national tripartite machinery on labour market and related issues began to gather momentum in the late 1990s. Today, the National Tripartite Consultative Committee (NTCC) is seen as an important forum through which key policy issues on industrial relations and other labour market issues are formulated. [17]

Social dialogue institutions (formal or informal) may also be created for a specific programme or its preparation. For example, in an effort to increase minority employment, in 1992 the Canadian Province of Saskatchewan launched the Aboriginal Employment Development Programme (AEDP), which started its activities in the health sector (described in more detail in subsection 2.8.2). After individual partnership agreements were concluded at district level, an agreement at provincial level was signed in 2000 between the Department of Intergovernmental and Aboriginal Affairs (IAA), the Saskatchewan Association of Health Organisations (SAHO) (as the employers' organization) and the Canadian Union of Public Employees (CUPE). Subsequently, a tripartite committee was created to prepare social dialogue and the relevant educational and training programmes.

National social dialogue might be limited through provisions in international agreements or treaties. In the EU, health care is the responsibility of Member States but EU

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[16] L. Héthy: *Hungary: Social dialogue within and outside of the framework of tripartism*, InFocus Programme on Strengthening Social Dialogue, Working Paper No. 4 (Geneva, 2000), pp. 10-11, 22.

[17] T. Fashoyin: *Kenya: Social dialogue and social and economic development*, InFocus Programme on Strengthening Social Dialogue Working Paper No. 3 (Geneva, ILO, 2001), pp. 25-26.

legislation influences the nature of delivery and hence the social dialogue on delivery. The areas in which EU legislation has an impact on national health policies are regulations on the internal market of the EU, as well as those on competition and trade. In relation to the internal market, freedom of movement of goods, people, services and capital has furthered the liberalization of national health policies. In this context, the European Court of Justice ruled recently that patients are entitled to treatment in another EU country, at the expense of their own health authority, if they face undue delays at home. [18]

The creation and maintenance of networks among the social partners are indispensable for social dialogue. In the EU, where the hospital sector alone is estimated to account for 15,000 hospitals and 5 million employees, information technology (IT) is being explored as a means of facilitating such sectoral networking. [19] Although such "virtual" institutions for social dialogue are still in their infancy, their potential should be taken seriously, since they may allow a sustained process of dialogue integrating a substantial number of persons and organizations over long distances at a limited cost. The experience of virtual learning institutions may be useful in evaluating the potential of IT in this context. Certainly, this type of communication is more amenable to processes of information and consultation. The possibility of establishing more formal types of social dialogue through IT is another dimension to be explored. In the context of European social dialogue, the launching of transnational projects in health services includes the establishment of a web site (www.eurocarenet.org) with the objective of promoting networking and social dialogue in the hospital sector. Besides access to information and documentation, the web site offers discussion forums on social dialogue issues and links to relevant organizations.

2.3. Government structures

For effective social dialogue, all relevant government structures have to be involved. In addition to ministries in charge of labour, the process should include the ministries of finance, planning, economic development and education. In the case of the health services, the ministries responsible for health and the public service should also participate. In decentralized services, various levels of government structures have to be involved, including local authorities.

Governments have a role to play, both as employer and as regulator, in health services. Certain government structures may also be responsible for ensuring coordination between the public and private sectors in health services.

In New Zealand, under the health reforms begun in 1999 upon the election of the Labour-Alliance coalition Government, the District Health Boards (DHBs), as decentralized health authorities, were assigned responsibility for providing "for the effective coordination of the planning, provision and evaluation of health services between the public, private and non-government sectors". [20]

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[18] C. Fischbach-Pyttel: opening statement at the Second Conference on the Social Dialogue in the Hospital Sector in Europe; http://www.eurocarenet.org/allefiler/Taler1/Tale4-Carola.shtm

[19] EuroCareNet: *Change of work organisation and development of key qualifications: A collection of experiences from a Leonardo da Vinci project* (2001), p. 125.

[20] Gauld, op. cit., p. 181.

In view of the function of the government as employer, a variety of decentralized structures and arrangements have to be considered. Decentralization is often intended to take place within the limits of existing financial and staff resources, if not less. Decentralization and devolved human resources responsibilities make it difficult, however, for the central government to calculate staff requirements and control staffing levels. In New Zealand, for example, during the 1999 health reforms, the Ministry of Health decided to keep staff levels stable when devolving functions to the 21 local agencies of the DHB system. It was often argued that the staffing numbers recommended by the central authorities were not sufficient to provide for the DHB functions. [21]

Collective bargaining in the public service raises specific problems. [22] On the one hand, there are often conditions of service which leave little room for negotiation. In the public health services sector, this has sometimes prompted proposals to delink the conditions of service of health workers from the public service. On the other hand, the remuneration of public servants has financial implications for public budgets, which makes the negotiating parties dependent on the administration at national level. Nowadays, certain limitations may even result from the budgetary implications of agreements and treaties at regional or international level. For example, the EU agreement on the introduction of the Euro prescribes maximum rates of budgetary indebtedness for the member countries.

These problems are compounded by other difficulties such as the determination of issues for negotiation and their distribution among the various levels within the complex structure of the State, as well as the determination of the negotiating parties at these levels.[23]

This is why the Labour Relations (Public Service) Convention, 1978 (No. 151), and the Collective Bargaining Convention, 1981 (No. 154), allow special modalities of their application to be fixed for collective bargaining in the public service. The cases in which this is possible have to be carefully examined, however. The ILO Committee of Experts on the Application of Conventions and Recommendations expressed the following opinion: "Legislative provisions which allow Parliament or the competent budgetary authority to set upper and lower limits for wage negotiations or to establish an overall 'budgetary package' within which the parties may negotiate monetary or standard-setting clauses (for example: reduction of working hours or other arrangements, varying wage increases according to levels of remuneration, fixing a timetable for readjustment provisions) or those which give the financial authorities the right to participate in collective bargaining alongside the direct employer are compatible with the Convention, provided they leave a significant role to collective bargaining. It is essential, however, that workers and their organizations be able to participate fully and meaningfully in designing this overall bargaining framework, which implies in particular that they must have access to all the financial, budgetary and other data enabling them to assess the situation on the basis of the facts." [24] A recent ILO study gives an overview of governments' practice of social dialogue in the public service

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[21] ibid., p. 203.

[22] See, for example, Gernigon et al., op. cit, pp. 48-49.

[23] ibid.

[24] ILO: *Freedom of association and collective bargaining*, Report III (Part 4B), International Labour Conference, 81st Session, Geneva, 1994, para. 263, ibid.

in selected countries, namely Australia, Barbados, Canada, Egypt, India, Mali, the Philippines and Spain. [25]

As regards the agenda of social dialogue, the challenge for the government is how to initiate and sustain reform processes which lead to quality and cost-effective health services but which do not require additional resources and raise difficulties for the implementation of the reform process itself.

The health sector reform initiated in 1999 in New Zealand is an example of the range of activities to be undertaken and the partners to be involved in this process. [26] After the 1999 elections, the Government established a reform process whose implementation was still under way in 2002 after the planning and legislative phases took place in 2000 and 2001. To avoid resistance against change and to mobilize the support and cooperation of all parties concerned, at central and decentralized levels, a detailed planning process with scheduled steps was established (table 2.1). Since the overall goal of the Government was to improve general health and to reduce disparities between population groups, particular attention was given to equal opportunities for all population groups, including the Maori indigenous people.

Table 2.1.   Timetable for health sector change in New Zealand

Policy development, consultation, legislation	Indicative dates
New Zealand Health Strategy development and consultation	Jan-June 2000
Structural design policy papers to Cabinet committees	Feb.-Apr. 2000
New Zealand Public Health Services Bill drafted	Apr. 2000
Bill introduced	May 2000
Bill before Select Committee, consultation, third reading	May-Sep. 2000
Implementing sector change	
Interim Health Funding Authority (HFA) Board established	Feb. 2000
Expectations to HFA and Hospital and Health Service (HHS) Boards (policy settings)	Feb. 2000
HHSs begin transition (additional directors, subcommittees)	From Feb. 2000
HFA disestablished (following enactment of legislation)	By Nov. 2000
Establish and appoint transitional District Health Boards (DHBs)	By Nov. 2000
DHB members elected (and appointments revised)	Oct.-Nov. 2001

Source: Minister of Health: Health and disability changes and their implementation, Memorandum to Cabinet Business Committee (Wellington), cited in Gauld, op. cit., p. 187.

The plan had to be amended, however, since implementation ran behind schedule and health providers had to be more closely involved. The process was described as a mix between a "top-down" and a "bottom-up" approach. A process of social dialogue took place to establish the policy itself and also to undertake implementation. As part of the decentralization process, the Ministry of Health itself underwent restructuring in 2000. During the transition towards the decentralized system of District Health Boards (DHBs) substantial problems were anticipated and DHB planners were asked to list the expected risks and the management strategies to tackle them (table 2.2).

[25] J.L. Daza Pérez: *Governments' practice of social dialogue in the public service*, Department for Government and Labour Law and Administration (Geneva, ILO, forthcoming).

[26] The information on New Zealand is mainly drawn from Gauld, op. cit., pp. 179-211.

Table 2.2. Transitional risks and their management in District Health Boards (DHB) in New Zealand

Risk	Management strategy
Increased costs of planning, consultation, communication, etc. Lack of expertise to undertake needs assessment; Community expectations too high	Ensure reimbursement from Ministry of Health Shared development process Recruit epidemiologists/demographers from abroad Regular engagement with community
Failure to achieve Maori partnership	Maori health committee established Partnerships established
Inability to establish priority framework	Work with Health Funding Authority (HFA) locality office to acquire knowledge and skills required
Inadequate information systems Inadequate information availability Perception of hospital/public provider favouritism	Local/regional action plan under development Work to attract experienced HFA staff Locate DHB away from hospital Ensure transparent contract process
Inability to finance DHB plans	Seek assurance on funding levels from Ministry of Health
Differing motivation/objectives of providers	Engage providers in annual and strategic plan development
Workforce under additional pressure through transition	Ensure active human resource management
Loss of key staff through transition from HFA	Request Ministry of Health to develop national human resource strategy
Increased transaction/management costs	Develop clear plans and budgets
Expectation of all interest groups being included in DHB committees	Promote service-based strategic planning groups
Existing risks and liabilities transferred to DHB without due recognition	Ministry of Health to lead process of "due diligence" of HFA and Hospital and Health Service (HHS); DHB input into this
Insufficient time to plan/prepare for 1 July 2001 transfer of funding responsibilities for personal health Lack of HFA contract information	Focus on supporting personal health working group Shared Services Bureau work to cover all issues in detail Make "ballpark" estimates based on available information
DHBs fail to develop "funder culture"	Reflect change at governance levels Recognize need for change in employment policies Involve/inform HHS management about change

Source: Gauld, op. cit., pp. 204-205.

Brazil and Chile have also decentralized their government structures in the health sector (for a detailed account of the Brazilian and Chilean experiences see subsections 2.8.1 and 2.8.3.). In Brazil, the Unified Health System (SUS) was created in 1988 to achieve universal coverage and equitable access to health care. This was to be done through the decentralization of health system management to municipal authorities. In 1997, a National Negotiating Committee was established by the Ministry of Health to address labour conflicts at the various levels of the SUS.

