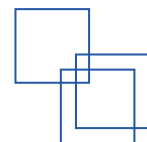




International  
Labour  
Office

Social dialogue in the health services:  
A tool for practical guidance

# **The handbook for practitioners**



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Print version: 92-2-118244-4 (print)

Web, PDF version: 92-2-118245-2 (web pdf)

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## Preface

Concern about public health and the increasing cost of health care have made the subject of health one of the most debated political issues in many countries. The vital role of governments, employers' and workers' organizations and the importance of social dialogue in addressing these issues have only been recognized recently. There is now wide recognition of the role of social dialogue in advancing and sustaining reform processes in many areas of the health sector, hence improving health care and mitigating any negative impact on public health. In order to ensure better delivery of health services, the institutions and capacity for social dialogue need to be strengthened.

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness was held from 21 to 25 October 2002 at the International Labour Office (ILO) in Geneva, under the Sectoral Activities Programme. The Meeting participants recognized the great potential of social dialogue to contribute positively to the development and reforms of health services, by enabling governments, employers' and workers' organizations to draw upon their knowledge and experience.

“Social dialogue in the health services: A tool for practical guidance” was developed based on the Conclusions of the Joint Meeting. The “Tool” has reached policy makers as well as those persons who plan and organize processes of social dialogue in the health services by providing instruments to manage and to facilitate processes of social dialogue and by offering guidance on issues to be considered.

In order to complement the Tool, this Handbook for practitioners has been developed as a companion document in order to provide practical direction for the facilitators and organizers of the ILO constituents and other stakeholders in health services. Practitioners will thus have access to a series of useful advice and exercises to assist them in either conducting training courses for participants in social dialogue, or in actually implementing social dialogue processes.

It is hoped that this publication will make a helpful contribution to the strengthening of capacity and institutions for social dialogue in the health services in many countries and in turn assist in the delivery of quality health services. We are grateful to Ms. Gabriele Ullrich for the development of this Handbook.

Norman Jennings  
Deputy Director  
Sectoral Activities Programme



# Contents

	<i>Page</i>
<b>Introduction</b> . . . . .	<b>1</b>
<b>Glossary</b> . . . . .	<b>3</b>
<b>First Part: Context of social dialogue in the health services</b> . . . . .	<b>5</b>
<b>Section 1: General considerations</b> . . . . .	<b>6</b>
Notes for the facilitator: Four steps to establish the framework for social dialogue . . . . .	8
1.1 Creating the basic infrastructure . . . . .	8
1.2 Discovering the common knowledge base . . . . .	10
1.3 Organizing dialogue . . . . .	11
1.4 Creating a common vision . . . . .	12
<b>Section 2: Health services and understanding social dialogue</b> . . . . .	<b>13</b>
Notes for the facilitator: Four steps to understand social dialogue . . . . .	15
2.1 Providing examples . . . . .	15
2.2 Identifying the participants . . . . .	15
2.3 Discussing the term “social dialogue” . . . . .	16
2.4 Initiating the choice of the relevant social dialogue elements . . . . .	16
<b>Section 3: Agenda of social dialogue in the health services</b> . . . . .	<b>18</b>
Notes for the facilitator: Four steps to set the agenda for social dialogue . . . . .	23
3.1 Recognizing needs and potentials . . . . .	23
3.2 Prioritising agenda items . . . . .	24
3.3 Identifying the decision makers . . . . .	25
3.4 Integrating gender issues . . . . .	25
<b>Section 4: Representation of the social partners</b> . . . . .	<b>27</b>
Notes for the facilitator: Three steps to establish representation . . . . .	33
4.1 Building capacity . . . . .	33
4.2 Recognizing representation . . . . .	33
4.3 Matching the agenda with the participants . . . . .	34

<b>Section 5: Social dialogue in situations of structural change</b> . . . . .	<b>35</b>
Notes for the facilitator: Three steps to address structural change through social dialogue	39
5.1 Mapping the current situation . . . . .	39
5.2 Enabling early warning . . . . .	40
5.3 Consulting with other stakeholders . . . . .	40
<b>Section 6: Identifying and enforcing quality standards</b> . . . . .	<b>42</b>
Notes for the facilitator: Three steps to identify quality standards through social dialogue	46
6.1 Creating quality standards . . . . .	46
6.2 Choosing quality standards . . . . .	47
6.3 Developing indicators . . . . .	48
<b>Section 7: Establishing and strengthening institutions for social dialogue in the health services</b> . . . . .	<b>49</b>
Notes for the facilitator: Four steps to strengthen social dialogue institutions in the health services . . . . .	53
7.1 Strengthening the understanding of social dialogue in the health service . . . . .	53
7.2 Selecting participants for social dialogue training . . . . .	54
7.3 Identifying training needs and potential . . . . .	54
7.4 Auditing the resources . . . . .	55
<b>Second Part: The process of social dialogue in the health services</b> . . . . .	<b>57</b>
<b>Section 8: Planning for social dialogue</b> . . . . .	<b>58</b>
Notes for the facilitator: One step to arrive at a mutually agreed plan . . . . .	61
8.1 Agreeing on a plan . . . . .	61
<b>Section 9: Initiating social dialogue in the health services</b> . . . . .	<b>62</b>
Notes for the facilitator: One step to start the social dialogue . . . . .	64
9.1 Choosing the right entry point . . . . .	64
<b>Section 10: Implementing social dialogue</b> . . . . .	<b>65</b>
Notes for the facilitator: Three steps to ensure the implementation of social dialogue in the health services . . . . .	67
10.1 Preparing guidance . . . . .	67
10.2 Ensuring continuity . . . . .	68
10.3 Preparing for the adjustment . . . . .	68
<b>Section 11: Monitoring and evaluating the process of social dialogue in the health services</b> . . . . .	<b>69</b>
Notes for the facilitator: Three steps to monitor and evaluate . . . . .	72
11.1 Standardizing m&e instruments . . . . .	72
11.2 Involving the social partners in m&e . . . . .	72
11.3 Analysing m&e results for possible adjustments of the plan . . . . .	73
<b>Section 12: Mobilizing the resources needed for social dialogue in the health services</b> . . . . .	<b>74</b>
Notes for the facilitator: Two steps to prepare for the mobilization of resources . . . . .	76
12.1 Preparing cost estimates . . . . .	76
12.2 Launching the discussion on resources . . . . .	77
<b>Additional information</b> . . . . .	<b>79</b>

## List of preparatory work before social dialogue events

• Notes 2.1: Identify and describe examples of the different elements of social dialogue . . . . .	15
• Notes 4.2: Compile background materials on the representation of the social partners . . . . .	33
• Notes 5.1: Gain an overview of the needs and ideas for structural change of the existing social dialogue institutions in the health services . . . . .	39
• Notes 5.3: Gain an overview of the needs and ideas for structural change of other stakeholders beyond the social partners . . . . .	40
• Notes 6.1: Identify quality standards in the health services by involving the social partners . . . . .	46
• Notes 7.3: Identify training needs and potential . . . . .	54
• Notes 11.1: Prepare questionnaires and other instruments to monitor and evaluate the process of social dialogue . . . . .	72
• Notes 12.1: Preparing cost estimates . . . . .	76

## List of exercises during social dialogue events

• Notes 1.3: Organizing dialogue . . . . .	12
• Notes 1.4: Arrive at a common vision of health care reform . . . . .	12
• Notes 2.3: Create a common understanding of social dialogue . . . . .	16
• Notes 2.4: Understand the implications of choosing social dialogue elements . . . . .	16
• Notes 3.1: Understand the current situation of the health services . . . . .	23
• Notes 3.2: Develop a sequence of priorities for the agenda . . . . .	24
• Notes 3.4: Sensitize on specific gender issues in the health services . . . . .	25
• Notes 4.3: Develop the “agenda-participants” matrix in a given situation . . . . .	34
• Notes 6.1: Identify quality standards in the health services involving by the social partners . . . . .	46
• Notes 6.2: Enable a participatory choice of quality standards in order to benefit from the knowledge and experience of the social partners . . . . .	47
• Notes 6.3: Develop indicators for quality standards and identify ways for implementation . . . . .	48
• Notes 7.4: Auditing the resources . . . . .	55
• Notes 8.1: Arrive at a mutually agreed plan . . . . .	61
• Notes 12.2: Discuss and decide on the estimated costs and the mobilization of the resources . . . . .	77





