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**PUBLIC SERVICES INTERNATIONAL
(PSI)
TERMS OF EMPLOYMENT
AND WORKING CONDITIONS
IN HEALTH SECTOR REFORMS**

POINTS FOR DISCUSSION



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1. Given that health care reforms are a key element of economic and social development of a country, what were the improvements achieved? How do they measure up to expectations? What are the elements needed to attaining quality health services and for a successful health care reform?

Health care systems throughout the world are undergoing major changes. The main impetus for reform has been brought about by the escalation in the cost of care. The growth in cost is attributed to the aging of the population (evidence in itself of health and social achievements), to higher levels of chronic disease and disabilities and to increases in the availability of new treatments and technologies. Rising expectations have also exerted an upward pressure on health expenditure.

Another significant factor in shaping the health reform process has been the challenge of insufficient and unequal access to health care. The Health For All programme (HFA) of the World Health Organization (WHO) sets out the global aim of achieving greater accessibility of health care through community-based provision of primary health care and other health services. Over the past two decades, governments have increasingly accepted HFA as a goal in their efforts to improve health, and generally there is a positive move to strengthen primary care facilities and to reduce the concentration on secondary and tertiary care.

Overall, there is a trend towards reducing hospital care. There has been a continuous fall in the average length of stay and in the number of beds and an increase in the number of patients treated in outpatient departments. The negative impact of the switch from institutional care to community care is that the latter has been viewed as a cheaper option. Consequently, funding has not increased sufficiently to allow community-based facilities to meet demand. This has left existing staff over-stretched and has had a negative impact on patient care.

Access to elements of primary care has increased, albeit with wide variations both within populations and between countries. Primary health care, together with economic, educational and technological advances, has contributed significantly to the worldwide decline in infant and child mortality and morbidity and to substantial increases in life expectancy at birth.

Despite these health gains, progress has been hampered by a number of factors. The pace of improvements and the achievements of targets have not been uniform. Disparities in health status and access to health care, including primary health care, among countries and among certain population groups within countries, are greater now than they were two decades ago. Millions of people still do not have access to some elements of primary health care and in many places effective primary health care services do not exist. While health infrastructures have physically expanded in the past 20 years, actual provision of care has been limited by inadequacies in national capacities. In addition some international and bilateral funding agencies have not significantly shifted their aid priorities towards low-income and least developed countries.

Perhaps the most influential agencies internationally were the lending institutions such as the International Monetary Fund and the World Bank. Since 1987 the World Bank has provided large-scale funding and technical expertise to the health sector, advocating a greater reliance on user charges, insurance mechanisms, the private sector and decentralization as the main pivots of policy change.

In the poorest countries a lack of funding for health and social services and the inability of government to raise domestic and international funds for health seriously hampers progress. The failure to establish or maintain essential health system functions has led to stagnation or deterioration in the health status of

populations; emerging and re-emerging diseases also constitute a significant threat to health. The rapid growth of private health care in many middle income countries has had a mixed impact on public sector services. In some cases it has brought about rising costs and inefficient care and aggravated inequalities in access to health care. In most countries private and public-sector health care providers have not established effective partnerships, thus further hampering health development.

However there is hope for a change in attitude. In recent times the World Bank has adjusted its position; Its 1997 World Development Report, *The State in a Changing World*, stated, “The challenge for governments and governmental agencies - planners and politicians - is to ensure that the reform and restructuring of the public service enhances its ability to plan and implement adjustment measures that promote economic growth and social and human development. To this end, the working conditions of public servants, the efficiency of their performance, and the quality of the service they deliver all have a crucial role to play.”

The emergence of the voice of the user/patient during the reform process is to be welcomed. Patients want a greater say in most matters that affect their health care, from choosing their doctor to participating in decision-making over their own care.

The ILO *Background report* highlights those advances in science and technology that may provide a direct benefit to health – such as biotechnologies, pharmacology and medical appliances. Other advances include developments in telecommunications and information technology. The report also states that these technologies require considerable investment in education and training and may not be available to those who cannot afford to pay for them.

Health reforms share a number of common elements: a separation of purchaser and provider functions, the introduction of market principles within the context of managed competition, an increased consumer choice and an emphasis on clinical effectiveness and on health outcomes. Another common element is that workers, patients and the public have greeted health system reforms in many countries with considerable scepticism. Many are opposed to the reforms on grounds of principle and through a sense of lost power and influence. Others are confused by bewildering new jargon, job titles and structures. Most occupational groups working in health care have sufficient expertise and experience to know if the changes are workable, and how they would affect standards of care. In many cases their views were not sought or considered. In addition there was often no collective consensus or support for the changes; these occurred with little or no testing and evaluation and without the agreement of the majority of workers and public alike.

On many counts the reforms have not met their pledges or promises. The privatization process has led to job losses in the public sector and to poor or worsening pay and conditions in the private sector, with a demoralized, insecure, stressed and overworked workforce. Standards of care have declined at a time when patient expectations have been raised. There is generally a lack of confidence and a lack of trust in the government and in the employers who implement the changes.

The WHO Ljubljana Charter on Health Service Reforms outlines the elements needed to attain quality health services and for successful health care reforms. The Charter outlines several fundamental principles driven by the values of dignity, equity and professional ethics. Its aim is centred on the principle that health care should first and foremost lead to better health and quality of life. Health reforms should incorporate the citizen’s voice and choice in what is care and in the way services are designed and managed. There should be a focus on quality and a clear strategy for continuous improvement. There should also be sound financing and, in order to guarantee solidarity, governments must play a crucial role in ensuring and regulating the equitable financing of health care systems.

The Charter also sets out key principles for managing change; this includes re-shaping of health care delivery, reorienting human resources, strengthening management and promoting an exchange of information based on experiences in reform. This should be supported by a well-validated knowledge base, which is understood and appropriately valued.

2. Taking into consideration the options and challenges of privatization, managed care and public/private mix in health care provision, how should reform processes be designed in order to achieve good standards of care that accommodate both the needs of the citizens and those of the health workers? In addition, how can health workers, employers and their organizations be involved in the formulation and implementation of reform policies and contribute to the success of such processes?

Health care reform has been influenced by the interlinked notion of markets and competition. In their drive for efficiency and for the containment of public spending on health, governments have been attracted to the progressive blurring of boundaries between the public and the private health sectors.

The public-private mix takes different forms in different countries but there is a general policy thrust in favour of extending the private sector's 'market share' within health care provision. Reforms have been least effective where there has been little or no consultation with trade unions, patients and the public. The wholesale importing of models that do not consider national circumstances, including history and the national economic position, is a recipe for failure. Health services are particularly susceptible to these changes, and they appear to have a propensity to turn ideas into solutions.