In Chile, the Ministry of Health manages and regulates the health sector through 29 regional agencies which are responsible for the delivery of health services, health promotion and health protection programmes. Since 1998, family health centres have been established to provide basic care, including home visits and family advice. Despite decentralization, these structures report to the central Ministry of Health. In the year 2000,

a health reform process was started with the participation of the social partners and other groups of civil society. [27]

2.4. Employers and their organizations in health services

Employers in health services have undergone considerable changes over the last two decades. In the past, the ministry of health was often the biggest national employer in the sector and led the collective bargaining process and other mechanisms of pay determination at national level. In many countries, health services have traditionally followed the general provisions for public service personnel. With the decentralization of health services to local and regional authorities, and the emergence of more independent public enterprises in the health sector, there are now a variety of public employers, with new representative organizations. Focusing on better quality and more efficient services, health services today have created smaller local units in which new managers have been given decision-making power. The public employer has in many cases been replaced by more independent employers striving to achieve efficiency under local conditions. At the same time, cooperation and coordination with other similar public or semi-public employers are still lacking in many countries. These public employers have created their own organizations, some of which have established close links with private employers, as in the case of Kenya, where the Association of Local Government Employers is part of the Federation of Kenya Employers. [28]

Employers in the non-profit sector of the private health services often maintain close links with the public employers. In a number of countries, such as Germany, they adhere to public service agreements on terms of employment and working conditions. In some cases, however, they do not conclude collective agreements with health workers' unions, but rely on individual contracts.

In the private sector, the medical profession is often largely made up of self-employed practitioners who employ a small number of personnel in their practices. In some countries, such as the United States, self-employed health personnel have become increasingly involved in negotiations with private health plans such as the Health Maintenance Organizations (HMO). Consequently, they have been seeking representation through networks and associations in order to enter into social dialogue with the purchasers of their services. In Brazil, about one-third of the country's independent medical doctors are organized in cooperatives which have federated into the world's biggest health provider cooperative, covering approximately 11 million users. [29]

The increasing need for health services has given rise to wider private business interest in the sector and has led to the emergence of new employers in other service sectors, such as insurance, cleaning, catering, information technology and management. A number of private employers have embarked on the provision of services in the public interest and thus entered regulated markets. These employers are often affiliated to associations outside the health sector and prefer to carry out bargaining at the enterprise or individual level.

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[27] Lethbridge, op. cit.

[28] Fashoyin: *Kenya,* op. cit., p. 8.

[29] G. Ullrich: "Innovative approaches to cooperation in health care and social services", in *Journal of Cooperative Studies* (Manchester), Vol. 33, No. 1, Apr. 2000, p. 57.

There are, however, other private companies with a long history of health-care provision: for example, Kaiser Permanente is one of the biggest HMOs in the United States and since the late 1990s has been developing social dialogue with a coalition of health workers' organizations (box 2.2).

Box 2.2.

Kaiser Permanente, United States

Kaiser Permanente evolved from industrial health-care programmes for construction, shipyard and steel-mill workers during the Second World War. Its founders, the entrepreneur Henry J. Kaiser and physician Sidney Garfield, pioneered the concept of prepaid health care which should be affordable, accessible and high quality. Kaiser is now one of the biggest HMOs in the United States, covering over 8 million users and employing over 100,000 physicians, nurses, allied health-care workers and business professionals. The organization consists of two parts: the not-for-profit Kaiser Foundation Health Plan and Hospitals, and the Permanente Medical Groups. In addition to its national headquarters in Oakland, California, Kaiser Permanente has divisional facilities in California (employing 7,000 physicians and 80,000 other professional and allied workers) as well as in eight other states.

In 1997, the AFL-CIO Coalition of Kaiser Permanente Unions (consisting of 33 trade unions and professional associations in health services and other sectors) and Kaiser Permanente entered into a National Labor Management Partnership (LMP) Agreement, followed by a long process of social dialogue and collective bargaining that led in September 2000 to the conclusion of a National Agreement. The National Agreement provides a framework in which trade unions and employees are integrated into planning and decision-making forums at all levels, including budget, operations, strategic initiatives, quality processes and staffing. It is intended to support the LMP at local and national levels. It covers the privileges and obligations of partnership, providing mechanisms for spreading partnerships and organizational transformation; it contains specific provisions on compensation, benefits and dispute procedures and on the scope, application and term of the agreement. The agreement was the result of cooperation among some 300 representatives of trade unions and management at all levels.

Partnership activities have since been extended to other facilities of Kaiser Permanente and to new issues. In the area of shared decision- making, a joint labour-management subcommittee is developing a national policy and a decision-making process. Among other issues, the subcommittee will examine the feasibility of "contracting back in" work which is currently contracted out by Kaiser Permanente.

Source: http://www.kaiserpermanente.org; http://www.unac-ca.org/pdf/nationalagreement2000.pdf

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A relatively new challenge for many such employers is public-private partnerships, whereby the public health services purchaser establishes agreements with private providers, as the National Health Service (NHS) of the United Kingdom recently did with the private multinational company BUPA. Under the agreement, the BUPA-owned Redwood Hospital, in Redhill, Surrey, will perform 5,000 routine operations each year in order to cut waiting lists. BUPA will bill the NHS for the work. The scheme was to start in April 2002. This will be the first of 20 diagnostic treatment centres promised by 2004 in the Government's NHS plan. The target is to reduce the waiting period for an operation to a maximum of six months by 2005. [30]

In the EU, in the hospital sector alone, it is difficult if not impossible to find one partner who would represent employers' organizations. [31] Hospitals are run by state, local or regional authorities, church or private organizations. These organizations are often, but not necessarily, affiliated to national cross-sectoral employers' organizations, which in turn are part of the Union of Industrial and Employers' Confederations of Europe (UNICE) or the European Centre of Enterprises with Public Participation and of Enterprises of General

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[30] BBC News: *Unions attack private hospital deal*, 4 Dec. 2001; http://news.bbc.co.uk

[31] M. Tast, opening statement at the Second Conference on the Social Dialogue in the Hospital Sector in Europe, 4-5 Feb. 2002.

Economic Interest (CEEP). All the municipal organizations are affiliated to the Council of European Municipalities and Regions - Employers Platform (CEMR EP). According to the preliminary results of a study on the representiveness of CEMR EP, at least in certain Nordic countries (Denmark, Finland and Sweden) and some other EU Member States, public local health care has been organized in such a way that local authority employers or their associations are bargaining parties in the hospital sector. However, there is no clear sectoral representation at European level for employers, neither for the public nor for the private health services.

In Denmark, the Association of County Councils serves as the central collective wage bargaining organization of the counties. The association and the national trade unions negotiated a central framework agreement on pay, working hours and other conditions of work, taking account of the national economic situation. A trend in recent years has been the further devolvement of power and responsibilities in regard to negotiations and agreements to social partners at the county or hospital level. This is part of a strategy aimed at giving workplaces more flexibility and freedom within a national framework. [32]

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Box 2.3.

An employer's perspective from Denmark

"I must stress that the defining characteristics of the health-care sector make it so obvious that you cannot simply take on an employer or management perspective when dealing with the sector. From my point of view you have to involve and commit the employees – otherwise you will not succeed in building and developing a health-care sector to match the needs of the twenty-first century."

Source: Bent Hansen, County Mayor of Viborg, Denmark, Chairman of the health services committee of the Association of County Councils in Denmark, speaking at the Second Conference on the Social Dialogue in the Hospital Sector in Europe, Brussels, 4-5 Feb. 2002; http://www.eurocarenet.org/allefiler/Taler1/tale7-BentHansen.shtm

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The challenges facing employers in social dialogue lie in the areas of recruiting and retaining qualified personnel, implementing performance management and keeping costs low while meeting the requirements of the purchasers of health services. These challenges exist irrespective of the public or private nature of the purchasers of health services. In view of the scarcity of qualified personnel, the concern for lifelong learning and the right skill mix is high on the agenda. For example, the European employers affiliated in UNICE have stressed the importance of developing lifelong learning.

2.5. Health workers and their organizations

Health workers have traditionally had a high degree of unionization and/or membership in professional associations. Since they are employed mainly in the public service, a relatively large proportion of these workers are members of public service organizations. For example, the unionization rate is over 90 per cent in Denmark, in Italy it ranges between 50 and 68 per cent, depending on the category of workers, [33] and in

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[32] B. Hansen: Presentation of national health system models: The Nordic Model, presentation at the Second Conference on the Social Dialogue in the Hospital Sector in Europe, Brussels, 4-5 Feb. 2002; http://www.eurocarenet.org/allefiler/Taler1/tale7-BentHansen.shtm

[33] S. Dragonetti: The Italian model of social dialogue in the National Health Service, presentation at the Second Conference on the Social Dialogue in the Hospital Sector in Europe, Brussels, 4-5 Feb. 2002.

Ontario, Canada, it lies at 43.9 per cent. [34] As a result of privatization and contracting-out, membership in public service unions appears to be decreasing, however. Some organizations have diversified to represent health workers in the private sector as well. Nevertheless, the main partner for health workers' unions is the government. Their approach to social dialogue is oriented towards health services as a public service, as expressed in various conceptual statements made by Public Services International (PSI) (box 2.4).

Box 2.4.

PSI and social dialogue: A policy statement

"No trade union strategy has a hope of success unless trade unions are determined to take themselves seriously and build strong, well-resourced, effective democratic organizations which give workers the power and ability to organize society in their interests. Any strategy which does not start from that premise is doomed to fail. Once workers are organized they must then set several political objectives (sometimes with the assistance of others in stronger positions) on which they have to convince their fellow citizens, their employers and their governments:

- the State is to play an agreed role in ensuring funding for, and provision of, a number of goods and services (social and material) which are essential for the effective functioning of their society;

- the State must treat its citizens, and especially its own employees, fairly;

- the political economy of the country is to be based on consensus and political and economic participation by all.

Specifically, trade unions, as workers' representatives, must demand to be treated as genuine social partners in all major socio-economic planning and decision-making. Full social dialogue. Nothing less. If these principles are respected by the government, then trade unions can consider any proposition because they will be able to negotiate in an atmosphere of genuine social partnership. Governments have to choose: either they want workers and their unions as part of the deal or they want them in united opposition. To be fair, some of these social dialogue principles will be seen as both impossible and suicidal by some trade unions because their government is hostile to these principles. In that case, it must be made clear that the government has chosen to throw away a chance for a redesigned society and quality public services and has asked for conflict. In those circumstances trade unions will have to adopt strategies based on entirely different principles from those discussed above. Trade unions must make this matter of the government's choice a very public issue."

Source: Contributed to this report by PSI, Mar. 2002.

In health services, workers' organizations today face the complex challenge of unity in situations of social dialogue. Besides occupational fragmentation in trade unions and associations representing health workers, another challenge to unity lies in the decentralization of public services to local governments or other public employers with their own collective bargaining authority. In fact, it may even be difficult for workers' organizations to identify their dialogue partners. Unions of health workers in Central and Eastern Europe affiliated to PSI report that central, regional and local management often refuse to acknowledge that they are the employer/management. This results in severe difficulties for workers and their unions in dealing with labour relations issues. In turn, this may lead to workers' perception that unions can do nothing for them.

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[34] The figure refers to health and social services. ILO: *Review of annual reports under the follow-up to the ILO Declaration on Fundamental Principles and Rights at Work, Part II*, Governing Body doc. GB. 283/3/2, 283rd Session, Geneva, Mar. 2002, p. 36.

In transition countries, the drop in union membership of health workers after the collapse of the communist regimes has been often dramatic. [35] In the 1990s, unionization fell from 100 to 20 per cent in Lithuania, from 93.5 to 32.5 per cent in the Czech Republic, from 99 to 50.2 per cent in Latvia and from 80 to 30 per cent in Armenia. In Poland the already low level of unionization of 40 per cent dropped to 20 per cent. Only in Kyrgyzstan and Ukraine did membership remain above 95 per cent. The reasons for this drop in unionization levels appear to be complex. In the public sector, management appears to take a neutral stance on trade union activities. However, it is unlikely that private sector discouragement of union membership is responsible for this development, since private sector employment in the health services is still limited in Central and Eastern Europe and the small increase in private facilities does not in any case match the drop in unionization. There remains the explanation that such a decline was to be expected when the obligation of membership was lifted and freedom of association was introduced.