# Introduction

## **The ILO commitment to health care through tripartism and social dialogue as a basic human right**

Tripartism and social dialogue are integral components of the Decent Work Agenda of the ILO and essential channels for achieving it. The resolution concerning tripartism and social dialogue, adopted by the 90th Session of the International Labour Conference in 2002, invited governments of member States to ensure that the necessary pre-conditions exist for social dialogue, including respect for the fundamental principles and the right to freedom of association and collective bargaining, a sound industrial relations environment, respect for the role of social partners in achieving employment goals and improving social protection. The ILO considers health care as a basic human right and an essential requirement for improving working and living conditions, as stipulated in the conclusions of the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms in 1998 and in the resolution concerning health care as a basic human right adopted by the Joint Meeting on Social Dialogue in the Health Services in 2002. Social Dialogue has great potential to contribute to this end as concluded at the latter meeting.

## **The origins of the “Tool” and the “Handbook”**

In its conclusions, the Joint Meeting agreed on a framework for practical guidance to strengthen social dialogue in the health services. Following the decision of the Governing Body of the ILO in its 286th Session, March 2003 to approve these conclusions, constituents requested these to be made available as a tool for practical guidance in order to establish and strengthen social dialogue in the health services. The Tool was published in January 2004 and was intended to reach policy-makers as well as those persons who plan and organize processes of social dialogue in the health

services. It was meant to provide instruments to manage and to facilitate processes of social dialogue in the health services, targeting particularly those groups of persons who were already convinced of the usefulness of social dialogue in health services.<sup>1</sup> More basic and general information on social dialogue is already available in other guidelines and resource books of the ILO.<sup>2</sup>

In order to provide better practical guidance to organizers and facilitators of social dialogue in the health services, this “Handbook for practitioners” (hereinafter called Handbook) supplements the text of the Tool with a set of practical notes and tips (hereinafter called “Notes”).

## **The structure of the Handbook**

The Handbook follows the original text of the Tool and is structured in two parts. The first part sets out the context of social dialogue in the health services and the second part describes the process of social dialogue in the health services. The 12 sections of these two parts quote the conclusions of the Joint Meeting on Social Dialogue in the Health Services. This text is printed in italics in boxes with a coloured background and is identical to the sections and their titles in the conclusions of the meeting as well as with the numbers of the paragraphs. This text constitutes the political guidance as recommended by the ILO tripartite structure. To make the text more accessible for the practical use in social dialogue in the health services, concrete examples on how the issues of the respective section were handled in a given situation are described in boxes. Some general explanations, tables and figures complement these examples and provide tools to be used in social dialogue in the health services. Furthermore, checklists in each section endeavour to facilitate practical implementation. These checklists propose a number of questions to be examined in a given situation, knowing that these lists

<sup>1</sup> These target groups may draw supplementary information and guidance from the publication of WHO/ILO/ICN/PSI, *Public service reforms and their impact on health sector personnel – Critical questions: A tool for action*, Geneva, 2001

<sup>2</sup> For example, J. Ishikawa, *Key features of national social dialogue: A social dialogue resource book*; ILO InFocus Programme on Social Dialogue, Labour Law and Labour Administration, Geneva, 2003; and ILO, *Practical guide for strengthening social dialogue in public service reform*, ILO Sectoral Activities Department, forthcoming.

are not exhaustive and that they may have to be supplemented.

The Handbook supplements the original text of the Tool with the Notes for organizers and facilitators on separate pages which are referred to in the original text of the Tool. These Notes include (a) practical tips for preparatory work to be done before individual social dialogue events and (b) exercises to be applied during such events. For ease of reference, both preparatory work and exercises to be done are listed in the table of contents. It is recommended that these be studied in the context of each Section.

### **The approach of the Handbook**

The Handbook endeavours to respond to the multi-faceted challenges of social dialogue in the health services that take place at various levels, such as national, local, enterprise and workplace levels. Social dialogue in the health services

requires parallel processes of learning in order to arrive at improved methods of adult learning, strengthened capacities for social dialogue and an improved quality of health services.

### **The target group of the Handbook**

The Handbook may be used as a “training of trainers” manual to assist in the development of organizers and facilitators of social dialogue processes, as well as of health services specialists who will work as part of training teams. This Handbook refers to the organizer and the facilitator, but these may well be the same person carrying out the two functions.

### **The terminology of the Handbook**

The terms used in the following text are taken from the conclusions of the Joint Meeting in 2002. Most important, the terms “social dialogue” and “social partners” are defined in the following way:

#### ***Social dialogue***

*“Social dialogue in the health services may include all types of negotiation and consultation, starting with 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 and their choice depends on this targeted outcome. A common understanding has to be reached on the purpose of social dialogue. Therefore, at the outset of a process of social dialogue, the social partners should have clear ideas on the elements of social dialogue to be included and who will decide on the inclusion of these elements.”*

#### ***Social partners***

*“The social partners in health services are in principle public authorities as regulators or as employers, private employers’ and workers’ organizations in the health sector. However, in view of the financial implications of the health sector for other government structures, employers and workers, other stakeholders beyond the health sector may also be involved in policy developments, except on matters properly the concern of negotiating and collective bargaining parties. The organizations or institutions which represent the groups in the health sector have changed over the past two decades. A greater variety of government levels are also involved. New private employers have entered the health sector and related services.”*

Social dialogue in health services may encompass a wider dialogue on broader issues in health sector reforms which will often include consultations with other stakeholders beyond the social

partners (e.g. professional associations or the users of health services). In issues such as collective bargaining, however, other stakeholders are not involved.

# Glossary

## Information on the terms used in the Handbook

### **Organizer:**

The organizer is the person who manages social dialogue events and processes in the health services, and is responsible for keeping the social dialogue event and process on track. The organizer puts into motion a plan that has been approved by the partners and uses the plan as a road-map. If the participants of the social dialogue process are moving the plan in new directions, the organizer has to alert them.

### **Facilitator:**

The facilitator is the person who assists the learning and dialogue processes. To serve as a facilitator in social dialogue one requires a solid knowledge of participatory training and planning methodologies. A facilitator's open and positive attitude in listening to various opinions will enable the participants to find their own solutions. The neutral function of a facilitator has to be distinguished from the function of an organizer or an expert who may have to take a position in a discussion. Even though the same person could act in all three functions, it has to be made clear, however, in which of these functions the person is acting in any given situation. In certain situations, it may be preferable to create teams of two to three persons who could divide the different roles among each other.

### **Organizer/Facilitator:**

Even when the same person is acting in the two functions, social dialogue may be effectively undertaken. It has to be made clear, however, in which of these functions the person is acting in any given situation. **For the sake of clarity, the Handbook will refer to the “facilitator”, even if the facilitator also has organizational responsibilities.**

### **Expert/Specialist:**

The expert or specialist is the person who can advise the participants of social dialogue events and processes on specific issues in the health services or on technical matters. The experts can evaluate the consequences of solutions and plans identified by participants.

### **Social Dialogue in the Health Services:**

The conclusions of The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness which was held in Geneva from 21 to 25 October 2002 (hereinafter referred to as the Joint Meeting) adopted the following description: “Social dialogue in the health services may include all types of negotiation and consultation, starting with 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 and their choice depends on this targeted outcome. A common understanding has to be reached on the purpose of social dialogue. Therefore, at the outset of a process of social dialogue, the social partners should have clear ideas on the elements of social dialogue to be included and who will decide on the inclusion of these elements.”