Managed care for example falls into this category. The term "managed care" is a North American concept that attempts to establish some principles with respect to evidence-based medicine and cost-containment, whereby clinicians are encouraged/required to observe strict guidelines and protocols governing treatment and interventions. Whether this translates well globally is questionable. Nonetheless the term has attracted attention among those countries reforming health care as a result of developments in separating the responsibilities of the purchaser (generally governments and employers) and the provider (often physicians in the USA). What is interesting is the lack of good evidence on the different policy models emerging. It is equally important to evaluate change in order to ascertain its effectiveness and in order to inform future policy development. In the USA for example, some physicians, such as surgeons and ophthalmologists, have shifted into other medical services not covered by managed care.

Crucial to the development of evidence-based policy making is the establishment of national and local health information systems that are transparent and publicly available. Information systems must ensure active surveillance and monitoring and provide early warning systems of threats to health. National and local health information systems must provide, analyze, evaluate, validate and distribute the information needed for decision-making, health management, clinical practice and public education.

Governments need to establish a legislative and regulatory framework that provides a sound basis for reform and to develop strategic management expertise in planning capabilities that focus on analytical skills, breadth and depth of sectoral understanding and interdisciplinary collaboration. Implementation capabilities should focus on organizational action, social dialogue, incentives, teamwork and results. Above all they must develop a supportive organizational culture that encourages health workers to innovate and move steadily towards clearly defined policy goals and targets.

Building a consensus includes a series of actions such as minimizing apprehension of cultural and social change, creating understanding of the need for the impact of change, generating positive support for change, building political alliances that support change, and communicating expected outcomes early, together with the implementation of projects that reflect specific policy decisions through consultation and involvement of trade unions.

3. What measures should be taken by governments, employers and workers and other concerned parties to guarantee equal access to health care? How can developing and transitional countries be assisted in providing the necessary services? What are appropriate roles for international institutions in these reforms?

Poverty and inequity in health care go hand in hand. The poorest in society remain socially excluded, suffer worsening health and greater health inequalities. Poor housing, poor diets, low income, long-term unemployment and older age lead to social exclusion, chronic disease and mental health problems. Economic policies that enhance equity are essential to the long-term health of the population and for sustained economic growth and human development.

Promoting health through health education programmes in a range of settings provides individuals and families with the information needed to improve their health when they are given the opportunity and the ability to make appropriate choices. People need knowledge, awareness and skills as well as access to the possibilities offered by society to cope with changing patterns of vulnerability and to keep themselves and their families healthy.

Poverty is multidimensional: the combined efforts of many sectors will be required for its sustained alleviation. The health system can play a vital role in reaching poor households and regions by focussing on those problems that disproportionately affect the poor. In addition to a broad-based approach, people's health and education must be protected during periods of temporary economic hardship. Health problems and reform issues are especially difficult in most of the low-income countries. At the end of the last decade basic health care was available to less than half the world population. Rural inhabitants – who make up the vast majority of the population worldwide – were particularly disadvantaged.

It is well known that improvements in health care lead to a more productive labour force, to an increased life expectancy and to a better quality of life. These improvements requires investments in health care that in many cases cannot be made by the respective countries alone but must be undertaken with the help of donors. Programmes such as the Africa Capacity Building Initiative – a specially focussed, long-term programme, as opposed to conventional short-term technical assistance projects – must be encouraged. More solidarity between poor and industrialized nations is necessary if the world's poorest countries are to advance in their struggle to provide basic health care for their people.

The growing crisis in the health system of developing countries is attributed mainly to the economic crisis, the debt crisis, and extended structural adjustment programmes, as the primary reasons for the decline in health care provision and infrastructure, among other things through their impact on the employment situation in the health care system. Because of poverty, many developing countries are unable to respond to growing health care needs and are unable to expand their health care facilities, to train their staff or to provide adequate medical supplies.

The international community as a whole must seek ways to provide more favourable conditions of trade, debt relief and generous and carefully targeted assistance. This will enable these nations to build and maintain the basic infrastructures needed for health and well being and to achieve economic growth, thus

leading to improvements in living conditions and in health. The conclusions of the ILOS/PSI workshop on Employment and Labour Practices in Health Care in central and eastern Europe (Prague 15-17 May 1997) state:

“The health sector in transitional countries had made some important achievements in the period from 1950-1990, including universal access to the available services, a good public health infrastructure and high levels of immunization, but there were also shortcomings. The system was funded at a low level, with problems of poor facilities, lack of equipment, low wages.

“The scale and scope of the economic changes in the Central and Eastern European region are unprecedented. In all countries there has been a significant fall and in some cases a massive fall, in GDP, with potentially catastrophic effects on living standards and the affordability of goods and services and already a drop in life expectancy.

“The pace and extent of health care reform has been dramatic. Its very speed has been in some cases dysfunctional and risks causing a near collapse of health care services. The pace of reform needs to be more measured to ensure the strengthening of the infrastructure, skills and processes. Most governments have been involved in a large experiment conducted on their people. It is essential to ensure that the lessons for policy making from this experience are learned as the process unfolds. The WHO Ljubljana Charter on Reforming Health Care endorsed by the vast majority of governments in Central and Eastern Europe, provides the principles that are key to managing change effectively”.

4. What are the future employment perspectives for health workers, including the sub-contracting of health care staff? What are the differences between occupational groups? What guidelines should be established for a discussion on the level of employment and the qualifications required?

The present report discusses 2 definitions that distinguish different groups of health sector employees.

1. The narrow definition covers the staff of health care provider units (hospitals, ambulances, and pharmacies) and within these institutions mainly the medical staff (doctors, nurses, midwives).
2. The broader definition covers all persons working in health care delivery including: private practices and health-related institutions such as spas and rehabilitation units, plus personnel working in units that supply medical or related aids for people with disabilities, staff in the administration of a health sector, in health information systems, in the Ministry of health and the staff developing and producing health products such as drugs, aids, spectacles or supplies and equipment for health care units (e.g., beds, technical equipment), as well as teaching staff, students, catering and maintenance staff.

It should also be noted that a considerable amount of health care is provided on a voluntary basis, particularly by women who often take care of relatives and also work for voluntary organizations.

For our purposes the broader definition more adequately reflects the wide spectrum of workers in the health sector and in our membership. The narrow definition only refers to approximately 60% of the workforce. It is important not to focus exclusively on the professional or skilled groups. Such an ap-

proach may lead to elitism and to a breakdown in the collective responsibility of public service trade unions by ignoring the multidisciplinary nature of the health sector. Reforms that affect one group such as ancillary staff will inevitably have an impact on other workers' pay and conditions of service and on their ability to deliver care.

There are marked differences in the density of health personnel between developed and developing countries and even the type of labour force imbalances differ. In established market economies, the employment level of doctors and nurses is up to 20 times higher than in developing countries. In some of the industrialized countries, especially in transitional countries, there is concern about a doctor surplus. In developing countries there is ample evidence of personnel shortages. This does not mean that posts remain unfilled but that posts are simply not created, in order to approach national and international targets that countries may have subscribed to. Another complication for developing countries is the drain of staff to countries where there are more possibilities of employment and better working and living conditions.