As the ILO/PSI project on the privatization of health-care in Central and Eastern Europe has observed, in some transition countries the number of trade unions representing health workers has remained unchanged, with a single union often representing the workforce, as is the case, for example, in Armenia, Belarus, Kyrgyzstan and the Republic of Moldova. In other countries, the number of trade unions representing different categories of health workers has increased, and may thus have contributed to a certain fragmentation of workers' organizations. This is the case, for example, in Croatia, Lithuania and Poland, where the monopoly of one organization has been replaced by ten, eight and seven organizations, respectively. This has sometimes led to the belief among workers' organizations that the interests of small groups or individual professions are being promoted at the expense of other groups, hindering general agreements and wider representation. The number of professional associations also seems to have increased in some countries, although the data on such associations are incomplete.

According to the research findings of the ILO/PSI project, the role of trade unions in Central and Eastern Europe appears to have evolved in some countries in the last ten years but retains a set of common activities. Most trade unions focus on the negotiation of wages, benefits and training. The negotiating powers of trade unions vary, depending on whether they operate in the private or public sector. Trade unions are more frequently involved in bargaining than are professional associations. Negotiations take place at national, provincial and establishment levels in most of the countries. The number of bargaining levels raises the question of how binding a national agreement can be on the institution employing the staff. Only in Croatia is collective bargaining limited to the national level. The activities of workers' organizations may go beyond collective bargaining: in some countries they are also involved in hospital management, especially on issues relating to workers' rights (for example, in Armenia, Lithuania and Poland); or they may provide financial support towards training and certification (for example, in Latvia). In addition, they may engage in consultations of varied frequency with national partners on topics such as training, working hours and hours of rest, as well as wider issues related to reforms and legislation.

Health sector workers in the region have mainly avoided strike action, although the right to strike is unrestricted in most occupations in the sector, with the exception of doctors in Poland, doctors working in essential services in the Republic of Moldova, and both doctors and nurses in Armenia. However, demonstrations have taken place in nearly all countries in recent years, which indicates that labour relations in health services have

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[35] C. Afford: *Privatization of health care in Central and Eastern Europe*, InFocus Programme on Socio-Economic Security (Geneva, ILO, forthcoming), pp. 40-41.

faced problems even where this is not statistically reflected in working days lost in industrial action. [36]

In contrast to these developments in some countries of Central and Eastern Europe, elsewhere in Europe trade unions in service sectors have merged at national level, providing workers with a more powerful voice in social dialogue. Two examples of such mergers are UNISON in the United Kingdom (box 2.5) and Ver.di, the world's biggest trade union in the service sectors, formed in 2001 in Germany. At the EU level, workers in health services are mainly represented by the European Federation of Public Service Unions (EPSU). It has established four sectoral standing committees, including a Committee for health and social services.

Box 2.5.

Health workers' representation by UNISON in the United Kingdom

UNISON is the result of a merger of three trade unions in the public sector in the United Kingdom. On its formation in 1993, UNISON became the largest union in the country and the most significant representative of workers in the public sector, representing 440,000 workers in the health sector. The formation of UNISON was not only a response to structural changes in public sector employment in the United Kingdom, but also emerged from the need of members to unite for a better position in collective bargaining. Pay has always remained the central issue for collective bargaining. Under the Conservative Governments during the period 1979-97 pay determination was increasingly decentralized in the public sector and further fragmented through privatization. The Community Care Act of 1990 marked the strongest challenge for national collective bargaining and the trade unions' representative role. The division of the functions of the purchaser and provider of health services, as provided for in the Act, also implied private provision of health services and the creation of "internal markets" in the public sector. This development gave the National Health Service (NHS) Trusts freedom to set pay locally and hence furthered the merger of UNISON in order to unite representative functions of trade unions at national and local levels. Subsequently, after many initiatives of industrial action, UNISON achieved a turn in the policy of the Conservative Governments on these issues. Other areas specifically addressed by UNISON have been the practice of replacing nurses by lower paid and less trained health-care assistants and, in general, salaries in lower paid occupational groups, which are overwhelmingly feminized. Today, under the Labour Government, pay systems have not yet changed as significantly as UNISON would wish and have resulted in widening pay differentials through decentralized pay determination and increased private health-care provision, which is associated with poorer pay and working conditions. Further, the competitive element of compulsory competitive tendering has remained an obligation for local governments and its impact on pay levels has not altered. An opportunity may lie ahead for UNISON in relating pay determination directly to the recruitment and retention problems for certain health professions which have resulted in staff shortages for the National Health Service.

Source: C. Thornley; M. Ironside; R. Seifert: "UNISON and changes in collective bargaining in health and local government", in M. Terry (ed.): *Redefining public sector unionism: UNISON and the future of trade unions* (London/New York, Routledge, 2000), pp. 137-154.

In Latin America, the picture is diverse in regard to unity of workers' organizations in the health services. Health workers' representation in Chile is carried out by a variety of organizations based on occupation and the type of health-care facility. This can lead to fragmentation. The main workers' organizations in the health sector are:

- National Confederation of Municipal Health Workers (CONFUSAM);

- National Confederation of Health Workers (CONFENATS);

- National Federation of Associations of Technical Staff of Health Services (FENTESS);

- National Federation of University Professionals in the Health Services (FENPRUSS);

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[36] ibid., pp. 40-42.

- College of Physicians of Chile;

- College of Nurses of Chile;

- College of Midwives of Chile. [37]

The situation is different in Brazil, despite a move towards decentralized collective bargaining in health services in recent years. By law, only one union with *"sindicato"* status can represent a profession and industry in a specific area. There is no legal basis for enterprise-based unions. State intervention has been replaced by judicial enforcement of interventionist laws. The courts play an important role in determining labour conditions and benefits, but their influence is challenged by the increased power of trade unions and the decentralization of collective bargaining. In the health sector, these arrangements are reflected in the number of trade unions at state level and by professional groups which are also affiliated in confederations, such as the National Confederation of Social Security Workers (CNTSS) and the National Confederation of Health Workers (CNTS). Under the Unified Health System (SUS), the SUS National Negotiating Committee was set up in 1997 in response to a need identified by the National Health Conference, the Conferences of Human Resources of SUS and health workers' organizations. The aim was to initiate a national negotiating process to resolve labour disputes. It was the responsibility of the Minister of Health to institute such a negotiating process. This was initiated when the SUS National Negotiating Committee was formally created, with the aim of establishing a permanent forum for negotiations between employers and workers in the health system. This forum was to maintain its links to the National Health Council (CNS) so that the CNS could play a mediating role in the event of conflicts. The National Negotiating Committee has nine representatives of employers in the public sector and government, but none from the private sector, and nine from trade unions and professional organizations. [38]

In Africa, in some countries, the possibilities for public service workers to participate in social dialogue do not exist. In Kenya, although public servants enjoyed trade union rights before independence, the Government banned the Union of Kenya Civil Servants in 1980. [39] The union was replaced by a staff association which had no right to negotiate terms and conditions of employment. Any attempt to organize by workers in parts of the public service, such as medical doctors, was seen as confrontational and firmly resisted. In the late 1980s, a strike by doctors in the public service seeking to establish their own union led to the dismissal of the striking doctors. These restrictions on the public services are not in any way typical of African countries in general. Zambia, for example, has been a pioneer in collective bargaining in the public service, which covers about 100,000 employees. [40]

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[37] Lethbridge, op. cit.

[38] ibid.

[39] T. Fashoyin: Kenya, op. cit., pp. 13-14.

[40] See T. Fashoyin: *Zambia – The contribution of social dialogue to economic and social development in Zambia*, InFocus Programme on Strengthening Social Dialogue (Geneva, ILO, 2002), pp. 16-17.

In some countries and regions workers' organizations have established partnerships with other partners in civil society, including organizations of users of health services. [41] In the EU, such partnerships are quite advanced, with joint policy statements and cooperation on broad social issues. [42] In the United States, after a period of only marginal engagement in broad social issues, a number of joint initiatives have emerged as partnerships between workers' and other civil society organizations. Building labour-community alliances has become one of the top priorities of the United States labour movement today. [43]

As regards issues for social dialogue, the challenges lie in areas such as access to education and lifelong learning in fast-developing health professions and identifying a sustainable skill mix; work organization; pay systems; and a gender balance in reforming health services.

For workers' organizations *lifelong learning* is a relevant issue from several perspectives. It is an instrument of organizational development, it can be a service to members through collective bargaining for vocational learning opportunities and more recently, it was identified as a subject for partnerships with employers. In the United States, the labour management partnership between Kaiser Permanente and the union coalition (see section 2.4) assigns a major role to education and training in developing the partnership itself and also in advancing skills development for the provision of higher-quality services. For UNISON in the United Kingdom, learning is increasingly seen as a strategic resource for social dialogue. Besides negotiating for vocational learning opportunities, UNISON itself offers an education and training programme through its Open College, including basic education courses (in the successful "Return to Learn" programme) and courses leading to vocational qualifications in a range of occupations. Together with education and training for members as unionists, these activities are intended to facilitate organizational renewal and individual development. [44]

Pay systems introduced or changed by governments in health sector reforms attempt to address the quantity and quality of health services with a view to outcomes for public health and for users. Despite concerns about staff motivation, governments will not primarily be guided by such concerns when introducing pay systems. During collective bargaining on remuneration, trade unions and associations have to be aware of the potential for conflict between this focus of governments and workers' interests. [45] In Central and Eastern Europe, remuneration for health workers, in comparison to national average wages, has, with some exceptions, fallen after structural reforms. This is also

[41] R. Simpson: *Decentralization and privatization of municipal services: The perspective of consumers and their organizations*, Sectoral Activities Programme Working Paper No. 176 (Geneva, ILO, 2001), pp. 10-11.

[42] R. Hyman: *Social dialogue in Western Europe: "The state of the art"*, InFocus Programme on Strengthening Social Dialogue, Working Paper No. 1 (Geneva, ILO, 2000), pp. 11-12.

[43] K. Quan: *State of the art of social dialogue: The United States,* InFocus Programme on Strengthening Social Dialogue, Working Paper No. 2 (Geneva, ILO, 2000).

[44] A. Munro; H. Rainbird: "UNISON's approach to lifelong learning", in M. Terry (ed.), op. cit., pp. 175-187.

[45] Afford, op. cit., p. 19.

associated with increased pay determination by individual institutions (public and private) at the expense of national collective bargaining. [46]

In the United Kingdom, nurses' pay has emerged as a key issue in collective bargaining since 1997, in recognition of growing staff shortages in the sector. Before 1997, nurses and other occupational groups in the sector were awarded a single percentage pay increase each year. Since then, pay increases have targeted specific groups in an attempt to recruit and retain nurses and other urgently needed health workers. Newly recruited staff have been given larger pay increases and pay scales have been extended at the top of the range to retain more experienced staff. This has even led to higher earnings in health services as compared to occupations in other public service sectors. There is also a move to compress the 12 existing pay scales into three, for doctors, professional staff and non-professional staff. [47]

Trade unions and associations have stepped up their efforts to address issues of *equal opportunity and treatment* of men and women and other groups of workers through social dialogue (see also section 2.8.2). In the mainly female occupations of the health sector, the challenge of gender issues is mainly related to equal opportunities in career development and pay equity for women. [48] In cases of staff shortages, the question might also arise of how to attract more men into these professions. The share of female employment in health services in general is high (see section 1.3), but varies among the different professional categories. The highest proportion of women can be observed in the different categories of nurses and in low-skilled occupations.

For a number of reasons, career prospects for women in health services are poor in many countries. Career advancement is often not possible under the part-time arrangements frequently used by women health workers. Moreover, in the public service career advancement is linked to seniority and length of service, which places women with family responsibilities at a disadvantage, since they often take breaks for family reasons during their years of service. Yet improved pay in the public service is conditioned on career advancement, and this often explains wage differentials. In 1992, specific consideration was given to this issue at the ILO sectoral meeting on the health services under the agenda item "Equality of opportunity and treatment between men and women in health and medical services".