### **Social Partners in the Health Services:**

According to the conclusions of the above meeting, “The social partners in health services are in principle public authorities as regulators or as employers, private employers' and workers' organizations in the health sector. However, in view of the financial implications of the health sector for other government structures, employers and workers, other stakeholders beyond the health sector may also be involved in policy developments, except on matters properly the concern of negotiating and collective bargaining parties. The organizations or institutions representing the groups in the health sector have changed over the past two decades. A greater variety of government levels are also involved. New private employers have entered the health sector and related services.”

**Elements of Social Dialogue:**

The major elements of social dialogue are information sharing, consultation and negotiation. Their choice depends on the targeted outcome of social dialogue and none should be excluded. The elements are not mutually exclusive, discussion flows are not necessarily sequential and the elements may overlap.

**Types of social dialogue:**

The types of social dialogue may be distinguished according to their geographical coverage at regional, national and local levels, or according to their coverage of workplaces at cross-sectoral, sectoral and enterprise levels.

**The Handbook:**

In the Conclusions of the Joint Meeting on Social Dialogue in the Health Services mentioned above, constituents requested the ILO that a tool for practical guidance be produced in order to establish and strengthen social dialogue in the health services. This “Tool” was published in January 2004 with the intention of reaching policy-makers as well as those persons who plan and organize processes of social dialogue in the health services. In order to provide better practical guidance to organizers and facilitators of social dialogue in the health services, the current publication supplements the text of the Tool with a set of practical notes. These notes have been integrated into the chapters to complement the original texts, and this new publication is herewith published as the “Handbook”.

**Conclusions:**

With the term “Conclusions”, the Handbook refers to the conclusions of the Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness held by the ILO in Geneva from 21 to 25 October 2002. The text of each Conclusion appears in a box at the beginning of each chapter.

**Bipartite Social Dialogue in the Health Services:**

This refers to social dialogue in the health services in which the employers and workers and their organizations participate without the presence of Governments as regulators. This type of social dialogue takes place mainly at enterprise level. The Government may participate in such dialogue as the public employer.

**Tripartite Social Dialogue in the Health Services:**

This refers to social dialogue in the health services in which Governments participate as regulators together with the employers’ and workers’ organizations. This type of social dialogue can take place at national, regional and local levels.

**Health services:**

Health services may be defined either in a narrow or in a broad sense. In a narrow sense, health services include the staff in health care institutions and persons working self-employed in health care. In a broader sense, health services may also include personnel of social services supplying medical aid (e.g. to the elderly), cleaning and catering personnel, teaching and research personnel, administrative personnel in health care and related institutions (e.g. health insurances, units for supplies and equipment for health care). The borders between various areas of employment in the health services and other health related or social services are often blurred and vary from country to country. In addition, these borders have changed over time with new demographic, financial and organizational challenges in the health services. For the purpose of this Handbook, it is recommended to analyse the given situations in each country accordingly.

First part:

## **Context of social dialogue in the health services**

The first part of the conclusions sets out the context in which social dialogue takes place. The following sections 1-7 endeavour to facilitate the understanding of frequently used terms in this context, of the variety of agendas to be dealt with in social dialogue, the representation of the social partners, the challenge of structural change in the health services, the need for quality standards in the health services, and of the challenge of strengthening social dialogue in the health services.

## Section 1: General considerations

### *Text of the conclusions*

***“1. There is widespread recognition that social dialogue has great potential to contribute positively to the development and reforms of health services, even though it cannot be a panacea for all issues. Health services also require appropriate policies to be adopted by governments and international institutions. They need to be affordable and sustainably funded to provide for growing, changing and diverse needs of the whole population. Social dialogue can contribute positively to health service reform by enabling governments, employers’ and workers’ organizations and other policy leaders to draw upon their knowledge and experience. Dialogue with user organizations and other stakeholders should also be encouraged where it is appropriate.***

***2. The social partners each bring their own interests and concerns to social dialogue. While they have many interests and concerns in common, they also have competing concerns and interests. Social dialogue can improve their ability to go forward together where they have interests in common and can also contribute positively to reaching compromises about matters on which they have different views. Social dialogue in the health services is, however, based on certain values and principles to which all social partners subscribe. Patients’ needs, professional ethics and affordable and universal access to health services are also fundamental components.”***

These general considerations of the conclusions of the Joint Meeting on Social Dialogue in the Health Services in 2002 (hereafter called the “conclusions”) may assist to develop a national policy on reforms of the health services through

social dialogue. When developing such national policy as the basis for processes of social dialogue in the health services, social partners may also be inspired by international policy positions on health sector reforms such as those in the box below.

### Box 1: International policy statements on reforms of health services

“Health sector reforms cannot be imposed from above and from outside. They are most likely to be successful if they are implemented in effective and efficient concertation with the representatives of the workers” ... “The ILO considers health care a basic human right and an essential requirement for improving working and living conditions” (conclusions of the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms in the Note on the proceedings, ILO, Geneva, 1998. (Complete text at: [www.ilo.org/public/english/dialogue/sector/sectors/health/publ.htm](http://www.ilo.org/public/english/dialogue/sector/sectors/health/publ.htm))

The Ljubljana Charter on Reforming Health Care in 1996 of the European Member States of WHO and the WHO of the European Region stipulates for health-care reforms as fundamental principles: Health-care systems are driven by values; targeted on health; centred on people; focused on quality; based on sound financing; oriented towards primary health care, and as principles for managing change: Develop health policy; listen to the citizen’s voice and choice; reshape health-care delivery; reorient human resources for health care; strengthen management; learn from experience. (Complete text at: [www.who.int/docstore/bulletin/pdf/issue1/ljubljana.pdf](http://www.who.int/docstore/bulletin/pdf/issue1/ljubljana.pdf))

## Checklist 1: Developing a national policy on health services reforms as basis for social dialogue

In order to develop a national policy on health sector reforms (see the “Four Steps” below) which is acceptable to the social partners, the following questions should be answered:

- **What national policy statements on health services exist?**

Almost all countries have undergone health sector reforms in the past decades. The policy papers to introduce such reforms mostly contain policy statements on the commitment to certain basic principles on public health and health-care systems. Such statements have to be traced and examined (see [Notes 1.2](#) below). In a number of countries, such statements on basic principles are also included in the constitution.

- **What codes of professional ethics exist?**

Organizations of health-care professionals subscribe in each country to a code of ethics in various forms. Codes of ethics also exist with international bodies, to which national organizations adhere, e.g. the International Council of Nurses (ICN) and the World Medical Association. Such different codes should be traced and examined (see [Notes 1.2](#) below) with regard to their visions on public health and health-care systems.

- **What international standards on health services exist and are ratified?**

International standards on public health and health-care systems exist with international and regional organizations. Such specific standards exist with the ILO and WHO. ILO labour standards which are of specific relevance in this context, are the Nursing Personnel Convention, 1977 (No. 149), and Recommendation (No. 157), as well as the Medical Care Recommendation, 1944 (No. 69).<sup>3</sup> Other relevant statements are contained in conclusions and resolutions of ILO sectoral meetings.<sup>4</sup> Relevant WHO health standards are for example contained in the Declaration of Alma Ata of 1978 adopted by the International Conference on Primary Health Care.<sup>5</sup> In a given situation, it should be asked which texts were ratified or confirmed at national level.

- **To which statements can the social partners subscribe or which common vision can the social partners formulate?**

Ratified legal texts, such as the Nursing Personnel Convention, 1977 (No. 149), are binding for the social partners, but also other texts should be examined by all the social partners (see [Notes 1.3](#) below) to see whether they subscribe to the content and how a common vision could be formulated (see [Notes 1.4](#) below) on this basis.