The migration of medical staff is a serious concern to the developing countries that have invested money in the education and training of doctors and nurses. This is often referred to as the "brain drain". It has reached considerable dimensions particularly towards countries such as the USA and the Gulf States. Asian nurses constitute the largest group of foreign nurses. The countries of origin include South Korea, India, China (Hong-Kong), the Philippines and Thailand. Migration for labour plays a particularly important role in the employment of nurses.

Worldwide, the report identifies 3 types of reforms that have affected the employment situation in the health sector:

1. Reforms induced by financial constraints, leading to a reduction of employment and increased productivity. This is especially striking in transitional countries and typically includes the reduction of benefit packages alongside a reduction in staff.
2. Reforms leading to an expansion of employment. This type of reform is rare but there are examples such as Mexico and Zambia.
3. Reforms that restructure employment; for example, privatization of the health sector has led to decreasing employment in the public sector but increased employment under other (often worse) conditions of service in the private sector.

The health sector has an estimated workforce of 35 million workers worldwide. Employment opportunities in this sector are on the increase in most of the industrialized countries, largely because of demographic changes in the aging population and the rise in chronic diseases. The change is mainly that (as mentioned above) employment is rising outside the public sector.

Another change in the workforce is the significant increase in the number of staff employed on fixed term and temporary contracts. The trend towards temporary or part-time employment with lower salaries is attributed to attempts by employers to develop more flexible employment practices in order to cope with competitive market contract uncertainties and financial constraints. The hiring of temporary staff is linked to funding by purchasers. This process is not new to ancillary staff who have been subject to compulsory competitive tendering for some time.

Reform processes that go along with cost reduction in many cases lead to retrenchments of workers. The reason for this is the fact that the health care sector is very much service- and personnel-oriented. Changes in structure and a lowered budget imply cuts in the staffing levels. Such reductions often involve a combination of several measures, such as compulsory redundancies, the non-filling of vacancies, replacement of full-time jobs by part-time jobs, early retirement and voluntary redundancy schemes, recruitment freezes, retraining and other methods.

Such reductions can be done either globally throughout the whole health sector or for a part of the sector only, whereas other parts may continue to look for personnel. For example, general workers in the hospital sector or in the pharmaceutical industry may be affected, whereas in other parts of the same sector, maybe at the same time, workers in general or workers with special skills are required.

The kind of staff reductions taking place also depends on the size and the sector of the enterprise. In the private sector, dismissal is normally easier than in the public sector. In larger enterprises flexible ways of retrenchment without dismissal are easier than in small enterprises. This is why small enterprises dismiss earlier than large enterprises.

In Eastern European transition economies dismissal has been the form of retrenchment most frequently applied. Among those who were dismissed the share of women was disproportionately high. In Latvia retrenchment took place mostly for doctors at retirement age and for those unable to speak the national language. On the other hand the admission of medical students was strictly reduced. In Slovakia, during the major reform process, most retrenchments took place by attrition or through migration to the private sector.

Staff reductions in the health sector also occurred in a number of developing countries such as Ghana where 4 years ago many health workers were dismissed. In Zambia retrenchment affected support staff. In El Salvador staff reductions were managed mainly via early retirement and among non-qualified staff. As already mentioned earlier, retrenchments also took place in a number of industrialized countries. In the UK reductions of staff occurred in the big city hospitals, which were subject to restructuring. In Sweden, the number of staff in the health service has started to stabilize in recent years and amongst certain groups, such as nursing auxiliaries, the number has declined.

Another form of flexibility is the change in working practices and boundaries between occupational groups. The World Bank, for example, has suggested that there are too many doctors in Central and Eastern Europe and that doctor nurse ratios should be more heavily weighted towards nurses. In many Central and Eastern European countries doctors were employed for work that in other countries is typically undertaken by nurses; in some western European countries there is an oversupply of trained doctors. On the other hand, in many industrialized countries there is a shortage of nursing personnel and in developing countries there is a general shortage of all kinds of personnel.

Most of the countries of the world have traditionally placed importance on secondary and tertiary care in large institutions like hospitals and specialized polyclinics, with the result that there is an oversupply of specialized doctors. On the other hand there is a lack of primary care and qualified primary care personnel. These conditions have led to reform activity that not only has an impact on the level of employment in different kinds of fields but also may change the structure of employment.

The reform process in many eastern European countries has led to a reduction in the number of doctors whereas nurses are still required. As primary care has been strengthened, specialized doctors have been retrained to work as primary care physicians.

In Germany where insurance for long-term care was created some years ago a new field of activity has been created. Full time employment in the field of long-term care is booming and new teaching facilities are being set up.

In the UK, total employment in the health sector remained stable but dramatic cuts took place among the ancillary staff (52%), reflecting the policy of compulsory tendering. The shift towards a more commercialized NHS and the establishment of a system of managed competition have led to an increase by 25% in administrative and management staff, and increased uncertainty in funding for individual trust hospitals has led managers to increase the numbers of staff employed under more precarious forms of employment and to increase work intensity. Although some occupational groups, particularly doctors and nurses, have experienced strong growth in real earnings, others experience reduced job security and more intensive working practices associated with the system of managed competition. This has led to sporadic industrial action and widespread stress and demoralization amongst NHS staff.

The roles of the physician (general practitioner and specialist) and of the nurse (professional nurse and auxiliary nurse). Are central to reorganization. Work patterns and the distribution of roles and tasks in health care services are largely conditioned by national traditions and culture. Cost containment measures have a major impact on these aspects. The management of health care services is challenging existing boundaries among occupational groups through the reorganization and reallocation of tasks to personnel. New grades or profiles are created, as in Brazil (cf. the “community agent”) and in the UK (cf the “health care assistants” and the demand for “multi-skilled” staff). On the one hand, this may turn to skill-dilution and lower the payroll; on the other hand, the workers are obliged to reassess the self-understanding of their roles.

For example, industrial action in France, Sweden and in the UK suggests that nursing staff are disenchanted with their low status and pay, and there is a move in many countries to revalue the profession and reallocate tasks that have in former times been allocated to higher paid doctors. In this respect, physicians are facing a loss of influence in the reform processes in many countries.

In the UK, changes in functions are also being discussed for pharmacists who might be attributed a wider health role as “gate-keepers” to the NHS. Doctors are likely to oppose such moves as they may feel that pharmacists are moving in on their activity.

A growing number of nurses are becoming self-employed, particularly in industrialized countries such as Canada. Reasons for becoming self-employed may include staff reductions and the shift towards outpatient care. Other reasons may lie in the attempt to introduce alternative managerial methods.

Nurses’ associations have helped interested persons to establish their own health care business. However, the advantages of more job autonomy, personal satisfaction and flexible management of working time must be examined against the risk of isolation, lack of job security and possible disruptions in home life. One of the major challenges is how to keep up care standards and know-how, as well as managerial skills. Another problem may be the usually very high indemnity insurances for which the income of independent midwives and nurse practitioners may not be sufficient, as appears to be the case in the UK.

5. What is the impact of health care reforms on gender issues in the work place and equal opportunity in employment and what kind of responses has there been to these issues?

It is increasingly recognized that macroeconomic policies and structural adjustment measures entailing reallocation of resources and of public expenditures are not neutral as regards gender.