Pay equity seems at first glance to be self-evident in the public sector, since the remuneration of employees traditionally follows fixed pay scales which are applied equally, often nationwide, to all persons having categorized functions, often across a variety of sectors. A closer look, however, reveals that: (a) the de facto pay of persons and groups of persons is conditioned by a variety of factors other than pay scales; and (b) the changes currently taking place in the public sector result in greater pay flexibility, which

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[46] ibid., pp. 43-44.

[47] Lethbridge, op. cit.

[48] "Pay equity" is defined as follows: "Raising women's wages through a variety of mechanisms including claims for equal pay, equal pay for work of equal value/comparable worth, living minimum wages, and the re-valuation of women's work". J. Pillinger: *Pay equity in the public services*, Research report for the PSI/ILO Partnership on Pay Equity as part of the PSI Pay Equity Campaign, InFocus Programme on Promoting the Declaration (Geneva, ILO, draft) (glossary).

may also pave the way for pay inequity. [49] In the public service, equal opportunity and treatment are not only a legal and social obligation, but also a necessity in times of more user-oriented focus. Women often make up the majority of the users of such services. Moreover, in some professions persistently low remuneration has led to serious shortages of qualified personnel. In 2001, Public Services International (PSI) launched a campaign among its affiliates to raise awareness about pay equity and, in partnership with the ILO, to promote the Equal Remuneration Convention, 1951 (No. 100), and the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), which are fundamental ILO Conventions. Many trade unions have been reassessing their pay equity strategies and putting increased emphasis on gender mainstreaming and the promotion of equality. [50]

The concerns raised above are often shared by workers' and employers' organizations and hence are relevant issues for social dialogue and partnerships.

2.6. Capacity for social dialogue: Prerequisites and criteria

The capacity for social dialogue is based on the legal situation, which is determined by the labour laws and civil service statutes in a given country [51] and by international labour standards and other international agreements and declarations. It is further conditioned by the organizational and human capabilities to initiate and maintain dialogue. These can be influenced and strengthened by education and training and other forms of capacity building.

For social dialogue to be effective, certain prerequisites have to be met, including the following. [52]

First, strong, independent and responsible social partners who have the ability to engage effectively in dialogue: This ability can be strengthened by training for social dialogue. The European projects and conferences on social dialogue in the hospital sector (see section 2.2) expressed the need for intensive training of all parties on social dialogue. Since 2000, the Wolverhampton Health Care NHS Trust in the United Kingdom has been developing a pilot training programme for managers, union representatives and employees. The programme is carried out in partnership with UNISON and is supported by the Department of Trade and Industry (see section 2.8.4). In the United States, the National Agreement of 2000 between Kaiser Permanente (see section 2.4) and a union coalition recognizes that "a significant commitment must be made to invest in the training and education of the workforce. Meaningful participation requires a high level of knowledge

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[49] Wage classifications may have to be replaced by more a detailed analysis of the work carried out. The former German public service union ÖTV (now merged in Ver.di) had demanded the inclusion of additional criteria in work evaluations, such as skills, work stress, leadership requirements and environmental conditions, which may be more appropriate for service occupations. M. Behrens; M. Fichter; C. Frege: *Unions in Germany: Groping to regain the initiative*, International Institute for Labour Studies, Discussion paper 131 (Geneva, ILO, 2002), pp. 21-22.

[50] For various strategies, see Pillinger, op. cit.

[51] For an overview, see J. Hodges Aeberhard: *Comparative study of contents of civil service statutes*, Department for Government and Labour Law and Administration, doc. No. 5 (Geneva, ILO, 2001).

[52] T. Fashoyin: *Promoting social dialogue ...*, op. cit., p. 37.

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and understanding of the business of health care, the operations of Kaiser Permanente and the principles of the Labor Management Partnership". The agreement provides for the joint design of employee education programmes and a joint committee to implement them. [53]

Second, the political will to engage in social dialogue on the part of government and of the social partners: This in turn requires that employers and workers are recognized as partners in development by the government and are also accepted by each other. In New Zealand, a framework was developed in 2001 for a tripartite approach on nursing issues by three District Health Boards (DHBs) in Auckland, the New Zealand Nurses Organisation (NZNO), the Public Service Association (PSA) and the Government. [54] The document identifies the principles, the possible process, the agenda and key success indicators and risk factors. The principles outlined view government, employers and unions as legitimate partners with different contributions and requirements, and reference is made to the system of social dialogue in the EU. Three key principles underpin the initiative to create a tripartite structure and process:

■ recognition of the legitimate role and interests of each party;

■ commitment by all parties to be constructive contributors to the agreed processes;

■ commitment by all parties to adhere to negotiated outcomes.

Third, a concrete agenda on economic, social and labour issues which defines the scope of the dialogue: This also includes the subject and type of dialogue (consultation, negotiation or information). Initiatives to establish a formal framework for social dialogue at the EU level have suggested the following themes for such an agenda: [55]

■ modernization;

■ quality development and changes in work organization;

■ new resource management;

■ best practices;

■ education, training and upgrading of skills;

■ gender and racial equality;

■ involving users/patients in improving health-care quality.

In New Zealand, the following issues for social dialogue were identified in the Proposal for a tripartite approach to nursing workforce issues in the Greater Auckland Region:

■ nurse shortages – recruitment and retention strategies;

[53] National Agreement: Kaiser Permanente – The Coalition of Kaiser Permanente Unions, AFL-CIO, Oct. 2000, p. 14; http://www.unac-ca.org/pdf/nationalagreement2000.pdf

[54] Proposal for a tripartite approach to nursing workforce issues in the Greater Auckland Region (New Zealand, 6 July 2001).

[55] *Social dialogue in the hospital sector*, Report of the Conference held at the European Parliament, Brussels, 12-13 May 2000.

- lifelong learning;

- staffing/workload/skill mix;

- wages;

- health and safety.

Fourth, various interrelated levels during the process of social dialogue, including national, sectoral and enterprise levels, through formal and informal mechanisms: In Denmark, the Association of County Councils, the Danish Nurses' Association, the Danish Association of Junior Doctors and the Danish Association of Public Employees launched a joint project on cooperation and development in hospitals which targets organizational and staff development. The project operates at the national, hospital and ward levels. The ability to take joint action and to develop work organization in a process of social dialogue is considered to be key to the project's success. [56]

Fifth, the type of dialogue suitable to the national situation, as labour relations systems are not always transferable: It is critical for social dialogue to be conducted in compliance with international labour standards. Nevertheless, each situation is unique, since it is conditioned by a number of elements such as the sector in question, the actors involved, and the socio-economic and political environment. A system is not necessarily transferable to another context, and any "patterns" and "lessons learned" have to be examined with care to determine their usefulness for other contexts. Social dialogue may be organized by sector or other criteria, but the criteria have to be explicit. These criteria are frequently identified jointly by the social partners and monitored in a process of social dialogue. Criteria may be of a methodological nature, such as "creating a sustainable process", "arriving at formal agreements", or "avoiding industrial action". The capacity and effectiveness of tripartite mechanisms will be dependent – among other factors – on the representativeness of the actors participating, but may also depend on the mix, frequency and coordination of activities.

2.7. Indicators for the effectiveness of social dialogue

The effectiveness of social dialogue is expressed in terms of the satisfaction of management and workers with the agreements achieved. Since agreements are the result of compromises, there must be a balance between the amount of satisfaction on both sides. Such satisfaction may be gauged from the economic results of the health services and the employment and working conditions of their personnel. The effectiveness of social dialogue also finds its expression in the wider impact of the health services on public health, often described as "health outcomes", and the satisfaction of patients and the general public with the health services received.

In order to monitor and evaluate this satisfaction and the effectiveness of social dialogue there is a need for indicators for assessment. Obviously, such indicators have to be agreed upon through a process of social dialogue. However, it might be even more effective if such indicators are actually developed through processes of social dialogue, thus ensuring the partners' ownership of the indicators and utilization of their specific knowledge.

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[56] B. Hansen, op. cit.

In Denmark, public employers took an initiative aimed at defining indicators for the development of quality of treatment and care in the health services. This project was carried out in hospital wards with the involvement of the associations of nurses, doctors and therapists. Indicators were established and a qualitative assessment was attempted. The main aspects assessed included work satisfaction; productivity and quality; new relations between the parties; and new relations in the wards. [57]

In New Zealand, the parties who signed the Proposal for a tripartite approach to nursing workforce issues identified a number of key success indicators by area of the agenda for social dialogue (table 2.3).

Table 2.3.   Key success indicators by area of the agenda for social dialogue (New Zealand)

Area for social dialogue	Key success indicator
Nursing shortages: recruitment and retention (R&R) strategies	– clear identification of scope of problem – defensible, consistent data – common R&R strategies where useful, and differentiated ones where necessary – reduction in number of vacancies – more appropriately targeted recruitment
Education continuum	– common understanding of career structure – less bureaucracy around skills portability – greater sector input into undergraduate and postgraduate education
Staffing/workload/skill mix	– excellent service delivery – lessening of clinical risk – nurses have more time to provide adequate and appropriate care
Wages	– reliable budget predictions for all parties – mitigate industrial action
Health and safety	– drop in sick leave – increased rates of retention – mitigate employer liability

Source: Proposal for a tripartite approach to nursing workforce issues in the Greater Auckland Region (New Zealand, 6 July 2001).

Indicators might also be developed for evaluating unsuccessful situations. In the case of negotiations, the frequency of industrial action, mediation and conciliation or of failure of negotiations could serve as indicators.

2.8.   Evidence of effectiveness: Cases of good practice

There are many examples of how the lack of social dialogue or its limited implementation has contributed to the failure of change and reforms in health services. However, good practice seems to be a more appropriate model for developing frameworks for how social dialogue should be designed and implemented. Nevertheless, it is a complex task to identify good practice and hence make a choice among various cases, since parts of the processes can always be improved in the view of one or the other social partner. The following subsections describe in more detail four cases, Brazil, Canada, Chile and the United Kingdom, [58] which illustrate how social dialogue has been implemented in the

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[57] EuroCareNet: Change of work organisation, op. cit., pp. 98-101.

[58] The description of the four cases is mainly taken from J. Lethbridge: *Social dialogue in health services*, op. cit.

health sector in different parts of the world. They also show how social dialogue may be complemented by other groups of civil society. It is left to those seeking inspiration for their own processes of social dialogue to draw the lessons learned.

2.8.1. Brazil: Decentralization

As indicated above (see section 2.6), the capacity for social dialogue is based on the legal situation of a given country, which is shaped by national laws and regulations, international labour standards, and other international agreements and declarations. As regards international labour standards, it is to be noted that Brazil has not yet ratified the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87). [59] Nevertheless, as a member State of the ILO, Brazil is bound to respect the fundamental principles and rights at work confirmed in the ILO Declaration on Fundamental Principles and Rights at Work. The right to freedom of association is included in these fundamental principles and rights.

The municipal health councils have been chosen as an example of social dialogue in health services in Brazil. Health councils were set up as part of the Unified Health System (SUS) under the decentralized health system reform in the early 1990s. Members of the councils are drawn from three groups: government officials/health service managers; health workers; and users of services. They operate at local, municipal, state and federal levels. The aims of the health councils are:

■ to monitor the health of the population in relation to health risk and health rights;

■ to promote, protect and rehabilitate the health of the population and those most at risk;

■ to develop strategies and implementation plans for achieving health improvements.

The municipal health councils provide an example of how a form of social dialogue can be set up and formalized within a wider system of health reform. They illustrate some of the dimensions of setting up a system of social dialogue at all levels and the challenge of encouraging popular participation.

The 1988 Constitution of Brazil sets out a number of objectives that govern rights to health, social security and social assistance. One of these objectives is "democratic and decentralized character of administration, through four-part management, with participation of workers, employers, retirees and the Government". Furthermore, section 377 of Act No. 8,080 (19 September 1990) establishes the National Health Council (CNS) and Act No. 8,142 (28 December 1990) lays down the requirement for a National Health Conference to meet every four years, and defines the relations between the CNS, the National Health Conference and the local, state and municipal health councils.