<sup>3</sup> For the complete text of these and other ILO Conventions and Recommendations, see [www.ilo.org/ilolex/english/index.htm](http://www.ilo.org/ilolex/english/index.htm)

<sup>4</sup> Published in the *Note on the proceedings* of sectoral meetings, for the complete texts see [www.ilo.org/public/english/dialogue/sector/sectors/health](http://www.ilo.org/public/english/dialogue/sector/sectors/health)

<sup>5</sup> For the complete text of the Declaration of Alma Ata in 1978, see [www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)

## Four steps to establish the framework for social dialogue

In order to demonstrate the steps in a practical manner, the development of a national policy on health sector reforms will serve as an example of establishing a framework. Because this situation might be one of the most complex for social dialogue, it has been selected on purpose as it sets out the basic conditions for the successful operation of health services. However the four steps can also be applied in other situations in which social dialogue would benefit health services, for example, the development of a policy on HIV/AIDS or for an enterprise strategy against violence at the workplace. As previously mentioned however, these steps are based on the assumption that the necessary legal framework for social dialogue has already been established. Examples of possible agendas below illustrate the variety of situations in which social dialogue could be applied in the health services:

### *Selected possible agendas for social dialogue in the health services*

- Health services reform
- Financing of health services
- Decentralization and privatization
- Staff shortages (recruitment and retention)
- HIV/AIDS prevention and treatment
- Pay systems
- Gender issues in health services
- Quality standards of health care
- Work organization
- Workplace violence in health services
- Education and training for health service workers
- Migration of health care workers

(see also Section 4 below)

### 1.1 Notes for the facilitator: Creating the basic infrastructure

#### ***Objective: Establish a team of facilitators for social dialogue events.***

Facilitators are needed even at the early stages of developing a national policy on health service reforms through social dialogue events. The challenge for facilitators is twofold: having a sound knowledge of the health services in a given country and having the right skills and approach to facilitate the dialogue without imposing models and ideas. Some of the features of a facilitator's profile in approaching social dialogue events are listed below. (see also explanations in Section 10 below)

#### ***Facilitator's profile and basic rules<sup>6</sup>:***

The facilitator:

- mobilizes the creative energy and the existing knowledge of the participants and opens space for the interaction of all;
- motivates by means of questions that stimulate curiosity and exploration;

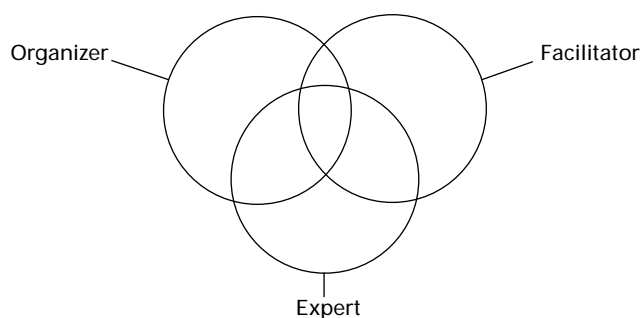
<sup>6</sup> Adapted from Ullrich, G., Krappitz, U., Gohl, E., Participatory Approaches to Cooperative Group Events, DSE, Feldafing, 1991, p16-18 and Oepen, M. Moderation and Visualization for Group Events, InWEnt, Berlin, 2003, p33.



- enables the exchanges of information and the resolution of conflicts by means of dialogue, but does not intervene directly;
- does not participate directly in the discussions and passes on questions about the subject matter to participants and experts;
- introduces rules and techniques of participatory approaches and makes proposals for a consensus of the group;
- formulates questions and procedures for group work carefully;
- visualizes the questions for group work on a board or flipchart, explains them clearly and asks whether further clarification is needed;
- does not change questions and procedures without consulting with the participants;
- allocates sufficient time for group work and provides appropriate breaks;
- often recapitulates the main objectives of the dialogue process,;
- allocates enough time for the presentation and discussion of group work in the plenary in order to recognize the efforts made;
- is not defensive about the training methodology and is open to suggestions for improvement.

In order to establish a team of facilitators for social dialogue events, a sequence of steps are needed which should result in the selection of a competent team while also containing the costs (financial and time) at a reasonable level.

- *identification of persons* familiar with health services and the interests of the various stakeholders: An appropriate approach would be to recruit the facilitators from the institutions of the social partners so that their training may be limited to the methodological part. However, a condition would be that the selected persons are willing to set aside their own institutional attachments and to facilitate the dialogue among the various institutions.
- *methodological training* of the identified persons: Facilitating social dialogue requires a solid knowledge of participatory training and planning methods and in particular an open attitude in listening to various opinions and enabling the participants to find their own solutions in conflicting situations. The neutral role of facilitator has to be distinguished from the function of an organizer and expert who has to take a position in the discussions. Even though the same person could act in all three capacities, it has to be made clear, however, in which capacity the person acting is in any given situation. It may be preferable to create for each event teams of at least two to three persons who could divide the different roles among themselves.



- *further on-the-job training and selection* of these persons: Serving as facilitators in social dialogue events is very demanding. Further on-the-job training or coaching for the facilitators may be necessary and professional training of trainers may be required. Experienced facilitators will be needed, in particular for more critical events when compromises for negotiated solutions have to be found such as joint policy statements on reforms of health services. In such cases, the role of the facilitator resembles that of a mediator.

## 1.2 Notes for the facilitator: Discovering the common knowledge base

**Objective:** compile the relevant international and national statements on health services as background material in order to prepare for a social dialogue event on health services reforms.

### *International statements:*

There are a number of international standards and statements that set out values and principles to be respected in reforms of health services. These are mainly the results of international meetings. Texts may be found in international policy statements subscribed to by the members of organizations such as the

- International Labour Organization (e.g. Standards on nursing personnel and medical care (complete texts at: [www.ilo.org/ilolex/english/index.htm](http://www.ilo.org/ilolex/english/index.htm)) Joint Meetings on Terms of Employment and Working Conditions in Health Sector Reforms, Note on the Proceedings, 1998 complete text at: <http://www.ilo.org/public/english/dialogue/sector/techmeet/jmhsr98/jmhsrn.htm> and Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness, Note on the Proceedings, 2002 –conclusions in this paper and complete text at: (<http://www.ilo.org/public/english/dialogue/sector/techmeet/jmhs02/jmhs-n.pdf>)
- World Health Organization (e.g. Declaration of Alma Ata, 1978, complete text at: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf))
- Ljubljana Charter on Reforming Health Care, 1996 complete text at: <http://www.who.int/docstore/bulletin/pdf/issue1/ljubljana.pdf>)
- International Council of Nurses (ICN) e.g. the Code of Ethics (complete text at: <http://www.icn.ch/icncode.pdf>) The ICN Code of Ethics for Nurses is a guide for action based on social values and needs. It guides nurses in everyday choices but it also provides basic orientation for possible reform processes.
- World Medical Organization (International Code of Medical Ethics – complete text at: <http://www.wma.net/e/policy/c8.htm> and the Helsinki Declaration on medical research - complete text at: <http://www.wma.net/e/policy/b3.htm>)
- Public Services International (PSI) outline their vision on health services at: [http://www.world-psi.org/Content/NavigationMenu/English/Policy\\_and\\_Issues/Health/PSI\\_Health\\_Sector.htm](http://www.world-psi.org/Content/NavigationMenu/English/Policy_and_Issues/Health/PSI_Health_Sector.htm)

### *National statements:*

To develop a national policy on reforms of the health services through dialogue between the social partners is a challenge currently faced by many countries, be they developing countries, transition countries or industrialized countries. The development of a national policy means that each of the social partners involved brings their own vision on health and health services into such dialogue. Before an event is organized it is therefore essential to have relevant texts available for the facilitator and all participants in the event. The texts have to be retrieved well in advance and reproduced in sufficient numbers so that they can be used during the discussions and also for the formulation of a new text.