The health sector is a very important employer of women, who are often employed on a part-time basis and concentrated at the bottom of the employment hierarchy. In some countries they represent up to 80% of staff and there is a problem with low salaries. In addition, much unpaid work in health care – with its own social and economic importance – is undertaken by women. This particularly applies to women taking care of ill family members and working for voluntary organizations.

Gender plays a role in redeployment, since women generally face social-cultural biases that limit Participation in the labour market. This is coupled with the structural constraints that disadvantage women in the process of redeployment to other professions. These trends affect the ability of women to compete in the labour market for access to better quality and adequately if not more highly remunerated jobs.

Participation of women in the labour force was in the past much higher in Central and Eastern Europe than in the rest of Europe. Various changes in the transition to a market economy, as well as privatization moves as part of health care reform, have eroded the formerly existing network of enterprise/employer-level social benefits (e.g. childcare) for women. A larger proportion of women in the health care sector – generally speaking a more vulnerable group employed in lower paid, lower status branches than men – have lost their jobs. Furthermore, outdated values that assign all family responsibility to women and assert that their natural place is in their home are re-emerging.

In other European countries the level of women representation at higher educational and decision-making levels has increased in the last decade. However, compared to women's share in the workforce of the health sector, they are still under-represented among senior grades and at the decision-making level.

The increase in part-time work is a leading trend. In some countries, it appears to have reached a stalemate in connection with a general stabilization of female part-time work. In Canada the degree of part-time work by – mainly female – nurses is significantly higher than the average for the overall female workforce. New nursing entrants often work on several part-time jobs.

A study among doctors in the UK also indicated that over 40% of women interviewed thought that their careers had suffered because of part-time work. The main reason for concern about the adverse effects of part-time work was that it was considered to give doctors less status.

In Canada, funding cutbacks to the institutional sector, where the vast majority of registered nurses work, and the lack of funding for community-based services have also contributed to the fact that health care reforms have affected nurses more than any other health care profession. Health care reform is contributing to a decrease in employment and career development opportunities at a time when more nurses with higher levels of education are entering the workforce. These developments have led to a growing interest by registered nurses in providing nursing services as self-employed entrepreneurs.

Widening the employment opportunities available to women – whether in the range of professions of health care providers or under the label of redeployment – requires multifaceted strategies. It is likely that the extent of women’s access to technological training will be a key factor in determining their future opportunities.

Overall, women tend to have lower pay than men even in occupations that are usually thought of as “women’s occupations”. In extreme cases, such as physicians in Nigeria, women and men cannot be on the same salary scale – the differences in average salaries is too great.

Reversing the trend that results in male colleagues having access to a broader spectrum of jobs and earning more income at every occupational level requires strategies that revolve around mainstreaming women and women’s issues into all areas of economic, social and political development. Mainstreaming is an evolving concept with the objective of putting women on a par with men in the process of initiating development activities and in the outcomes of development. A reactive commitment to gender equality will strengthen every area of action because women can bring new impetus and a new basis for organization.

Specific attention must be paid to occupational health protection. This is a gender issue not only because of the high proportion of women working in the health sector but because of the specific forms of violence such as workplace sexual harassment, which is predominantly directed against women. The mainly female workforce is also exposed to risks of violence and harassment on their way to or from work, also due to atypical working hours.

The issue of various forms of harassment is being taken up in the European Union. Particular attention is also being given to racial harassment, which is especially relevant in view of the number of migrant workers. Racial discrimination at work, including racial abuse by patients and relatives, is increasingly being examined. Guidelines to address such incidents have been developed by UNISON in the UK and Sweden has established a specific legislation against victimization at work. (These issues resurface under point 7 below.)

6. How do reform processes and structural changes influence the working conditions and the payment of health workers and what has been the response to these changes?

Overtime is increasing because of shortages of staff or cost containment measures; both of which can be related to health care reforms. In 1992, the German Union of Salaried Employees (DAG) estimated that the overtime worked by health care providers was equivalent to 20 000 extra full-time staff posts. Today, trade unions in Canada and the United Kingdom express particular concern about using overtime to substitute for recruitment and about the increase in unpaid overtime.

Long hours of work and heavy overtime is also a problem for physicians. A report in 1996 by the Permanent Working Group of the European Junior Doctors (PGW) gave examples of the long hours worked and showed that 49% of doctors considered “sufficient leisure time” a major problem, while 46% considered the major problem to be “exhaustion”.

Nurses in Japan have long since complained about the difficult hours and the heavy pace of work. The number of nurses for 100 hospital beds has been reported as less than 20 against more than 40 in Britain, almost 60 in the USA and more than 60 in Sweden and France, although a recent survey of the Japanese Nursing Association does show some improvement.

It is also important to consider the combined effects of “deviant” working hours with the pace of work. An intense rhythm of work can greatly add to the risk of atypical working time arrangements. Respondents to the ILO questionnaire indicated that normal working or even actual hours of work do not reflect the increase in intensity of the work. Early discharges in hospitals, additional tasks, the presence of fewer standby staff and the need for supervision of less experienced and less qualified colleagues require more energy and staff care for the performance of inpatient services, a phenomenon that cannot be reflected by the term “increased workload” alone. In the Canadian province of Alberta, layoffs have resulted in heavier workload for the remaining staff, and “the quality is reported to have reached crisis level”.

In general, reform processes accompanied by cost containment have resulted in increased overtime and in atypical working time arrangements, while normal working hours have remained more or less the same.

The need to provide a continuous health care service has led to a large range of shift patterns. This is particularly relevant for inpatient establishments, where not only the medical professions but also administrative and auxiliary personnel are affected. Throughout the European Union the workforce are involved in a range of shift patterns. In Belgium about 83% of nursing staff are exposed to working 2, 3 or 4 shifts. In France about one third of the hospital workers are concerned by shiftwork, in Germany 48% do mostly 3 shifts, as do 75% of nurses in the UK.

In France, it has been noted that people often make choices in favour of “deviant” working hours, especially night work, for reasons linked with familial and social life constraints, for instance child care.

In developing countries the situation is not well documented. Niger reported to the ILO that the reforms did not change the normal working hours in the public service. In the private sector, staff reductions led to the introduction of two 12-hour shifts.

Reform processes seem to have brought about changes in the shift work, night work and rest periods that are targeted at higher efficiency (e.g. 2 shifts of 12 hours). If run according to agreement, these arrangements may also reduce the pressures of “deviant” hours. However, the shortage of staff may prevent the implementation of working hours according to agreement. Although it is very difficult to provide guidelines on the organization of shift systems it is generally recommended that shifts should be: a) rotated rapidly; b) rotated in a forward fashion; c) arranged so that the longest period of rest should follow the night shift. Several studies have shown the importance of supervisor support to buffer work stress and a recent study has indicated that supervisory support is especially important for shift work.

Contract flexibility and part-time work can be considered a concept that is in the interest of the enterprises, the employees or both. For the employee, it may allow adapting the working periods to family responsibilities and other personal concerns. This may coincide with the enterprise’s interests. However, a joint interest cannot be assumed per se and must be examined jointly.