The National Health Conference and the health councils, as two forms of popular participation, are given responsibility for overseeing the management of the SUS. Both of these structures are seen as central to the discussion of health policy in each area of SUS management. As well as having specific aims, the health councils are also responsible for: (a) monitoring worker-management relations; (b) addressing complaints from health

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[59] Brazil has, however, ratified all of the other seven core Conventions, including the Right to Organise and Collective Bargaining Convention, 1949 (No. 98).

service users; and (c) organizing multidisciplinary projects for the promotion, protection and rehabilitation of people's health.

How were the partners prepared for the social dialogue?

Preparation for the social dialogue in which the health councils are to play a leading role is based on three forms of action:

- initial development of the concept of social action within the health sector;

- previous experience of participatory structures;

- capacity building for members of health councils provided through support from the CNS, the National Council of Municipal Secretaries of Health (CONASEMS) and municipal authorities.

From 1979 to 1986 a coalition of health professionals, academics, leaders of public agencies and parliamentarians developed a plan of activities for a health reform that would deliver health care to the whole of the population. These activities, termed Integrated Health Measures (AIS), developed a priority policy agenda consisting of a guarantee of universal access to health services and measures for the regulation of relations between public and private sectors, and the democratization of decision-making on policies and priorities. This agenda was discussed at the Eighth National Health Conference in 1986, and a proposal for reform was made to the National Constitutional Assembly which was meeting at the time. The health reform that followed was the result of political and ideological factors rather than financial ones. The health reform law complemented the right, set out in the new Constitution, of the population to participate in decision-making. The coalition that had shaped the health reform introduced in 1988 had been influenced by health participation experiences during the 1960s and 1970s, which continued with the reintroduction of democracy in 1982. These experiences that shaped the health reform and legislation provided important preparation for setting up municipal health councils.

Recent research that has examined the experience of 12 municipal health councils in different states of Brazil found that four municipalities already had local health councils before 1993, when municipal health councils were legally established. The early experience of strong local organization of popular participation in social issues and health meant that these municipal health councils were better prepared to fulfil their responsibilities.

The National Health Council (CNS) has played an important role in supporting the members of the health councils through the National Health Conference and other events. It has facilitated regular meetings of the secretaries of the health councils, while the National Council of [State] Secretaries of Health (CONASS) and CONASEMS have made a substantial contribution by providing opportunities for health councils to meet, discuss common issues and identify capacity building and training needs.

How was the social dialogue initiated?

The social dialogue began with the introduction of the SUS decentralization reform. As a new approach to managing the health sector, the health councils were given a legitimate role in developing health policy. In 1992, the CNS approved resolution No. 33/92 to establish municipal and state health councils. Over 3,000 municipal health councils have been set up throughout Brazil and over 70,000 people are estimated to be involved in such councils.

What methodology and stages were used in the social dialogue?

The process of operating a municipal health council has resulted in changes both in the membership of the council and in the structures and processes linked to such councils. Many of these changes can be seen as developments in the wider process of dialogue established by the municipal health councils.

As a starting point, it is helpful to have an impression of how members of the municipal health councils see their own role and the functions of the council. A study of the user representatives of a municipal health council in Rio de Janeiro was carried out covering a total of 18 members representing users of health services, 15 of whom were males and three females. The largest occupational groups represented were pensioners, professionals and skilled workers. Many of the members were on the health council because of their commitment and others felt that their responsibility was to convey the concerns of the local population about health and health services to the municipal health council and to communicate the views of the council back to local people.

With regard to municipal health councils in general, the study indicated that half of the representatives felt that the councils were important for resolving problems and contributed to social action. However, there were different perceptions of the council's role in improving health services. Some of the representatives felt that their main purpose was to improve health services, others that they were intended to expose the condition of health services and to identify those responsible, while still others considered that their role was to identify problems and involve local people in finding solutions. These responses show that the municipal health councils cover large areas of responsibility and may sometimes be in conflict.

Other forms of popular participation in health services included working groups established by some of the municipal health councils or the regular conferences which the municipal health councils were required by law to hold. Newly emerging groups, such as those formed by trade unions concerned with workers' health, were involved initially through discussions at the municipal health conferences and later by formally joining the municipal health councils. Health conferences provided an important opportunity for discussing the work of the councils. Some municipalities have also set up local health councils to cover localities within their geographical area. These decentralized participation structures have helped improve the dissemination of information and decisions from the municipal health councils, which in turn has led to more effective functioning of municipal health structures.

The overall health reform and decentralization process is gradually reaching all municipalities. Some municipalities have full responsibility for managing the whole health care system, while others manage outpatient and primary health care services. The introduction of even partial management responsibilities has often led to changes in the municipal health councils. It was found that five municipalities made changes in the composition of their councils when they took responsibility for management of outpatient and primary care services. All five increased the number of community representatives.

There have also been changes in the process of choosing the president of the municipal health councils. Initially, in 11 out of 12 municipalities the local Secretary of Health, often a doctor, was the "natural" president of the council. Six municipalities subsequently made internal changes to allow an election. Gaining control over the municipal health budget seemed to be an important factor leading to a more transparent process for electing the president.

Among the persistent issues facing the councils, as seen in the agenda of the National Health Council's annual meeting in 2000, was the need to strengthen the institutional infrastructure for supporting the health councils, to provide information and communication between the councils at all levels, and to strengthen the capacity of the council members. The experience of the past decade is that some councils have been successful in some districts and at some levels in terms of influencing health policy and overseeing the delivery of health services. In some states and municipalities, however, there are still problems with regard to the capacity of council members, as well as splits between members.

How was the social dialogue monitored and evaluated?

In 2000, after ten years of operation, the (CNS) reviewed the experiences of the health councils and the results were discussed with the secretaries of the councils in December 2000. The review examined several aspects of the role and functioning of the councils. It highlights some of the issues that have faced the councils since their establishment.

The municipal health councils are made up of representatives from health service managers/providers (state and private), health workers and users. These three main interest groups have different perspectives. The challenge is for these groups to be able to work together so that they can gather information, analyse strategies and oversee the implementation of health policy. The review argues that this requires the development of a new political culture that will be greater than the sum of the separate interest groups.

Within Brazilian society, social action during the 1990s has been strongly influenced by the transformation of urban workers' movements into pensioners' action groups (Caixas de Aposentadorias e Pensões). There has also been an increase in the number of residents' associations, religious groups, women's groups and other community groups that have started to make demands on health services. The growth of these groups has also had an impact on the municipal health councils. In the 1990s, there were two meetings of council members drawn from state and municipal health councils to discuss the experiences acquired during the setting up and functioning of the councils. Both meetings focused on the role and needs of users and the lowest-paid health workers. In this sense, the concerns of the health councils reflect the wider struggles taking place within society.

The CNS has played an important role in supporting the development of health councils at both state and municipal levels. There has been a successful partnership between the CNS and the health secretaries of the state governments who worked together to register all the health councils (state and municipal) and to improve their functioning through capacity building for their members. The CNS has also been successful in mediating some of the tensions between the state and municipal health councils.

Over 3,000 municipal health councils have been set up during the 1990s. The CNS review concluded that by 2000 there were "new actors" in the health system who had developed a strategic view and awareness of their power within the decentralized health system. The potential of these new actors to influence and change health policy has only just begun to be developed. The secretaries of the health councils concluded that although the councils had developed this vision there were still problems with regard to capacity and operating with other agencies and players.

2.8.2. Canada (province of Saskatchewan): Equal opportunity

A Partnership Agreement signed on 15 November 2000 between the Saskatchewan Association of Health Organizations (SAHO), the Canadian Union of Public Employees (CUPE) Health Care Council and the Saskatchewan Department of Intergovernmental and Aboriginal Affairs (IAA) has been chosen as an example of social dialogue. The aim of the partnership agreement is to increase Aboriginal employment in the health care sector in Saskatchewan province.

In 1992 IAA established the Aboriginal Employment Development Program (AEDP), which used a partnership approach to develop a representative workforce strategy. The health sector was chosen for a partnership agreement because it has a large workforce with a wide range of different occupational groups and because Aboriginal people were significantly underrepresented in the health sector. They only constituted 1 per cent of the health sector labour force at that time but make up about 12 per cent of the population of Saskatchewan.

By 1995, the AEDP had implemented the Representative Workforce Strategy and signed its first partnership agreement with the Saskatoon District Health Board. Between 1995 and 2000, 20 health districts signed partnership agreements and by 2001 they had employed over 900 qualified Aboriginal people.

The aim of the Representative Workforce Strategy is to develop a workforce that is representative of the Aboriginal population at all occupational levels in proportion to their numbers in the province's population. Only about 47 per cent of the Aboriginal population of working age are employed and 46,000 Aboriginal people are expected to be ready to join the workforce in the next nine years.

How was the social dialogue initiated?

SAHO is the bargaining agent for all the health employers in the province. In 1996 it signed a partnership agreement with IAA, under which the parties agreed to identify, in conjunction with unions, provisions in collective agreements that may be discouraging or limiting Aboriginal workers from gaining access to health-care job opportunities and identify and encourage the incorporation into collective agreements of provisions that promote fairness and equity for all current and future health-care employees.

In 1999, the partnership (SAHO and IAA) sought dialogue with the trade unions on the AEDP and invited representatives from CUPE and four other health worker unions to the partnership steering committee table. The committee set up a series of groups to take the work forward. SAHO led two of the groups, which addressed policy development and assessment of human resource and training needs.

How were the partners prepared for the social dialogue?

What methodology and stages were used in the social dialogue?

In order to develop an Aboriginal employment development policy, SAHO invited trade unions, employers, training institutions and the Aboriginal community to participate in a series of group discussions on human resource development and it was agreed that a final policy tool kit and planning guide for a representative workforce were to be available in February 2002. The human resources and training needs assessment process led to a final report in 2000.

CUPE became increasingly interested in signing its own partnership agreement with SAHO and IAA as a result of the discussions with these partners. The three parties prepared a draft agreement, which they submitted to a number of CUPE members in the province and to employers to review and discuss the document.

After initial group discussions, SAHO set up an employer working group made up of chief executives and human resource professionals. After this group had approved the content of the agreement, it was taken to the SAHO board. The formal signing of the agreement between CUPE, SAHO and IAA took place on 15 November 2000.

Under the agreement, CUPE, SAHO and IAA agree in principle to work together to identify possible solutions with regard to the following issues:

■ collective agreement initiatives;

■ development of an Aboriginal/health sector communications strategy;

■ career planning;

■ training needs strategy with appropriate institutions; and

■ cooperation with health sector employers to adopt a strategy to recruit, hire, train and retain Aboriginal workers.

Since the signing of the agreement, a tripartite partnership steering committee made up of representatives from CUPE, SAHO, IAA and additional trade unions has been set up to develop a framework for inclusion of the "representative workforce" in the next round of negotiations. This was taken into the negotiations for the next collective agreement which was ratified in October 2001. Other trade unions have included similar language in their collective agreements. The following issues were covered:

■ workforce representation;

■ workplace preparation: education opportunities for existing staff to deal with misconceptions and dispel myths about Aboriginal people;

■ in-service training, which may include literacy training and career path counselling;

■ Elders: at the request of an employee, an Elder may be present when dealing with issues affecting Aboriginal employees; and

■ accommodation of spiritual or cultural observances.

The steering committee also requested the Government to assist with funding for training – up to Can$3 million for the next three years. Extensive training and educational activities have been set up by CUPE and SAHO for the workforce and employers. SAHO is developing on-line training for new employees in the health sector (both Aboriginal and non-Aboriginal). Both CUPE and SAHO have employed full-time education and programme coordinators to run educational workshops across the province and SAHO has provided training by satellite across the province with its own training videos.