Texts which describe a country's current position on health and health services may be found in:

- the constitution of a country: some countries have clear reference to the population's health in their constitutions (e.g. Brazil), others refer to the well-being of the people (e.g. United States). Since "health" is defined by WHO as the physical, mental and social well-being of the population, it is also recommended that such references be identified in the Constitution. These can provide a common denominator in social dialogue and politically solid grounds for a national policy statement on health services reforms.

- policy papers of the Ministry of Health: existing policy papers on the health services and related issues are often known to the participants of social dialogue by their titles but less frequently by their full text. The availability of such texts at social dialogue events is therefore essential. Related policy papers may also exist in other sectoral ministries such as labour, agriculture and consumer protection.
- statements of employers' organizations: since the type and structure of employers in the health services (public and private) are undergoing fundamental change in many countries, policy statements of employers' organizations for this sector may still be under development. It may be worthwhile to retrieve statements of individual employers that could serve as models.
- statements of workers' organizations including professional organizations: these exist in many countries, covering various categories of the health services personnel. However, in many cases there is no unified overall organization and no overall statement of vision for health services and their reforms. Therefore, it is important to retrieve all existing statements in order to have them available for reference and comparison at the social dialogue event.
- statements of political parties: since health services reforms often require legislative change and hence need broad support from various parties in a country's legislative body, it may be advisable to identify whether the represented political parties dispose of statements on health and health services and to make such statements available to the participants of the social dialogue event.
- statements of user organizations, research institutions and other stakeholders: due to the broad support needed for health service reforms, it is important to also screen other relevant statements on health and health services including those of patients' organizations, consumer protection associations, health research institutions as well as health and pension insurances. Essential information may be drawn from these resources.

## Exercise during social dialogue events

### 1.3 Notes for the facilitator: Organizing dialogue

**Objective: Examine and discuss existing texts among the social partners (separately and jointly) in a social dialogue event with regard to their vision of a reform of the health services.**

In a social dialogue event for establishing a policy statement on the reform of health services, the first step is to examine existing texts of the social partners and other relevant stakeholders. It is preferable to conduct this exercise for each social partner separately in working groups, and then to bring the social partners together in which each present their findings.

A list of basic criteria against which the texts should be examined in each group and in the plenary should follow the conclusions of the Joint Meeting and other international statements. The criteria should indicate that:

- 1) Health services need to be affordable and realistically funded in order to provide for the growing, changing and diverse needs of the whole population;
- 2) Patients' needs and choice are to be respected;
- 3) Professional ethics and quality are to be respected;
- 4) Universal access to health services are guaranteed;
- 5) Social dialogue is considered as contributing positively to health services reforms;
- 6) Dialogue with user organizations and other stakeholders is encouraged.

The plenary discussion should give further indications on how these criteria can be completed. Further criteria should, however, be agreed by all groups of participants.

## Exercise during social dialogue events

A scenario on how the working groups and the plenary may analyse a text against these criteria could be designed in the following way:

- On a flip-chart or otherwise visible area, list the basic criteria that were agreed upon throughout the discussion;
- Decide on an order of priority and allocate discussion time for each text;
- Write the results of the discussion of each text next to each listed criteria in the following matrix on a flip-chart:

	Text A	Text B	Text C	Text B
Criteria 1				
Criteria 2				
Criteria 3				
Criteria 4				
Criteria 5				
Criteria 6				

- Prepare this matrix for presentation to the plenary.
- Discuss common and competing concerns in the plenary giving each of the social partners the opportunity to express their views.

### 1.4 Notes for the facilitator: Creating a common vision

**Objective: Arrive at a common vision of health care reform.**

Various methodologies exist on how to bring the visions of the different stakeholders into one common vision acceptable to all, and on how to formulate this vision. The Notes 1.3 above outlined a procedure of how to listen to each partner's view points.

## Exercise during social dialogue events

In the plenary, the next steps would be to:

- jointly identify the common and the conflicting concerns and list them separately;
- formulate a text for each of the common issues, using as much as possible the texts which were already examined beforehand;
- discuss the contentious issues and ask volunteers or volunteer groups to formulate compromises likely to be acceptable to all social partners (alternatively ask the facilitator or a specialist of the team to make a proposal);
- finalize the texts of the compromises in the plenary;
- discuss the complete text of the objective for the health services reform in separate groups of the social partners;
- finalize the concluding text in the plenary.

## Section 2: Health services and understanding social dialogue

### *Text of the conclusions*

***“3. Social dialogue in the health services may include all types of negotiation and consultation, starting with 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 and their choice depends on this targeted outcome. A common understanding has to be reached on the purpose of social dialogue. Therefore, at the outset of a process of social dialogue, the social partners should have clear ideas on the elements of social dialogue to be included and who will decide on the inclusion of these elements.”***

The term social dialogue describes a cooperative approach to labour relations. This term is particularly used in the ILO and the European Union (EU), but also other terms such as partnership at work or labour management partnership are used for the same approach. The above definition was

established for the health sector in the conclusions of the Joint Meeting on Social Dialogue in the Health Services in 2002 and includes different elements (see box 2 below) and types of institutions, at sectoral, cross-sectoral, local and national levels (see [Notes 2.1](#) below).



## Checklist 2: Reaching understanding on social dialogue

In order to reach understanding on the basics of social dialogue in the health services questions such as the following have to be addressed by the social partners:

- **What is social dialogue?**

The discussion of this question has to be led in the context of a given situation in the health services (see [Notes 2.3](#) below). This discussion may be extended and lengthy but it can not be replaced by simply adopting a definition from policy statements, technical literature or other papers. The discussion will not only result in a common understanding of social dialogue, it also will be a social dialogue in itself, a “warming-up” exercise for the various parties involved in the dialogue process. The common understanding of social dialogue will also condition the agenda (see section 3 below).

- **Which elements of social dialogue should be chosen?**

The above box 2 lists the major elements of social dialogue. Their choice depends on the targeted outcome and none should be excluded a priori. The elements are not isolated from each other, the sequence in implementing these elements is not preconditioned and they may be overlapping and supplement each other.

- **Who will decide on the inclusion of these elements?**

The first steps of social dialogue may have been only initiated by one or more of the social partners in the health services. The opinion of the social partners concerned may differ as to which elements of social dialogue should be included. Therefore, it should be carefully discussed who (persons, committees) takes the decision on the elements of social dialogue and what power or authority these parties have in order to implement the decisions made (see [Notes 2.2](#) and [2.4](#) below). This phase of social dialogue is essential and should ensure that social dialogue does not break down at such early stages.

## Four steps to understand social dialogue

These Notes provide guidance on creating an understanding among the social partners of the different elements and the different types of social dialogue and their selection. This fundamental understanding is essential for a common view of the process, and it has to be established in the early stages so as to select the elements to be used in the social dialogue process ahead.

### 2.1 Notes for the facilitator: Providing examples

**Objective: Identify and describe examples of the different elements of social dialogue.**

The selection of examples to be used have to be relevant to the participants and as close as possible to their realities. Therefore examples for the different elements of social dialogue are not given intentionally in this Handbook. It is strongly suggested that examples emanate from the immediate environment of the participants.

#### Preparatory work before social dialogue events

Examples should be described in advance according to key elements that would result from answering the following questions:

- Which element of social dialogue will be illustrated by the example? (negotiation, consultation or information?)
- Which types of social dialogue institutions are involved? (at national, sectoral, local or enterprise levels?)
- How prepared are the partners for social dialogue?
- How is social dialogue to be initiated?
- What methodology and stages are to be used in the social dialogue?
- How is dialogue to be monitored and evaluated?