Paralleling time-based flexibility, contract flexibility allows enterprises to increase their productivity and their competitiveness in the market. This is particularly important when enterprises undergo situations of structural adjustment and transition to the market economy.

Traditional full-time contracts can still be the majority in the health sector but the trend is decisively towards more flexible contracts. A 1994 study in the UK shows that most organizations expect to maintain or increase the use of fixed term contracts, although these forecasts are likely to change due to the commitment of the Labour Government to reduce the levels of flexible short term contracts.

In the hospital sector of the European Union, the percentages of part-time contracts vary between less than 1% (in Greece) to 52% (in the Netherlands). A European Court decision in 1997 has ensured that part-time workers acquire the same benefits as full-time workers in pension schemes, as was ruled in the case of 2 Northern Irish nurses.

Although an increase in part-time work is the leading trend, it appears to have reached a stalemate in some countries, in connection with a general stabilization of female part-time work. The Canadian Nurses Association reported that part-time employment of nursing personnel has grown from 29.3% in 1970 to 38.8% in 1995. Finland reported a relatively low level of part-time work but with an accelerating tendency. From 1992 to 1994 it increased from 4.6% to 6.3%. In Germany, part-time work counted for 24% in 1995.

The trend to more part-time work has not reached the sector in the African countries, since personnel are employed in the public service, where full-time jobs are still the rule. Ghana, Niger and Zambia report that the workforce in the public sector works full time and no flexible working time is foreseen. Other developing countries, such as Colombia and El Salvador, report no part-time or flexible work arrangements. Countries in transition, like Latvia and Slovakia, do not note any substantial share of part-time work.

Part-time work has also become an important feature in doctors' work. As mentioned above in discussion point 5 on gender issues, a survey in the UK shows that part-time female doctors often mention that they are treated less well than their full-time counterparts. Adverse effects of being on-call are also mentioned by doctors.

Other forms of flexibility can be created through temporary contracts, seasonal contracts, standby contracts and flexible working times.

Health service occupations in different countries have had different experiences of changes in their relative pay in the 1990s. While reductions in pay follow contracting-out or privatization of services, it is rare for wages to be reduced without a change of employer. Occasionally however there are reductions in money wages. The minimum monthly wages for physicians and dentists in Italy in 1993 was 4 855 829 Lire. This was reduced to 4 608 563 Lire in 1994. Other medical occupations had small increases of about 1.5% in their minimum monthly wages. In 1995 physicians and dentists minimum remained unchanged and the other occupations received increases of around 2.3%.

The report also gives examples of changes in real pay in some countries. In Austria the improvement in average real wages for the medical occupations over the years from 1990 to 1996 was a modest 1.4% in total, the same as for the civil service. The exception noted is for average hourly earnings for ambulance drivers where hours worked fell drastically so that average real hourly earnings rose by 70%.

In Finland average real wages of male physicians fell by 2% over the period 1990-95 and those of professional nurses fell by 10%. In the UK between 1990 and 1996, average real weekly earnings of male physicians increased by 16% and those of female physicians by 30%, while professional nurses' earnings rose by 13-16%.

Apart from male physicians who gained 17.4% in real median weekly earnings, the medical occupations in the USA all had reductions in real earnings between 1990 and 1996: median earnings fell by 16.7%, female professional nurses' by almost 5%, female auxiliary nurses' by 4% and others by around 1%.

In some transition countries in Central and Eastern Europe and in developing countries, a problem of increasing concern is the delayed payment or non-payment of wages (for up to 6 months) in the health sector. This entails negative social consequences for the workers and their families and has negative consequences for the economy and the quality of services. The regional ILO/PSI workshop on health services in Prague 1997 acknowledged this problem and concluded that “in accordance with the ILO Protection of Wages Convention 1949 (No. 95) ratified by a number of countries of this region, wages should be paid regularly (as stipulated in Article 12) to all other workers which includes health workers”.

In many countries the reforms in the health sector did not provoke conflicts. Trade unions supported the reform processes, even when they were not directly involved, as was reported by the workers’ organizations of Ghana and Niger replying to the ILO questionnaire. In El Salvador, the process of health sector reform gave rise to more reflexion on the need for increased worker participation. In Austria, the workers’ organizations were in the beginning quite supportive. However, they are becoming now more and more sceptical, as was reported by the Government.

Some labour conflicts did nevertheless arise during health sector reforms and were triggered by different reasons, such as local pay determination, changes in representation of staff and employers, restructuring of health services, contracting out, income reductions through managed care, financing of health care, slow rates of wage increases (compared to inflation) or non-payment of wages. Some cases of such labour conflicts in recent years are described below.

In the UK, the trade unions resisted the reforms as a whole. The resistance culminated in a national dispute in 1995. This dispute over local pay determination was further complicated by the multiplicity of forms of staff representation. Unions and professional associations were divided over bargaining objectives and strategies. In Sweden, bargaining at county level has led to lengthy periods of industrial action by medical and nursing staff in recent years. Following nearly 2 months of industrial action during 1995, the nurses agreed to a new agreement until the year 2000.

The restructuring of the health services in the Canadian Province of Alberta was a big challenge to workers and their unions and the bargaining was confrontational rather than co-operative. This was mainly caused by the political decision for major budget cuts and by administrative reorganizations that changed bargaining rights. The unions tried to co-ordinate their bargaining power even though strikes were not allowed. When large numbers of health workers retrenched, including nurses, a workforce generally in short supply in the country, hospital laundry workers went on a wildcat strike over the plan to contract out their jobs to the private sector. The laundry workers received broad support from other health workers and the public in view of increasing individual expenses and lengthening waiting lists. As a result, the laundry workers were given a one-year extension of their employment and the provisional government began to add funds back into the system.

In France, industrial action including strikes and demonstrations evolved at the end of 1995, after a variety of proposals to reform the public sector and to alter governance for the health system. They reflect the anger amongst the French health workers that these reforms were challenging the fundamental principles of liberalism and solidarity that are deeply embedded in the French health system. The public hospital sector is characterized by the civil service status of the staff. The agreements reached between the unions and the state are normally also the basis for bargaining with the private employers. The highly centralized system of collective bargaining seems not always to have satisfied the needs of all occupations in the health sector of the country. Representation of the mainly female workforce in the nursing profession became increasingly fragmented. Initiatives outside the mainstream unions led to co-ordinated

strikes in 1988 and 1989 and achieved changes in working conditions and pay. In the spring of 1997, France again witnessed prolonged industrial action among junior doctors who were concerned about their future income through independent practice and by the introduction of elements of managed care and personalized medical cards.

Demonstrations and industrial action related to health sector reforms have also taken place in Germany since the end of 1996, when doctors and nurses became increasingly concerned about efforts to curb health expenditures. The dispute with doctors arose over government plans to make them financially responsible for the sickness funds of their prescription budgets. Nursing organizations were particularly concerned about government plans to lift a law introduced in 1993 to ensure quality of care through tighter regulation of workloads. They also resisted the introduction of new, less qualified and lower paid nursing occupations.