How was the social dialogue monitored and evaluated?

Partnership agreements are co-monitored and co-evaluated through the tripartite partnership steering committee which meets on a regular basis, ranging from twice a year to once a month. At the meeting, IAA and the partners review progress and identify

difficulties, adopting a shared approach to developing solutions. Some of the partnerships have strategic plans, which are reviewed once a year to assess progress. Projects are then prioritized in areas where more progress needs to be made. Regular meetings ensure joint commitment and continuing support.

The AEDP also has provincial initiatives which provide complementary support for the health sector partnerships for example by meeting with trade unions outside the partnerships to raise awareness of the importance of union participation in the Representative Workforce Strategy.

2.8.3. Chile: Health sector reform

The consultation process for the health reform is an example of social dialogue in Chile. Begun at the end of 2000, it is still in progress. The process of social dialogue has not been easy; the account below illustrates some of the pressures that arise in a national policy consultation involving many, often diverse interest groups.

The health sector had been reformed since the 1970s with the expansion of private sector participation through a private health insurance scheme. Many groups in the health sector wanted to develop a new reform that could begin to address some of the problems facing the sector, for example:

■ increasing demand for family health services via the Family Health Plan;

■ a conflict between per capita funding provided by the central Government and increasing demand for services by individuals;

■ inability of municipal providers to deliver services because of lack of funding and lack of financial control at municipal level;

■ skimming of the risk pool by private health insurance schemes – *Instituciones de Salud Previsional (ISAPRE)* with the majority of members aged 25-40 and only 2 per cent over 65.

How were the partners prepared for the social dialogue?

The public debate on health and other social issues since 1990 has provided some experience for different groups, such as trade unions, civil society groups and different levels of government. In 1990 a general framework agreement was concluded, which provided an opportunity for the development of dialogue between the Government, employers and trade unions. More recently, there has been an increase in negotiations between the Government, employers and trade unions on social and economic issues. Many of the trade unions have been preparing statements about future health policies. The overall experience of a wider social debate on health and other key issues has also prepared other civil society groups for this process. In addition, the College of Physicians of Chile, which was excluded by the Government in 1981 from the formulation of health policy, has been regaining its important voice on medical and health issues in Chile.

How was the social dialogue initiated?

In 2000, the Government initiated a process of social dialogue with trade unions, health service users, health professionals, private sector groups and non-governmental groups. This has to be viewed in the context of the previous decade when, with the return to democracy, there were initiatives to stimulate dialogue between the Government and other groups and sectors on a range of issues.

What methodology and stages were used in the social dialogue?

The consultation process can be divided into two stages. The first stage started towards the end of 2000 and continued until April 2001, and involved discussions that informed the public on the proposed health reform. The second stage began in May 2001 with the launching of the proposed health reform and a Health Rights Bill.

At the end of 2000, the Ministry of Health organized a series of "community participation days" to discuss what a future national health strategy and plan should include. Discussions focused on the theme "The health we want for Chile". The information gathered from these discussions was used to develop proposals for the health reform. A wide range of groups were involved in these discussions, including health workers' unions.

A series of meetings with leaders of citizen, community and consumer organizations identified the following main themes:

■ the most important problems at regional and national level should determine national health goals, which would inform the development of a health system based on expert and lay views;

■ improved treatment and quality of care;

■ the health system must be improved in the regions;

■ vulnerable people and those most at risk must be treated without discrimination;

■ health must be recognized as everyone's responsibility; and

■ people must contribute to the promotion of health and the creation of healthy environments.

Additional discussions in March and April 2001 enabled people at local level to contribute to the process.

When the President of Chile launched the health reform, he emphasized that the Government considered health as a priority within other social policies and placed human dignity of the individual at the centre of the reform. The aim of the reform was to achieve a healthy population, with the focus on prevention. Chile would have a guaranteed health plan which would improve access to services. Primary health-care centres would be open all week and on Saturday mornings. The President added that the private sector required regulation, and that people insured under the private health insurance schemes (ISAPREs) would be given improved rights against discrimination. The Government did not advocate either a private or state-run system, but rather one in which both sectors worked well together.

The Health Rights Bill was published in June 2001 and sets out the health rights and obligations of the population. The health rights cover:

■ access without discrimination;

■ treatment with dignity and in a friendly manner;

■ access to family, friends and spiritual support during stays in hospital;

■ opportunities for people to give their views to health workers;

- information on all aspects of health care – clinical and administrative;

- informed consent to receive care and accept or reject invasive procedures; and

- private and confidential information.

Health obligations hold people responsible for working with others to develop healthy environments, and contributing to the care of their own health and that of their family and the community. The health reform will consolidate the protection of people's rights to health and health care and clarify their obligations.

A second phase of the consultation process started with a series of meetings to debate the Bill. Some of the responses from professional groups, trade unions and community groups show the range of perceptions and principles that are being presented and discussed within this process of social dialogue. Many of the responses are a reassertion of people's right to health and the need for a health care system that is equitable and universal. Another shared theme is the importance of strengthening the public health system and the rejection of the idea of health care as a commodity.

Nurses outlined a set of demands to the Minister of Health during the National Conference of the College of Nurses of Chile in 2001. They asked for:

- a greater role in the health reform;

- career improvements that would lead to improved working conditions;

- professional and human resource development;

- an explicit policy to encourage the training of more nurses; and

- a greater role for nurses in the community and in prevention.

These demands of nurses are much more specific than those of doctors and reflect some of the difficulties facing nurses within the public health system.

The College of Physicians of Chile presented a long submission that was very positive about the health reform. They argued for an increase in spending on health to levels comparable to those in other countries. They set out a series of principles to guide the reform:

- a healthy country;

- respect for human dignity;

- health and health care as a social good;

- health and health care as a responsibility of the State;

- equality, solidarity, universality, efficient use of resources, quality and effectiveness;

- a mixed health system, bringing the public and private sectors together with transparency.

The next stage in the consultation process was a series of round tables on health reform which brought together trade unions, employers, health service users, community and neighbourhood groups, consumers and other groups of civil society. These round

tables were launched by the Minister of Health. There were delays in setting up these discussions, and many felt that not all those wishing to participate were present. The round tables ended in a breakdown in October 2001, with criticisms from all participants that there was not enough discussion of fundamental problems and that the elections due in 2002 were politicizing the issues.

The breakdown of the round tables was triggered by the announcement of new draft legislation to guarantee rights to care for ISAPRE users. There had already been a leak of a document in August 2001 that had set out a draft proposal for the reform of the ISAPREs, suggesting a model similar to health maintenance organizations (HMOs) in the managed care systems of the United States. Although this was denied by the Minister of Health at the time, in November the new draft law included some of these recommendations.

By mid-November, many participants in this process of social dialogue were openly critical of the Government and decided to develop their own proposals. The College of Physicians proposed that a national health assembly should be held on 21 November 2001 to put forward an alternative plan. The Government was also criticized for not providing clear leadership, while the Minister of Health and the Executive Secretary of the Commission of Health reform were accused of failing to present a coherent government view.

The process of social dialogue has not been an easy one up to now because of a lack of clarity about the structure of the consultation process. For trade unions, this means that the "spectre" of privatization is hovering over the discussions. A statement by the National Federation of University Professionals in Health Services (FENPRUSS) on 1 December 2001 commented on government proposals to privatize public hospitals through concessions to the private sector. The Government had proposed that the public sector manage and enter into partnership with private companies to build new hospitals. FENPRUSS argued that health workers' unions must oppose this proposal as it furthered the privatization of the health-care system and would affect health service users and health workers. Cleaning, security, laundry and catering services had already been contracted out, which had affected the rights and conditions of workers.

There are obviously differences between the social partners, which are perceived as a conflict of interests arising out of different visions for the health sector. A review of the responses of some of the key health workers' unions, professional organizations and community federations, however, shows that the concept of health as a right is widely shared. The question of funding of the health sector, reform of the public health sector and the role of the private sector within the health sector have been contentious issues.

How was the social dialogue monitored and evaluated?

The process of consultation is still taking place. Different groups will evaluate the process and outcomes in relation to how their visions, aspirations and interests are met in the final reform. The initial results show that there is currently extensive controversy with regard to the process and outcomes so far, largely focused on the lack of clarity about the overall process. Although there has been some consensus on the right to health and health care, agreement has not been reached on how health care should be organized and funded. On the positive side, however, the process of dialogue has enabled different groups to articulate and debate their views. The situation has also made the Government aware of the strength of public feeling in response to its proposals.

2.8.4. United Kingdom: Partnership at work

Another example of social dialogue is the Developing Partnership at Work initiative at Wolverhampton Health Care NHS Trust, a community and mental health organization in the West Midlands region of the United Kingdom.

What changes conditioned the social dialogue?

The concept of partnership at work has been promoted in the United Kingdom by several government departments and organizations. The Department of Trade and Industry (DTI) endorsed this approach in the White Paper "Fairness at Work" presented to Parliament in May 1998. In the supplementary manifesto to this White Paper, "Working for the Future", the DTI envisaged partnership as a way of creating "a better organization of work … to better manage change … based on high skills, trust and quality. [...] working together to develop solutions and achieve consensus". The Employment Relations Act 1999 also aimed to change the culture of relations at work through partnership. Consequently, the DTI set up a fund in 1999 to award grants to organizations in order to encourage this approach.

The Trades Union Congress (TUC) has been promoting partnership at work through the TUC Partnership Institute, which provides research, information, training and support for working in partnership. The TUC's own analysis of the 1998 Workplace Employee Relations Survey (WERS) shows that organizations with partnerships are more likely to be successful. A non-governmental organization (NGO), the Involvement and Participation Association (IPA), has found that a high level of partnership within companies and organizations has led to lower rates of staff turnover and absenteeism and greater employee commitment. [60]

In the health sector, the NHS Taskforce on Staff Involvement recommended that all NHS organizations should make staff involvement in decision-making a priority. One of the Taskforce's goals is to promote good industrial relations in order to increase staff involvement through effective partnership at all levels.

How were the partners prepared for the social dialogue?

In 1995, when the Wolverhampton Health Care NHS Trust was established, several of the services that it delivered were of poor quality and did not meet the needs of the patients/users. The new chief executive felt that the internal culture of the Trust would have to change from a system divided into "two worlds", in which managers took the decisions while staff delivered the services, to a more integrated way of working with greater staff involvement in decision-making. Staff involvement was also considered important because of the need to recruit and retain high-quality staff, reduce absenteeism and improve the organization's ability to cope with change. The Trust also wanted to improve the negative image of the NHS in the media.

From a series of ad hoc initiatives that involved staff in parts of the decision-making process, the approach became more strategic, with management and trade unions working together. As a result the Trust was invited to bid for DTI funds. In 2000, in partnership with UNISON, the Trust was awarded a DTI Partnership Fund grant for a project to develop training for managers, union representatives and employees in partnership skills, including effective communication and joint problem-solving. The aim of this training is to

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[60] The IPA specializes in helping organizations improve their performance and productivity through partnership and employee involvement; http://www.partnership-at-work.com

spread the partnership approach throughout the Trust and thus have a fundamental impact on how the Trust operates.

The training took place in three groups. The trade union representatives received training first. The second group was a mix of trade union representatives and management. The third group involved all staff and management. The trade union felt that the training "broke the ice" with management and staff. It led to the setting up of a communication action group, which has helped to improve communications within the Trust. Communication takes place through a hotline, notice board, briefing bulletin, magazine, newsletter and the Intranet site.

How was the social dialogue initiated?

Wolverhampton Health Care NHS Trust has 1,700 employees organized in seven recognized trade unions. In 1999, the Trust set up a long-term project to promote staff involvement in decision-making. It appointed a union representative to sit on the Board of the Trust. Staff representatives were invited to attend and contribute to the monthly "management forums".

What methodology and stages were used in the social dialogue?