Examples may be found in the health services of the given country at national or local levels but also at the level of individual hospitals, in particular when the issue for social dialogue has direct and very practical impact on the social partners, such as working time organization, violence at work or HIV/AIDS prevention. (see also the list of Selected possible agendas in the Section 1). Some examples are described in the ILO Report to the Joint Meeting.<sup>7</sup>

### 2.2 Notes for the facilitator: Identifying the participants

**Objective: Establish a group of participants who can carry out the social dialogue process.**

The common understanding of social dialogue constitutes the basis for choosing the right elements (negotiation, consultation, and information sharing). The choice of the right elements might even entail a negotiation process in itself. Participants in these early stages should be well equipped with the authority to implement decisions taken. They should decide whether:

- government should be represented by the authority to decide on the health services in a given country (ministry of health and regulatory authority);

<sup>7</sup> Report to the Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness, ILO, Geneva, 2002. Complete text at [www.ilo.org/public/english/dialogue/sector/sectors/health](http://www.ilo.org/public/english/dialogue/sector/sectors/health)

- the public employers should be represented by the authority to decide on terms of employment and working conditions of the staff of the health services (which means in many countries not only the ministry of health but also the ministry in charge of public services and labour);
- the private employers in the health services should be represented by an organization of employers (not just only by individual employers); and
- the workers in the public and private health services should be represented by those organizations and bodies recognized under national law and practice as “representative” (see also Section 4 below).

The result of this selection process should be a group of participants who can later carry on the process. If the decision makers cannot participate themselves, they should endorse their representatives with decision making powers. The dynamics of a social dialogue event cannot be maintained if the participants have to constantly check with their institution or organization during the event.

### 2.3 Notes for the facilitator: Discussing the term “social dialogue”

**Objective:** Create a common understanding of social dialogue.

The ideal environment to create a common understanding on social dialogue is a social dialogue event itself. The facilitator should create an environment in which the discussion does not appear as an academic exercise of definition but as an interaction among the social partners in which they establish their own common understanding of social dialogue.

#### Exercises during social dialogue events

As warm-up exercises, the facilitator may use:

**role play** to illustrate social dialogue. The plenary will be divided into groups representing the respective social partners and each group is asked to prepare a position based on a fictitious example chosen by the facilitator. However, in plenary the groups will be requested to defend the position of *another* social partner, and not the one for which they had prepared. This playful switch may not only create a relaxed atmosphere, but may allow more in-depth reflection on the position of each social partner and on the meaning of social dialogue.

**open brainstorming:** by noting the ideas on a flipchart and then discussing the different perceptions. The facilitator asks each participant to respond spontaneously and briefly on the meaning of social dialogue. The facilitator or a second person notes down these statements in bullet form without any comments from their side or from the side of the participants. Once each participant has contributed, the plenary is invited to comment and discuss openly.

**noting ideas on cards:** Each participant receives one or two cards on which he/she quickly summarizes the meaning of social dialogue. The facilitator collects the cards, reads them out to the participants and groups them in clusters of similar meanings and then initiates a general discussion.

### 2.4 Notes for the facilitator: Initiating the choice of the relevant social dialogue elements

**Objective:** Understand the implications of choosing social dialogue elements.

In a social dialogue event, the facilitator has to initiate the choice of the social dialogue element (negotiation, consultation, information sharing) between the participants for the continuation of the social dialogue process. This choice may be limited by legal provisions (e.g. public service status of



health services staff) or by the choice of the agenda of social dialogue. (see Section 3 below) Therefore, the facilitator has to present such limitations to the participants and discuss their implications. For the social dialogue element “negotiation”, these limitations might be more relevant than for the element “information sharing”.

### Sample exercise in social dialogue

It is proposed that the facilitator opens the discussion with the examples in the following matrix:

#### Overview of selected examples for choosing social dialogue elements

	Negotiation	Consultation	Information sharing	Possible Limitations
Financing of health services		X	X	
Pay systems	X	X		Provisions for the public service
Quality standards of health care		X	X	
Education and training for health service workers	X	X	X	Provisions for the national educational system

If the participants are experienced in the process, the facilitator might use this matrix to collect the information from the social partners prior to the social dialogue event. The social partners can then express their preferences in writing, with the final decision being taken in a discussion between the social partners.

## Section 3: Agenda of social dialogue in the health services

### *Text of the conclusions*

***“4. Social dialogue in the health services does not take place in a vacuum. It requires concrete economic, social and labour issues to be on the agenda. In principle all matters concerning the health sector should be included in the social dialogue. These issues should be identified and each social partner should have the right to examine such issues. In the health sector these issues are often related to institutional reforms, financing of health services, the quality of health services, working conditions, skills and lifelong learning, recruitment and retention of personnel, career development, pay systems and gender issues. All social partners should set the agenda together and hence agree on a number of questions in relation to the agenda of the social dialogue such as the issues to be covered and how the agenda for the social dialogue in the health services will be set. Women, who make up the majority of the health-care workforce, continue in many countries to face discrimination, including inequitable pay. Social dialogue can contribute positively to addressing the issue and to enabling women to be proportionately represented in social dialogue institutions.”***

The above paragraph 4 of the conclusions stipulates that all matters concerning the health sector should be included in the social dialogue. However a choice has to be made among these matters for the agenda of social dialogue in a given situation (see [Notes 3.1](#) below). The variety of the

agenda chosen for social dialogue in the health services can be illustrated by two examples: New Zealand’s latest health sector reform at national level and the labour management partnership initiated by the US health care provider Kaiser Permanente at enterprise level.

### **Box 3: New Zealand’s Health Sector Reform of 1999**

The agenda of the health sector reform initiated in 1999 in New Zealand is an example of the range of activities to be undertaken and the social partners to be involved in this process. 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. 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, the indigenous people.

The timetable for health sector change had the following indicative dates:

#### *Policy development, consultation, legislation*

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

The timetable 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.

Source: ILO, *Social dialogue in the health services: Institutions, Capacity and Effectiveness, Report to the Joint Meeting*, Geneva 2002, p30

An agreement on the agenda at enterprise level will in general be discussed in a bipartite social dialogue, between the employers’ and the workers’ representatives. Also, such agreement can be formulated in much more detail than in the case of setting the agenda for reforming the health-

care system. The following box will introduce the experience on setting the agenda for a social dialogue at enterprise level in Kaiser Permanente in the USA. Since this experience is documented comprehensively, it will also serve for illustration in the later sections of this Tool.

#### Box 4: Setting the agenda for the partnership of labour and management in Kaiser Permanente (USA)

“In 1997, the Unions of the AFL-CIO Coalition of Kaiser Permanente Unions and Kaiser Permanente entered into a National Labor Management Partnership Agreement. By involving employees and unions in organizational decision-making at every level, our partnership is designed to improve the quality of health care, make Kaiser Permanente a better place to work, enhance Kaiser Permanente’s competitive performance, provide employees with employment and income security and expand Kaiser Permanente’s membership. The cornerstone of the Partnership is an innovative labor management relationship. In that spirit, the parties decided to embark on a voyage – one that had never been attempted – to collectively and simultaneously bargain 33 Partnership union contracts.

The Common Issues Committee, made up of union and management representatives from across the country was responsible for drafting this Agreement. To inform their work, they chartered seven Bargaining Task Groups (BGTs) in April of 2000. These seven groups were made up of approximately 300 management and union representatives from across the program.

The BGTs were charged with making comprehensive, long-term recommendations in the areas of Quality and Service, Health and Safety, Performance and Workforce Development, Wages, Benefits, Balancing Personal Life and Work Life, and Workplace Innovations to make Kaiser Permanente the best place to work. Over the course of several months, the Bargaining Task Groups developed comprehensive solutions for transforming our work environment. ...

The Pathway to Partnership was developed to provide a roadmap for making a transition to an environment characterized by collaboration, inclusion and mutual trust. Within the framework of the Pathways to partnership, this National Agreement provides for a new way to work and a new way to provide care. We will continually improve service, patient care and performance by enabling each person to engage her/his full range of skills, experience, and abilities. The National Agreement describes an organization in which unions and employees are integrated into planning and decisions-making forums at all levels including budget, operations, strategic initiatives, quality processes, and staffing. In our vision, decisions are jointly made by self-directed work teams – giving people who provide the care and the service the ability to decide how the work will be best done. We look forward to a time when all eligible employees participate in the Partnership and are covered by this National Agreement.