Nurses took a leading role in strikes in South Africa in 1995 regarding working conditions, and labour conflicts in Zambia were taken to court. Nurses went on strike in Israel over a dispute between the Health Ministry and the local authorities regarding the sharing of costs to run the 500 family health stations throughout the country. The municipalities claimed that the national health insurance was, according to a recently passed law, responsible for financing the services to their members. When the municipalities announced the closing of a number of family health stations, the nurses claimed that they had become “hostages” over this dispute between central and local authorities.

In Russia strikes have increased in general, radically so since 1995. Most of the strikes were locally limited, but some developed into regional protests and in November 1996 and March 1997 they turned into nationwide rallies with tens of thousands going on strike in the health sector. The targets of the protests were mainly broken promises and non-payment of wages. In the Czech Republic, disputes over poor management were brought to court and in Romania up to 150 000 health workers went on strike and demonstrations in early 1998, requesting an increase in their wages in a situation of hyper-inflation. They finally achieved a 30% increase in pay –far below the inflation rate.

7. How do stress and violence at the workplace influence the performance and motivation of workers and the quality of service? What could be done to reduce these negative factors at the workplace?

Work Related Stress

Reforms are frequently characterized by intensification of the workload, extension of tasks, job insecurity, and increased dangers at the workplace. In addition, there is growing strain regarding the quality of working conditions, workers’ emotional involvement, the feeling that their professional value is undervalued and that the quality of health services is declining. The last point also highlights the increase in stress from ethical dilemmas, often arising from the conflict between health care ethics and commercial interests.

Several major sources of stress with direct organizational relevance have been identified for nursing personnel:

- job design and workload, including job ambiguity, overload and lack of supervision
- interpersonal relationships at work, including conflict with other staff, conflict with medical staff and conflict with other nurses

- relationships with patients and their family, particularly under situations of inadequate preparation for dealing with their emotional needs
- work organization and the management of work including difficulties with management and supervisors, lack of resources and staff shortages
- technical aspects of nursing, particularly concerning technical knowledge and skills.

All of the above have major effects on the quality of work and the health of personnel. There is general agreement that work-related stress detracts from the quality of working lives, increases minor psychiatric morbidity and may contribute to some forms of physical illness. This is supported by governmental statistics in several countries.

A major cause of stress lies in the specific working time and work organization of health occupations. This is reinforced by health sector reforms. Shift work disrupts the biological rhythm of workers and bad work schedules may result in health-related problems. Shift work also disrupts social and family life. Surveys point to workers' feelings of irritability and nervousness without apparent reason, difficulty in concentration, amnesia, obesity, and gastro-intestinal disorders. There is evidence that nurses on rotating shifts and night shifts suffer more seriously than nurses on other shifts in terms of well being. The absenteeism rate is also higher for the night shift.

The causes of stress are often organizational and an organizational response is what is required. Typical organizational reactions to stress may include ignoring the problem; using stress to force people to work harder; intervening on the consequences rather than on the cause ... or developing preventive responses that attack stress at its origin.

Only the last reaction may lead to more permanent and long term positive results. This requires responses that fit into the managerial, economic and social strategies of the enterprise. Costs of the response can be contained and become an integral part of the development of a sound organization if this is accompanied by appropriate training, communication and workers' participation.

Prevention measures to eliminate or reduce stress may include improvement in job design and content; the setting of realistic goals, performance standards, targets and deadlines; a better organization of working time; and a better interface between workers and equipment or new technologies.

Managers play an essential role: organizational responses must concentrate on improving systems of work planning, control and evaluation, introducing supportive management styles and training on how to deal with stress – for management and workers both.

Improvements can also be best achieved by a control cycle for risk assessment and risk management in the work place; this should include the following steps:

- identification of hazards
- assessment of associated risks
- implementation of appropriate control strategies
- monitoring of effectiveness of control strategies
- reassessment of risks
- review of information needs and training needs of workers exposed to hazards.

Work Related Violence

Violence is so common among workers who have contact with people in distress that it is often considered an inevitable part of the job. Areas of health care where frustration and anger are known to arise out of illness and pain include old age wards/units, psychiatric hospitals, alcohol- and substance abuse rehabilitation centres.

Violence may also be induced by increased public expectations of health services. These expectations are based on public knowledge about new technologies and the promises made by health care reformers about improved services. The public increasingly see themselves as customers of services. The staff on the other hand face the limitations of given resources and may not be able to satisfy the demands of patients. This can lead to violence especially in emergency departments.

Other health care workers at the forefront of contact with violence include staff in ambulance services, who are the most exposed group because they are often the first, alongside the police, to arrive in situations of criminal violence, alcohol and drug abuse. Staff working in community services, working on their own, may be targeted on their journey to or from their home care patients.

Other contributing factors to an increase in work-related violence are:

- poverty and marginalization in the community in which the aggressor lives
- insufficient training and interpersonal skills of staff providing services to this population
- a general climate of stress and insecurity at the workplace.

As mentioned above in discussion point 5 on gender issues, sexual harassment is a specific form of violence at the work place and is predominantly directed against women. The psychological effects of sexual harassment lead to stress and serious physical conditions. Besides the personal impact, a direct effect on the efficiency of the health care organization can be expected, since work performance will be reduced.

Another form of harassment at work that is receiving increasing attention is termed “bullying at work”, and can be described as offensive and intimidating behaviour designed to undermine an individual or groups of employees. Bullying at work seems to occur more frequently and intensively in situations of general pressure and major change. The personal and organizational effects are described as similar to those of various types of stress and violence. Particular attention is also being given to racial harassment at work, including racial abuse by patients and relatives. This is especially relevant for migrant workers.

Tackling violence at work by preventive strategies and early intervention is becoming recognized as the most effective way to contain and diffuse such behaviour and these approaches are progressively being incorporated in the responses to violence at work. Reactive responses, based on the use of fear and counter-aggression, still remain prevalent, however, even though these responses concentrate on the effects of violence rather than on its causes, with consequent waste in terms of the cost effectiveness of the action undertaken.

In too many cases violence is a forgotten issue and little or no action is taken to deal with it. The lessons on prevention need still to be transformed into practice. To achieve such a goal the following initiatives may be envisaged:

- disseminating information about positive examples of innovative legislation, guidance and practice

- encouraging anti-violence programmes, particularly at enterprise level, specifically addressed to combatting violence at work
- assisting governments, employers and workers' organizations to develop effective policies against violence at work
- assisting in the elaboration of training programmes for managers, workers and government officers dealing with or exposed to violence at work
- assisting in the elaboration of procedures to enhance the reporting of violent incidents
- assisting in anti-violence initiatives at different levels and introducing these into organized strategies and plans.

There is no evidence on how much stress and violence at work have a bearing on the behaviour of health care workers towards patients. In cases where violence against patients has been reported, this has seldom been examined in relation to the position of health care workers as victims of stress and violence themselves. However, research has shown that employees treat customers in ways similar to the way in which they perceive themselves to be treated by their organization. Stress and violence can be mitigated or prevented in an organizational culture that communicates a clear vision, mission, value system and strategies for quality health care services.