An initial stage was the development of a consultation paper written by the Chief Executive and Human Resources Director entitled "Developing real staff involvement" and drawn from successful experiences of staff involvement, including examples from the private sector. The paper highlighted three areas as being important for effective staff involvement: effective Trust-wide communication; ensuring a balance of work-life activities; and the relationship with trade unions.

A strategy was adopted and agreed by management and the trade unions. It covered the following five steps:

■ defining and developing management standards of behaviour and a leadership style in which staff involvement flourishes;

■ agreeing to the role of trade unions;

■ implementing a communications strategy;

■ developing flexible working; and

■ undertaking an annual staff attitude survey and acting on the results.

The approval of DTI funding for a project gave support to the development and dissemination of a model of partnership and staff involvement in the NHS. The project started in May 2000 and involves four phases. The first phase (June-September 2000) produced a "snapshot" of the Trust, identifying the existing culture and managerial style through interviews and focus groups with staff, managers and union representatives. The results were used as a benchmark for measuring progress. In the second phase (November-December 2000) a practical problem-solving tool was developed for managers and trade unions. The last two phases are ongoing and cover the application of the problem-solving tool to real problems faced by the Trust and the dissemination of the results to other trusts.

The problem-solving tool has five basic themes:

(1) identifying the problem or issues;

(2) clarifying the problem;

(3) involving other stakeholders/players;

(4) problem solving; and

(5) sharing success and learning from failure.

How was the social dialogue monitored and evaluated?

An independent evaluation has been conducted by two academic centres, funded by a DTI grant, but the results have not yet been published. The more tangible results can be seen in some of the changed practices within the Trust. A trade union representative has been included on the board of the Trust and staff representatives have been appointed to many other committees within the organization. This has led to greater staff influence on decision-making and the running of the Trust. Communications have also improved, and staff have more knowledge and understanding of the issues facing the Trust.

Managers now take account of patients and the reality of patient care, and service providers have a better understanding of the external environment within which the Trust operates and why some choices have to be made. Staff turnover is now at its lowest.

There are, however, some reservations about the initiative. The Chief Executive of the Trust feels that there is still a long way to go before employee involvement in decision-making can be considered the "norm". The process is long term and often slow. UNISON's view of the Partnership at Work initiative is that it has been useful in relation to training, health and safety and involving staff in decision-making, but it has been less successful in pay negotiations.

3. A possible framework for strengthening social dialogue in the health sector: Suggested points for discussion

3.1. ILO action to strengthen social dialogue and the relationship of this action to health services

The concept of social dialogue that shaped the ILO's activities in the late 1990s included all types of negotiations and consultations between the social partners at international, national, local, sectoral and enterprise levels. This approach evolved against the background of three main challenges to the social partners:

- How can traditional collective bargaining, which was often confrontational, be enriched by a dialogue carried out in cooperation in order to achieve a "win-win" outcome for all parties concerned? Can collective bargaining be widened upstream to allow the social partners to participate in the earlier stages of decision-making in order to facilitate collective bargaining processes later?

- How can dialogue with the social partners, as well as with other stakeholders, be taken into consideration when their participation in upstream decision-making is targeted?

- How can collective bargaining, which is often decentralized to local and enterprise levels, be pursued according to each country's situation, bearing in mind that social dialogue at central levels can impact on socio-economic development, while that at decentralized levels can provide flexible and appropriate responses to labour market developments?

Social dialogue offers an opportunity to address the above challenges, but in order for it to be successful there are certain prerequisites that need to be met, for example:

- recognition of workers and employers as partners in the dialogue with governments is essential;

- while it is not always necessary to reach consensus, mutual trust and understanding are indispensable: each party needs to recognize the other parties without abandoning the interests of those whom it represents;

- the parties must bear in mind that success is largely dependent on the socio-economic environment.

Although the aim is to arrive at "win-win" situations, social dialogue is not necessarily a process devoid of confrontation among the parties. Another point to bear in mind is that patterns of collective bargaining are shaped by changing work organization and organizational change. For example, contracting out and the globalization of enterprises make participation in upstream decision-making all the more necessary. As the pace of change accelerates, social dialogue needs to be established as a permanent process. Social dialogue as a process can help employers and workers to cope with processes of change.

Within the ILO programme of work, social dialogue reflects the basic ILO constitutional principle of tripartism, and is thus at the core of ILO action. It is a strategic objective in its own right and a fundamental process for achieving all ILO objectives.

However, many countries face difficulties in using social dialogue to its full potential. Today, there are three major factors which help to explain this situation and which the ILO is expected to influence for the better. [1]

The first factor is the lack of effective social dialogue frameworks and institutions in many countries. Many governments are not committed to meaningful dialogue with the social partners on social and economic policy issues. This can be reflected in a lack of guarantees for freedom of association and collective bargaining, especially where the public sector is the major employer. Even when these guarantees exist and are normally respected, privatization and public sector reform processes have often proceeded without the involvement of the social partners for more positive outcomes. Such outcomes are very important in the health sector.

The lack of effective frameworks and institutions for social dialogue can also be due to the fact that employers' and workers' organizations are neither strong nor independent of government influence. Even where the climate is more supportive, employers' and workers' organizations often lack broad membership bases and effective services. Many find they have less influence over policy decisions than they expect, and some lack the capacity to address increasingly complex policy debates. This is especially true in the health sector, which has been and often still is part of the public sector.

The second factor is rapid change in the traditional environment of collective bargaining. National and industry-level collective bargaining is giving way to enterprise-level decision-making and more fragmented labour markets. Governments often take a less active role in the labour market and their labour ministries usually have limited influence on major government economic and social policy choices. These policy decisions are nearly always made by government. Key decisions are also being made by the many new or growing regional or subregional organizations that may or may not involve a role for the social partners.

The third factor concerns representation and links to other groups. For example, labour ministries and employers' and workers' organizations do not always effectively address issues of particular concern to women. This reflects the low representation of women as participants and decision-makers in many organizations. Some of these organizations also need to develop effective strategies to work with the many groups in civil society that have an interest in workplace, social and economic issues.

Promoting a participatory process through social dialogue gives a voice to those most directly involved in the world of work and is essential to the conceptual framework of decent work. This cannot take place in a vacuum. ILO activities in support of social dialogue serve to strengthen the capacities of partners to achieve specific decent work priorities at a national, regional or sectoral level. They are also meant to bring the experience of working men and women to the global forefront.

To do so, the ILO has expanded its research base and its work with other international organizations, such as WHO in the health sector, especially those most involved with economic and social development. It continues its support to workers' and employers' organizations and labour ministries that are faced with the challenges of a rapidly evolving social environment. Much of this work takes place through technical cooperation and involves collaboration between headquarters and field structures. Mostly it centres on helping to build coherent country-level strategies for social dialogue and decent work based on full participation of the social partners. The ILO's work on sectoral activities

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[1] ILO: *Programme and Budget for the biennium 2002-03* (Geneva, 2001), p. 37.

involves action under each of the strategic objectives, guided by the selection of agenda items for sectoral meetings by the Governing Body and by the results of these meetings. Coordinated work on social dialogue to promote decent wages through wage-fixing machinery and collective bargaining, including reducing the persistent gender wage gap, is an important part of the ILO's activities. [2] This is especially important in the health sector, where many services are highly feminized.

The ILO's strategy to support the development of employers' organizations and to attract new members to those groups continues to stress strategic planning and in-depth dialogue that will enable identification of the priorities of social dialogue.

Achievement of this objective is critically linked to the improved management of employers' organizations. Accordingly, the main vehicles are: staff training; support for networking with other employers' organizations and institutions; building or improving organizational information and applied research capacities; support for service development through information, research and training materials; and strengthening the organizational capacity to bring about the changes needed for business and socio-economic development.

One way in which the ILO supports the delivery of new or improved services for social dialogue is by using case studies on benchmarked best practices in employers' organization services.

Employers' organizations receive support on human resource management issues for members to apply in their own workplaces. The values expressed in the ILO Declaration on Fundamental Principles and Rights at Work figure prominently in this work.

The ability of employers' organizations to participate effectively on behalf of members through social dialogue on enterprise growth and development, competitiveness and labour market issues is important. The ILO works with employers' organizations to enhance the technical competencies of these organizations on topics that are often the focus of dialogue, such as competitiveness policies and labour law and relations reform. In particular, this helps them better influence the policy environment and deal with specific opportunities and situations at the national level. [3] This includes health service reforms such as those in Brazil and Chile.

The ILO continues to use a comprehensive strategy to support workers' organizations in providing new or improved services and in extending their representation. This strategy is proactive in identifying opportunities to advance social dialogue and the decent work agenda and responsive to requests for specific assistance. It involves collaboration with workers' organizations, international trade union organizations and all ILO sectors and field offices.

Beyond the traditional roles of workers' education, research and meetings such as this Meeting on the health services help to strengthen the capacity of trade union organizations to participate effectively in debates on globalization and social dialogue and contribute to the elaboration of proposals for policy changes with international trade union organizations and their national affiliates.

[2] ibid., p. 38.

[3] ibid., p. 39.

As part of helping workers' organizations to mainstream gender issues, which are particularly important in health services, trade unions are encouraged to pursue strategies to attract more women as members, by focusing on work settings that are more predominantly female. Through workers' education programmes, trade unions also have tools to support greater involvement and leadership by women in trade union activities and social dialogue.

All these programmes are increasingly expected to have impacts outside the traditional workplace. They enable trade unions and their members to be more effective partners in social dialogue across all decent work issues. Consistent with that orientation, support for education on organizing techniques increasingly addresses the new contexts arising from, for example, structural adjustment, industrial restructuring and privatization, [4] such as that taking place in the public service and in health services.

Freedom of association is central to social dialogue and to progress on the Decent Work Agenda. Therefore, the ILO promotes the ratification of international labour standards relevant to social dialogue, with a particular focus on the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144). This takes place through ratification initiatives in cooperation with the ILO constituents at the national level. Such initiatives raise the awareness of sectoral partners and bipartite and tripartite bodies on how they can become involved in ratification processes and engages labour ministries, parliamentarians and parliamentary bodies. [5]

Another important area of ILO action is providing assistance to States on the adoption, reform or enforcement of labour legislation that fully reflects international labour standards. To help achieve the target, a comparative study will be published by the end of 2003 on national and regional labour law reform. It will identify lessons learned, issues of concern to workers' and employers' organizations and the impact of social dialogue. The results should promote social dialogue on labour law reform and contribute to active ILO participation in subregional and regional economic integration processes.

Because privatization and restructuring have made the public sector, including health services, a significant focal point of social dialogue issues, the ILO encourages governments, as well as public sector employers, to engage in more effective social dialogue with their employees during periods of structural adjustment and transition. This includes promotion of the Labour Relations (Public Service) Convention, 1978 (No. 151), and sectoral standards as part of assistance to strengthen labour ministries and the labour policies and practices of other government departments. [6]

Gender issues are integrated throughout social dialogue efforts. An important contribution to this work will be a major report on the participation of men and women in trade unions, employers' organizations and labour ministries, including in leadership positions. This report, to be published by the end of 2003, will include baseline data, compiled by region. It will offer comparative experiences on the mechanisms and strategies that bipartite and tripartite institutions use to promote gender equality. It will identify positive uses of social dialogue to address gender equality issues as well as

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[4] ibid., pp. 39-40.

[5] ibid., p. 41.

[6] ibid., pp. 41-42.

practical strategies for mainstreaming gender concerns. [7] This is highly relevant to professions in which women make up the majority of the workforce, as is the case in the health services.

International, regional and subregional initiatives on labour issues have important implications for workers and employers. This underscores the critical need to bring social dialogue to bear well beyond the traditional ILO bipartite and tripartite networks. For that reason, the ILO is improving its links to international financial institutions, such as the World Bank, and to United Nations specialized agencies, such as WHO and UNESCO, to encourage greater use of dialogue mechanisms that engage all social partners. In the area of health services, cooperation with WHO on human resources in health services and health sector reforms was carried out jointly with international organizations representing ILO constituents, Public Services International (PSI) and the International Council of Nurses (ICN).