The National Agreement is designed to support two goals: implementation of the Partnership on a national and local level and movement toward nationwide consistency. Partnership implementation is supported through the reinforcement of regional and local partnership teams. And in some instances, the document provides specific timeframes required to assure progress toward implementation. The National Agreement also takes steps toward nationwide consistency in determining wages, benefits and certain other terms and conditions of employment. It is our blueprint for making Kaiser Permanente the employer and care provider of choice.

Section 1 of this Agreement covers the privileges and obligations of partnership, reflects our continued commitment to the Partnership, and integrates the work of the Bargaining Task Groups into partnership implementation. It provides mechanisms for spreading partnership, collaboration, and organizational transformation throughout our organization. It begins to define how workers and managers engage in areas such as quality and service, training and education, health and safety, and life balance programs. Section 1 also covers areas such as union security, partnership governance, and problem solving processes and elaborates on other privileges of Partnership. Recognizing that different areas and facilities are starting at different points, this section must be used in conjunction with the Pathways to Partnership. Some timeframes are included, but where not specifically noted, the foundation for transition, as outlined in the Pathways to Partnership, must be built for organizational transformation to be successful and enduring.

Section 2 identifies the specific provisions of the National Agreement which pertain to compensation, benefits and dispute procedures.

Section 3 describes the scope, application and term of the Agreement. ...”

Source: Kaiser Permanente, The Coalition of Kaiser Permanente Unions, AFL-CIO, *National Agreement*, October, 1, 2000, pp. 3-4, <http://www.unac-ca.org/pdf/nationalagreement2000.pdf> and <http://www.kaiserpermanente.org>

### Checklist 3: Establishing the agenda for social dialogue

To reach agreement on the agenda for social dialogue, the social partners involved should discuss and come to an agreement on the following questions:

- **How should the agenda for social dialogue be set?**

In informal and formal events, the social partners concerned should list and discuss various methods for identifying the agenda of social

dialogue (see [Notes 3.2](#) below). The examples of Kaiser Permanente and New Zealand’s health sector reform show that such discussions may already result in a plan for the social dialogue process.

- **Who should decide on the agenda?**

The first initiative for the consultation on health matters may come from one of the social partners, including the relevant govern-

ment structure. Nowadays, the awareness is widespread that also the other social partners should be involved at an early stage if the change to be introduced should be sustainable. Therefore, the initiating party should list the various organizations, their competence and authority to decide on the issues targeted and invite the appropriate levels to participate in the information and decision-making process (see [Notes 3.3](#) below). The following section 4 gives more details on the representation of the social partners.

- **How could gender issues be integrated into the agenda?**

Gender issues on the agenda of social dialogue in the health services may be multifaceted: they are related to the workforce and also to the effectiveness of the public health policy and the delivery of health services. Health sector reforms and related budgetary decisions may not be gender-neutral. In the past, reforms in some countries have had a higher impact on women than men, since the occupations in which women prevail had been

more affected. On the other hand, in many cultures, women are the “guardians” of the family’s health. Access to women is therefore important for the success of public health policies which in some cultures is only possible through female health professionals.

Female representation of the social partners is therefore a necessary condition for integrating gender issues into the agenda of social dialogue. However, this condition may not be sufficient. Men and women representatives may have to be reminded to put gender issues on the agenda by appropriate checklists which examine the gender implications of each of the agenda items. The European Union obliges therefore national authorities to examine their regulations and administrative decisions in the health sector in view of their impact on gender equality. Furthermore, the specific composition of the workforce in the health services and frequent staff shortages (see [box 5](#) below) require an innovative approach to gender issues in the health sector which has also to include men into the deliberations (see [Notes 3.4](#) below).

#### Box 5: Gender issues in the health services

The health sector is a major employer of women, in some cases up to 80 per cent of all workers in the sector. A wide range of health professions are traditionally female. The share of female nurses is often over 90 per cent among the nursing staff. Thus in a number of countries, addressing gender issues against the background of staff shortages, means exploring possibilities to increasingly interest men to enter the health services. When looking at the hierarchy of employment and the more prestigious and better paid professions, the situation appears quite different. Women are significantly under-represented in decision-making and managerial positions. Even in female-dominated professions, men are disproportionately well represented in management. In general, jobs held mainly by women tend to pay less than those in which men predominate. In the health sector of most countries, women have lower average earnings, even within the same job classification. However, due to a large variety of patterns of work organizations and allowances, it is statistically difficult to establish whether women and men obtain different compensation. Different average incomes are frequently the result of gender-specific obstacles to training, promotion and career. And certain work patterns, such as shift work and frequent overtime, might not be possible for women with family responsibilities and thus will reduce their average income.

Obstacles for women to enter and to remain in health professions include long periods of education and lifelong learning as well as working hours and work organization which may not be compatible with family responsibilities during their professional life cycle. Because of the requirement for continuous, high quality delivery of health services, these obstacles cannot easily be removed and often lead either to career breaks during periods of intensive family responsibilities, or to women leaving the workforce altogether. To counteract this trend, the health sector must offer women a number of

incentives and facilities to enter – and to remain – in the health professions, and to enhance their professional careers. Among factors facilitating women's continuous participation in the sector are more flexible (but not precarious) working arrangements, facilities for family care during working hours and tailor-made career development. This flexibility may be more difficult to create in the public service than in the private sector.

Staff shortages have become an urgent problem in certain health professions in many industrialized countries and have led to accelerated recruitment in developing and transition countries which in turn may create shortages in these countries. This applies particularly to the nursing profession and general practitioners, professions which have a high share of women. Since additional recruitment is limited, many countries seek to extend the period which professionals remain active in the health sector. In the future, women may have a better chance to more adequately be represented on the career ladder and to be offered better facilities to carry out their health professions. And men might be a still-untapped source for recruitment into traditionally female professions.

## Four steps to set the agenda for social dialogue

The following Notes provide guidance in identifying the most relevant items for the agenda of social dialogue and in developing a sequence of priorities in which they will be treated. It is key that the agenda is agreed upon by all social partners concerned, and that the representatives are in a position to take decisions.

### 3.1 Notes for the facilitator: Recognizing needs and potential

**Objective: Understand the current situation of the health services.**

When entering into social dialogue events the facilitator has to be aware of the general needs and the potential for social dialogue in the health services at national, local, enterprise and workplace levels. Distinct needs have to be noted in particular for developing countries, transition countries and industrialized countries. Both, human and financial resources have to be assessed. If possible, it would be preferable to commission a survey on the general situation of the health services or to compile existing assessments.