The report makes a passing reference to racism. Apart from questions of discrimination, racism contributes to stress and is a factor behind some violence at work. Some Workers' group representatives feel that racism in their country is an item that should be more fully addressed during the meeting.

8. How can training and re-training prepare and respond to changes in health policy and health care provision, and contribute to the improvement of health services and career development of the workers?

The combination of new technologies and diverse demographic epidemiological and social challenges requires health workers' knowledge and skills to be constantly upgraded. A well-trained and motivated workforce is essential in order to function and adapt appropriately. Human resource management must recognize the need to provide ongoing and comprehensive capacity building for all health workers.

Career development is most commonly defined as a process that sets goals, identifies specific talents, capabilities and interests, assists in the implementation of career plans and makes counselling and guidance available. Career development and in-service training are essential for retaining staff.

In an effort to reorient human resources for health, greater attention needs to be paid to identifying and stimulating appropriate professional profiles that can be part of the multi-professional teams of tomorrow's health care systems. There is a need for a broader vision than that of traditional curative care in the basic training, specialization and particularly continuing education of health care personnel. Quality of care, disease prevention and health promotion must be an integral part of this professional reorientation. In the wake of structural adjustment, particular emphasis is placed on retaining the staff most suited to their task, whilst offering adequate opportunities for re-training and redeployment of health care personnel in neighbouring professions. Examples of such retraining programmes exist in Finland in the context of reinforcing community care and occupational health care. Severance and redeployment arrangements are an important aspect of retrenchment programmes; appropriate training enhances the employability of health care personnel.

Newly designed curricula for health care providers will have to take into account the overall context in which health care reforms are implemented, including economic and administrative training. Technological progress in medicine requires health workers to keep their knowledge up to date. This counts not only for doctors and nurses but also for the full range of staff, including ancillary and support staff.

The concept of lifelong learning is also of high relevance in the health sector. In Ghana it was integrated into the Act of 1996 and a programme for the rehabilitation of training institutions was launched. Respondents to the ILO questionnaire in Austria, Brazil, Canada, Colombia, El Salvador, Finland, Latvia, Lithuania, Mexico, Poland, Slovakia and Turkey pointed out that education and training systems were being adapted, with a focus on the link between practical work, primary health care and lifelong learning as one of its main features.

Key components to successful reform processes that achieve good standards of care accommodating the needs of both the citizens and the health workers include: national and local health information systems; capacity building throughout the structures; continuous opportunities to advance and upgrade knowledge and skills; and minimizing apprehension through consultation and inclusiveness.

9. What should be done to improve managerial professionalism and capacities?

The ILO report recognizes that major health reform moves tend to occur under circumstances of severe financial crisis, guided by donor conditionality. That being said, it is important to emphasize the importance of capacity-building as part of health care reform. Capacity-building applies to all levels, including both planning and implementation capabilities.

Changes in management are one of the most often mentioned instruments for the implementation of health care reforms. These changes imply the use of modern management and information technologies and of outsourcing and alternative management methods such as workers' participation and self-management.

New information technologies have allowed the computerization of personnel administration, patient admission, discharge and billing. This applies to hospitals and individual practices. Such technologies have also facilitated the reporting of data on sicknesses and their processing by the public health authorities. The information systems of public health have been further rationalized by linking various data processing systems within and outside hospitals and individual practices. In the past, these links were carried out by administrative staff and middle management – the application of new technologies has led to the abolition of a substantial number of such posts.

Major rationalization in some countries and the outsourcing of auxiliary services such as catering, cleaning, laundry and transport have reduced the number of administrative and management posts in health services. On the other hand, the demand for management skills has increased at all levels. Countries in transition and developing countries have undertaken major efforts to upgrade management. One example is the case in China where programmes for management improvement are being implemented with WHO. Moreover, partnerships of Chinese hospitals with universities and private health providers in the USA have been established.

Several countries with structural adjustment programmes are undertaking management support and training programmes under World Bank and UNDP auspices. Examples can be found in Ghana and, as mentioned above, in China. Considerable resources are provided by the European Union to various executing agen-

cies, such as the SIGMA/OECD programme, in order to assist Central and Eastern European countries to improve management and organization of those elements of their public services that also affect the health services.

There is a need to interpret capacity building as encompassing planning and implementation dimensions. By drawing attention to both planning and implementation capabilities, the importance of strengthening the capacity for action is being emphasized. Planning capabilities focus on analytical skills, breadth and depth of sectoral understanding and interdisciplinary collaboration, while implementation capabilities focus much more on organizational action, incentives, team work and results. Those engaged in capacity-building need to note the interdependence between the two elements. Capabilities to assess and design organizational structures, systems and processes, to create and enforce a suitable legal and financial framework, and to motivate and to provide guidance to people at different levels are of critical importance.

It may be useful to examine different elements of health reform along these lines to identify the nature and mix of capacity dimensions required in a specific country context. Irrespective of the sector, capacity-building would seem to involve more than the transfer of knowledge or skill. It is appropriate, therefore, to conceive of it in terms of knowledge and processes – referring to the institutional strengths and dimensions to be created and practised.

The report highlights the benefits of establishing autonomous centres and institutes for policy analysis and implementation, whether as “free standing” entities or as part of universities or even private sector organizations. It suggests that autonomous centres can build in greater flexibility than government agencies in terms of compensation and incentives, thus making it easier to attract and retain competent professionals. The report goes on to argue that this is a chronic and well-known problem for government. The report also emphasizes that it is essential that autonomous centres function as independent sources of policy advice and analysis, to ensure the creation of viable institutions with a critical mass of expertise in the relevant subjects: This can be achieved because the autonomous centres are more likely to maintain objectivity and independence than the captive policy units within government.

Unfortunately the example given for the “free and independent” initiative is the World Bank (and other donors) Africa Capacity Building Initiative (ACBI). While it is to be welcomed that the World Bank and other donors are assisting with a long term specially focussed programme rather than short term projects, it should not be assumed that such institutions will remain objective or independent. The World Bank’s record on donor conditionality in health service reforms has been ideologically driven and explicitly biased towards the implementation of unevaluated marketization and privatization in the health sector. What can be considered common to all reform efforts is that managerial and implementation skills are indispensable preconditions to make systems work. Moreover, efficient institutional arrangements are critical in addition to individual skills.

10. What is the appropriate role of labour relations in the health services in the process of structural changes and reforms? What should be done to avoid conflicts?

Health sector reforms have certainly had an impact on unionization, but it is not clearly identifiable whether changes are due to general trends in unionization or to health sector reforms. The ILO World Labour Report 1997-98 states that membership levels of trade unions in general declined between 1985 and 1995 in 72 countries. The decline was most apparent in the former communist countries when mem-

bership was no longer compulsory. Union density fell in Central and Eastern Europe by between 50.6% (Czech Republic) and 22.8% (Belarus). A radical drop in trade union density also took place in Israel (75.7%). In 20 countries the level of unionization rose, for instance in South Africa.