The ILO also strives to show how social dialogue can have positive impacts through sectoral dialogue. For example, facilitating social dialogue on occupational safety and health in sectors such as construction, forestry, mining, chemicals, maritime activity and agriculture at the international and national levels should provide opportunities for tripartite agreements on areas in which social partners can work together to promote decent work. [8] The same can be said of the health services.

Box 3.1.

ILO action to promote social dialogue in the health sector

ILO action on social dialogue in the health sector is guided by the conclusions of the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, held in 1998, which stipulated that: "In the health care reform process, policies should be developed for social dialogue since the best reforms are developed through such a dialogue. In accordance with ILO Conventions Nos. 87, 98 and 151, health workers have the same right to organize and to bargain collectively as workers in other sectors. Pay determination and working conditions should be subject to bargaining procedures between health workers and employers. Especially in times when the contents of work, the financial environment and job security are subject to rapid changes, collective bargaining mechanisms are an appropriate way to improve the situation of the workers and their families."

One of the means of action requested from the ILO by that Meeting was to "increase the cooperation with other international organizations, its technical assistance and advisory services to governments, employers' and workers' organizations, particularly in developing countries, especially on the integration of relevant labour standards and planning and implementation of health sector reforms". This led to close cooperation between ILO and WHO, together with international workers' organizations and the German Foundation for International Development (DSE), in order to develop instruments for promoting social dialogue in health sector and public service reforms. In the period from 1999 to 2000, a number of studies and meetings took place which resulted in practical tools for the social partners to launch social dialogue in their countries.

Source: ILO: *Note on the proceedings*, Joint Meeting on Terms of employment and Working Conditions in Health Sector Reforms, Geneva, 1998, pp. 26-27.

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[7] ibid., p. 43.

[8] ibid., p. 44.

Box 3.2.

Interagency cooperation to facilitate social dialogue in the health sector:
Public sector reforms and their impact on health care personnel

In 1998, the ILO and WHO, supported by the German Foundation for International Development (DSE), Public Services International (PSI) and the International Council of Nurses (ICN), launched a joint research programme to study selected reform processes and document their impact on health care personnel. The lessons drawn from the individual cases were designed to assist international advisers, governments, the social partners and organizations of civil society to implement more effective health sector reforms through social dialogue. The ILO and WHO each had different reasons for launching this project, but they prompted the same interest in the theme for the joint programme. The 1998 Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms requested the ILO to facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers, workers and governments and to facilitate research activities on the impact of health reform processes on the workforce. The joint programme with WHO, which included a Round Table held in 1999 in Berlin to discuss the research results, was a first response to these requests. For the ILO, this programme contributes to the follow-up of a series of sectoral meetings on reforms in both the health services and the public service sectors which concluded that reforms are most likely to achieve their objectives when planned and implemented with the full participation of the social partners through social dialogue.

Building on the case studies and the broad experience of the participants in the Round Table, a set of critical questions were proposed to assist policy-makers in improving the quality and efficiency of public sector reforms. They were published in several languages and widely disseminated among the social partners. Although these questions might be considered obvious or common sense, they are often ignored and remain unanswered. This tool provides a checklist of important areas that are often interrelated with others that require attention if public service reforms are to be consistent with national social goals. When using this tool, gender issues, equity and equal opportunity have to be considered and addressed across all questions. The questions have not been placed in order of priority. They are by no means exhaustive, nor will they all be raised in every member State. Rather, they are meant to initiate discussion at appropriate levels and will need further development as experience matures and reform continues. The tool is relevant to ongoing processes as well as to newly initiated reforms. Its application has to take into account the particular national context in which reform is taking place. As reform is an intrinsically ongoing process in every country, the questions reflect the different phases of reform: review/preparation; policy formulation; implementation; and monitoring and evaluation. The questions allow the agenda and the process of social dialogue on reforms to be tailored to countries' specific needs.

Source: ILO/WHO: Public service reforms and their impact on health sector personnel: Case studies on Cameroon, Colombia, Jordan, Philippines, Poland, Uganda (Geneva, 2000); DSE: Public service reforms and their impact on health sector personnel, Report on the Round Table, Berlin, 13-15 Oct. 1999; ILO/WHO/ICN/PSI: Public service reforms and their impact on health sector personnel – Critical Questions: A tool for action (Geneva, 2001).

In promoting social dialogue, there is a need for extensive compilation and analysis of information on the context in which the social dialogue is to take place and the expectations of the social partners. Such compilation and analysis will also serve to develop the capacity for social dialogue and the indicators to assess its effectiveness. In the case of the transition countries of Central and Eastern Europe, little information is available about the impact of restructuring and privatization on the workforce in the health services and their organizations. After one decade of transition, the ILO, together with PSI, undertook a major research project in a number of countries in this region to assess the impact of the reforms on remuneration, working time, career development, occupational health and different aspects of workers' security. The findings were discussed at a technical consultation in December 2001 with the national partners of the project. They were also used in preparing this report, but the most important result was that the research provided more solid data and information to the social partners than existed before and hence helped to advance social dialogue itself.

3.2. Suggested points for discussion

The points for discussion suggested below are grouped into two categories, the first dealing with the need to strengthen the understanding of social dialogue and the second concerning issues of participation in processes of social dialogue. In view of the objectives of the Joint Meeting, it may wish to consider how the responses to the questions raised could be used to develop a possible framework for social dialogue in the health services.

Health services and understanding social dialogue

When agreeing to enter into social dialogue, the social partners need to have a common understanding of the key factors conditioning the process of dialogue. To achieve a clear understanding a number of questions have to be considered. Addressing these questions is essential to the success of a process of social dialogue. The key questions to be raised might include the following.

1. What is social dialogue?

The concept of social dialogue may be expressed in various terms, such as "partnership at work", "labour-management partnership" or "partnership for quality". Social dialogue may include all types of negotiation, consultation, or simply the exchange of information, between and among representatives of governments, employers and workers on issues of common interest relating to economic and social policy. These elements of social dialogue are crucial to the outcome sought by the social partners. A common understanding has to be reached on what social dialogue is.

What elements of social dialogue should be included? Who should decide on the inclusion of these elements?

2. What are the issues to be covered by social dialogue in health services?

Social dialogue does not take place in a vacuum. It requires concrete economic, social and labour issues on the agenda. These issues have to be identified. In the health sector these issues are often related to institutional reforms, cost containment, the quality of health services, working conditions, skills and lifelong learning, recruitment and retention of personnel, pay systems and gender issues.

How should the agenda for social dialogue be set? Who should set the agenda?

3. Who represents the social partners?

The social partners in health services are governments as employers, private employers and workers in the health sector. The organizations or institutions which represent these groups have changed over the past two decades. A greater variety of government levels are involved. New private employers have entered the health market and related services. Health workers have migrated across national borders and also between public and private sectors of national health services. Changing skills and skill mixes have had an impact on professional representation.

Which government levels are involved, and are they represented together? Which private employers are involved – for-profit enterprises and non-profit organizations? Are the two types represented jointly? How is the representativeness of workers' organizations determined? Are these representatives of the social partners recognized as partners by each other?

4. How to foresee structural change?

Social dialogue has proved particularly important in situations of structural change and health sector reforms. Such situations are particularly complex, however, and take a long time to evolve. They involve a wide variety of social partners who have to deal with a long agenda of issues. The task often appears to be so overwhelming that some of the social partners do not have the technical capacity to participate to the full extent necessary while at the same time carrying out their day-to-day activities. Difficult situations may be better tackled if there is a continuous process of social dialogue to enable the partners to discuss issues long before they become urgent and thus to participate in upstream decision-making.

What mechanisms could provide an "early warning system" when reforms of health services are needed? Who should participate in continuous consultations on reform processes?

5. How to identify quality standards?

All structural changes and reforms in the health sector are geared to the overall goal of improving the quality of public health and, to this end, raising the quality of and access to health services, or at least maintaining their quality where there is a decrease in budgetary resources. The issue of quality is used by all social partners in order to achieve their objectives. In social dialogue, however, it is necessary to identify quality standards which are shared by all the social partners. A common understanding of quality standards has to be reached.

What type of quality standards should be identified? Who should decide on the choice of quality standards? What mechanisms should be used to monitor their implementation?

Health services and participating in social dialogue

Participating in social dialogue to improve the quality and cost-effectiveness of health services requires the social partners to address a number of questions throughout the process of social dialogue. Moreover, the process needs mechanisms to monitor and evaluate how successfully these questions are addressed. These questions should take into consideration the particularities of health services as services in the public interest and which belong to a large extent to the public sector. Key questions might include the following.

6. How to establish and strengthen institutions for social dialogue in the health services?

Social dialogue is conditioned not only by legal and institutional provisions but also by human capabilities to initiate and maintain social dialogue. Dialogue can be promoted through training and human resource development, which in turn will strengthen the institutions for social dialogue.

How should training programmes be designed in order to achieve this outcome? Who should be involved in such training? How can the individuals involved be prepared for social dialogue? How can they be trained while continuing to carry out their professional activities?

7. How to plan for social dialogue?

Planning for social dialogue in health services has to be based on the current situation in the health sector and to be closely related to general processes of health sector reforms. Planning has to anticipate the process of reaching a common understanding of social dialogue, of recognizing the social partners and of identifying indicators for the effectiveness of social dialogue. This planning process has to be designed in advance.

Who should be involved in the planning process? Who should set the goals to be achieved through social dialogue? How should the agenda of social dialogue be set? How should the type of social dialogue be selected? How should the time frame and different phases for social dialogue be determined?

8. How to enter into social dialogue?

Social dialogue is not a single event but a continuous process of consultation and negotiation aimed at the improvement of health services and public health. Nevertheless, the process needs to be initiated by persons, organizations, institutions or an event. In the health services, structural adjustment, public sector reforms or crisis situations have often prompted a process of social dialogue. This process may start in an informal, ad hoc way or through a formal procedure well prepared in advance.

Who should take the initiative to enter into social dialogue? Should social dialogue start as an informal or formal process? What should the agenda be for this initial stage of social dialogue?

9. How to carry out social dialogue?

If a process of social dialogue is well prepared and well planned in advance, it may appear as if implementation were just a matter of clear and well-informed action. The reality in health services, however, means that the implementation of the plan is often difficult, and hence new attempts have to be made to adjust or reinitiate social dialogue. The social partners have to plan a realistic approach to implementation.

How can the process of social dialogue be maintained? Who should manage and facilitate the process of social dialogue? What mechanisms should be provided to match the plan against reality?

10. How to monitor and evaluate the
    process of social dialogue?

The act of implementation is closely related to mechanisms of monitoring and evaluating the process of social dialogue in the light of the goals to be achieved. Already during the implementation process, action has to be taken to monitor implementation in the light of the initial plan agreed upon by the social partners. Substantial deviations from the plan need to be examined and corrected. Furthermore, the impact of the implementation of the plan also has to be evaluated against the goals to be achieved. If the results are not satisfactory, corrective action has to be taken by the social partners.

Who should identify deviations from the planned process of social dialogue in terms of substance, timing, methodology and other aspects agreed upon? Who should evaluate the impact on the health services? Who should set the indicators for this impact? And who should initiate the action required?

11.   How to mobilize the resources needed
       for social dialogue in health services?

Social dialogue is often seen as a positive, helpful instrument to activate understanding and facilitate the implementation of new, improved approaches to health services. It may also be recognized that the process of social dialogue is complex and time consuming. However, there is not always recognition of the fact that social dialogue requires financial and human resources.

What financial and human resources are needed for the process of social dialogue? Who should contribute to mobilizing these resources? How can resource mobilization be maintained throughout the process of social dialogue in health services?