Health workers are represented by a wide range of trade unions. In many countries, they are included in the membership of unions for the public sector, with special units for health workers, such as the Public Services, Transport and Communications Union (ÖTV) in Germany and UNISON in the UK. With privatization, membership in the public sector unions is declining and more recently discussions have been started about mergers with other unions. In Germany, ÖTV has started such discussions with unions covering also other sectors. Workers' organizations in Brazil report a tendency towards one comprehensive workers' organization for the health sector in the country.

The nurses associations from Canada and France also report declining levels of organization in the health sector. The Canadian Association of Nurses attributes the decline to the increase in the number of part-time nurses and to increasing entrepreneurship among nurses who for various reasons would not seek membership. In other countries, such as Ghana and Slovakia, the level of unionization did not change.

Changes have also taken place as regards the structure of workers' organizations. In the USA, there is a marked interest by doctors in getting more organized in order to face the challenge of managed care and collective bargaining with insurers. The concerns of the physicians are working time and pay, but above all the interference in their medical decision-making.

In Central and Eastern Europe social dialogue appears to be only beginning. Several countries face problems in identifying the employers with whom bargaining processes should be initiated. Employers, be they public or private, are often not yet organized in a comprehensive way that allows collective bargaining. In Latvia, only 10 hospitals have jointly formed an employer's organization since the central authorities are not the employers anymore. Similar problems may appear in developing countries. The workers' organizations from Zambia report that only individual hospitals would be the partner in negotiations. However, the Brazilian workers' organizations report that there is a move to strengthen the municipal employers' organization. In Lithuania, the employers stressed the need for social dialogue.

Workers' participation in the reform process and their commitment to reform are essential for its successful implementation since health workers are those who in the end have to manage the reform and put it into place. Participation of health care workers and their unions in health reforms has varied across countries. In some countries health workers and their unions are involved in the preparation and implementation of health reforms. In general, however, they have had a limited role in planning and implementing health reforms and have sometimes been even viewed as impediments to reform.

According to some Canadian provincial jurisdictions, health care workers are eligible to serve on regional health authorities and in fact there is an increasing number of registered nurses serving as members of regional health authorities.

In Ghana, Niger and South Africa, health care personnel participates in the design and implementation of the reforms. Moreover, in Ghana, the unions will be represented in the Health Service Council at various levels. In Mexico, the governments of the Federal States signed with the trade unions of the health sector a national agreement on the decentralization of the services and in Finland, where health workers enjoy high prestige, they were consulted during the decision-making process that led to the reforms and participated in the implementation of these reforms. In Colombia, workers also participated through their organizations in the discussion on the shape of the national health body.

In Austria, the health personnel was involved in planning and implementation of reforms. In Central and Eastern European countries such as Latvia, Lithuania, Poland, the Russian Federation, Slovakia, the health staff are involved in reforms. In the UK, staff were in the past expected to implement the reform but were not involved in planning. A change is promised there by the new Labour Government.

In other countries, health care workers are mainly regarded as a cost factor and do not participate in the reform process. This is the case in Zambia. In Brazil, health workers are not consulted either and this may be one reason why they resist the reforms.

11. What is the best way to deal with ethical problems of accountability towards patients, employers and professional bodies? How can workers be protected in employment relationships against such dilemmas in raising matters in the public interest?

Although privatization moves have occasionally contributed a “notion of efficiency” to the functioning of the health sector, application of monetary, fiscal and pricing policy solutions to health, as to other sectors, has in some cases damaged health objectives. By the same token, ethical values have been to a certain extent undermined, as commercial interests have been entering into the health sector through privatization and marketing initiatives.

Although privatization and social marketing **may** be effective instruments in order to improve equity and access to health care and health promotion, this process may have unpredictable consequences, with managers responding to market signals in a way that is implicitly and explicitly harmful to the purposes of socially provided health care. Beyond the criteria of economic efficiency, a wide range of other criteria (epidemiological, health, technological, social) needs to be taken into account in assessing whether any particular configuration of health resources is socially efficient or not.

The replacement of registered/licensed nursing personnel with less skilled workers can be observed with increasing frequency in several countries. While this may allow immediate reductions in cost it may have a devastating effect on the level of care for patients, on the general quality of the service provided and on the overall image of the health organization. In the longer run, it may also have a negative impact on the financial situation of the providers, as shown in numerous cases that involved injuries and death of patients in the US. Consequently, additional training of staff must be introduced, consuming parts of the savings made. Other costs have been incurred through the need for intensive supervision and longer hospital stays – including intensive care – in order to correct the effects of negligence. Information on the quality of care is not however monitored systematically by independent bodies.

Particularly in reforms of the health sector, health care workers and managers find themselves increasingly exposed to a dilemma between medical and health care ethics on the one hand and business and policy perceptions on the other. Health workers have professional responsibility and accountability towards the patients and the public that may bring them into conflict within their employer-employee relationship. This may also apply to “gagging clauses”, clauses in the employment contract introduced specifically to prevent staff from raising matters in the public interest.

Whereas ethical issues appeared in the past to be more related to the performance of specific services, the dilemma emerges today from the general conduct of managers and workers. The impact on health workers is even more critical, since their registration/license – which is based on professional patterns of

conduct – could be at stake. The ILO Sectoral Meeting in 1992 discussed integrating the codes of ethics and practice for health workers and managers into collective agreements.

It is in this context that initiatives have been undertaken to provide more protection to staff who give information on the quality of services, often termed as “whistle blowers”. In the UK, the groups “Freedom to Care” and later “Freedom to Nurse” were created to offer fora for the free expression of concerns about the quality of care and to campaign for “whistle blowers”, who often act against specific contract clauses. Such initiatives contributed in the UK, as previously in the US, to the adoption of a law protecting workers against dismissal on the basis of public interest disclosure.

Exposure to professional dilemma can occur in an extreme form when health workers are exposed to political pressures in situations of human rights. In this respect, Amnesty International launched in 1996 a campaign defending the ethics of medical and health personnel by establishing minimum standards for their profession.

12. To what action(s) should the ILO give priority in order to assist its constituents in successfully initiating and adapting to the changes described in this report?

The ILO attaches great importance to the fact that the improvement of employment and working conditions of health and medical staff is vital to a satisfactory delivery of services in this sector.

Considering the critical importance of the health sector in terms of its workforce and in terms of percentage of global GDP, the ILO adopted a sectoral perspective, in accordance with its mandate, to deal with terms of employment and working conditions of health care delivery staff affected by recent health care reform moves. Such sector reforms are most likely to achieve their objectives of delivering efficient, effective and high quality services when planned and implemented with the full participation of health workers and their unions and consumers of health services at all stages of the decision-making process.

It goes without saying that the commitment of health care personnel to reform constitutes one of the cornerstones to it's the success of such reform Effective communication, consultation and negotiation with a view to reaching agreement with workers and their unions are essential during restructuring.