#### Exercise during social dialogue events

An intermediate solution to gain an overview of the situation of the health services would be an exercise for a “SWOT” Analysis (Strength, Weaknesses, Opportunities and Threats) in a preparatory meeting or at the beginning of a social dialogue event. Such a SWOT analysis can be used for the situation of the health services at national, local, enterprise and workplace levels. Depending on the level, such analysis would require between one half to one full day of meeting. The facilitator should use the following model flipchart to guide the discussion:

<p><b>Strength:</b></p> <p>Describe the strength of the level of health services being discussed by considering its</p> <ul style="list-style-type: none"> <li>• comparative advantage</li> <li>• human and financial resources</li> </ul> <p>Ask the following questions:</p> <ul style="list-style-type: none"> <li>• What are our advantages?</li> <li>• What do we do well?</li> </ul>	<p><b>Weaknesses:</b></p> <p>Describe the weaknesses of the level of health services being discussed by considering its</p> <ul style="list-style-type: none"> <li>• disadvantages</li> <li>• resource and capability shortfalls</li> </ul> <p>Ask the following questions:</p> <ul style="list-style-type: none"> <li>• What could be improved?</li> <li>• For what are we not prepared?</li> <li>• What should be avoided?</li> </ul>
<p><b>Opportunities:</b></p> <p>Describe opportunities in health services which could be explored, for example</p> <ul style="list-style-type: none"> <li>• changes in the social, economic and political environment</li> <li>• organizational changes</li> <li>• changes in human resources</li> <li>• changes in financial resources</li> </ul> <p>Ask the following questions:</p> <ul style="list-style-type: none"> <li>• What are the interesting trends?</li> <li>• What are the best opportunities to act on?</li> </ul>	<p><b>Threats:</b></p> <p>Describe threats which could prevent health services from achieving its objectives, for example</p> <ul style="list-style-type: none"> <li>• resistance to change</li> <li>• lack of flexibility</li> <li>• mismatch of skills and resources with the strategic direction</li> <li>• high risks or impossible odds</li> </ul> <p>Ask the following questions:</p> <ul style="list-style-type: none"> <li>• What obstacles do we face?</li> <li>• What results could these obstacles produce?</li> </ul>

The SWOT exercise can be done in a plenary or by breaking into small groups for each of the levels of the health services. The answers to the questions can be written by the participants on cards or by the facilitator on a flipchart. The analysis of these answers can be guided by the following “SWOT Matrix”:

	<b>Strength</b> Positive characteristics and advantages of the issue or situation	<b>Weaknesses</b> Negative characteristics and disadvantages of the issue or situation
<b>Opportunities</b> Factors and situations that can benefit, enhance or improve the situation	<b>S-O Analysis</b> How can strengths be employed to take advantage of development opportunities?	<b>W-O Analysis</b> How can weaknesses be overcome to take advantage of development opportunities?
<b>Threats</b> Factors and situations that can hinder the situation	<b>S-T Analysis</b> How can strengths be used to counteract threats that tend to hinder the achievement of objectives and pursuit of opportunities?	<b>W-T Analysis</b> How can weaknesses be overcome to counteract threats that tend to hinder the achievement of objectives and pursuit of opportunities?

The SWOT exercise gives an overview and an analysis of the current situation of the level of the health services discussed. An additional next step is required however to identify and prioritise issues which should become the agenda items for social dialogue.

### 3.2 Notes for the facilitator: Prioritising agenda items

**Objective: Develop a sequence of priorities for the agenda.**

Following-up on the first discussion of the social partners on the choice of the social dialogue elements (see [Notes 2.4](#) above) and on the analysis of the current situation in the health services, the facilitator now has to enable the social partners to identify a list of agenda items for social dialogue and to prioritise the sequence of the discussion. The substance of these agenda items can range from international migration of health care workers at the national level in a tripartite dialogue, the bipartite reorganization of a hospital, or implementing a violence prevention programme at the workplace level.

#### Exercise in social dialogue events

It is advisable to list the possible agenda items according to the levels concerned. The following methods may be used by the facilitator in a social dialogue event:

- Prepare a list of agenda items by brain-storming with the participants in a workshop with all stakeholders;
- Distribute three to five cards to each participant (depending on the complexity of the level of health services being discussed), and have them write down the most important agenda items of their choice. With their participation, structure the proposals into clusters, and lead an open discussion. Summarize the items on a flipchart.

In order to attach priorities to the agenda items, the facilitator asks the participants to attach their three highest priorities to the listed agenda items which will result in a sequence of priorities. (see also the list of Selected possible agendas in the Section 1)



In a process or series of tripartite social dialogue events, bipartite meetings at enterprise level or joint committees are another form of dialogue and communication methods that could be used to identify and prioritise agenda items. Electronic sharing of proposals and priority setting may also include the members of the representative organizations. Electronic discussion forums and voting systems could be introduced.

### 3.3 Notes for the facilitator: Identifying the decision makers

**Objective: Ensure the continuity of participation.**

The facilitator should examine whether the same participants who participated in the choice of the elements of social dialogue (see [Notes 2.2](#) above) can also participate in the decision of the agenda items for social dialogue. Depending on the level of the health services targeted, selection of participants may be limited to a bipartite group (employers' and workers' representatives). Alongside with the decision makers, the contact persons who will carry on the social dialogue process should participate as much as possible in this stage of social dialogue. Thorough briefing of the next set of participants has to be ensured.

### 3.4 Notes for the facilitator: Integrating gender issues

**Objective: Sensitize participants on specific gender issues in health services.**

Although female representation of the social partners is indispensable in social dialogue events, it does not necessarily lead to the integration of gender issues into the agenda for social dialogue in health services. In addition, due to the multi-faceted challenge of realistically integrating gender issues, it may not be sufficient to create just one agenda item on "gender". Facilitators need to constantly probe whether the gender dimensions of an issue have been considered. It is important to note that a key discussion on gender issues in health services refers mainly to the need to recruit and retain men at different levels of the workforce, since the majority of the total workforce is female (Even if some professional subgroups, such as physicians, are male dominated). This specific aspect of gender sensitisation may warrant its own session.

## Exercise during social dialogue events

After reviewing the basic concepts of gender equality and gender issues, the facilitator could introduce the issues regarding gender specifically in health services through the following exercise:

Prepare cards with the most striking challenges of gender issues in the health services of the given country or institutional setting. These cards should at least name:

- *gender issues in the workforce;*
- *gender issues in payment of staff;*
- *gender issues in education and training;*
- *gender issues in staff shortages;*
- *gender issues in public health;*
- *gender issues in delivery of health services;*
- *gender issues in migration in health services;*
- *gender issues in health care reforms;*
- *gender issues in budgetary decisions.*

These cards are placed into a container and participants of a group or the plenary draw out one card which they will read out. They will then express their views on the subject and others can add their own views. This exercise will create awareness among the decision makers and ideally lead to agenda items already selected. The themes discussed in relation to gender issues should be noted on a flipchart and later matched with the selected agenda items. Another result may be to establish a specific task force to monitor the discussion on gender issues in the health services during the social dialogue process. (see also Section 11 below)

## Section 4: Representation of the social partners

### *Text of the conclusions*

***“5. A prerequisite for effective social dialogue is strong, independent and responsible social partners who recognize the legitimate roles and interests of each other, commit themselves to constructive engagement in agreed processes of dialogue and deliver their side of negotiated outcomes. Freedom of association and clear and transparent rules in each country in accordance with ILO Conventions Nos. 87, 98, 135 and 151 are essential.”***

The above paragraph 5 of the conclusions refers to basic International Labour Conventions which are also essential for the social partners in the health services. Beyond them, there are also other Labour Standards of specific relevance to the health services which can facilitate the discussion

on who assures the representation of strong, independent and responsible social partners in this specific sector. Such Labour Standards are the Nursing Personnel Convention, 1977 (No. 149), and Recommendation (No. 157), as well as the Medical Care Recommendation, 1944 (No. 69).

### Box 6: ILO Conventions essential for the representation of the social partners in the health services

Convention No. 87: Convention concerning Freedom of Association and Protection of the Right to Organise, 1948

Convention No. 98: Convention concerning the Application of the Principles of the Right to Organise and to Bargain Collectively, 1949 (may be cited as the Right to Organise and Collective Bargaining Convention, 1949)

Convention No. 135: Convention concerning Protection and Facilities to be Afforded to Workers' Representatives in the Undertaking, 1971 (may be cited as the Workers' Representatives Convention, 1971)

Convention No. 151: Convention concerning Protection of the Right to Organise and Procedures for Determining Conditions of Employment in the Public Service, 1978 (may be cited as the Labour Relations (Public Service) Convention, 1978)

Freedom of association and the effective recognition of the right to collective bargaining are included in the fundamental principles and rights at work confirmed in the ILO Declaration on Fundamental Principles and Rights at Work of 1998. Member States of the ILO are bound to respect, to promote and to realize these fundamental principles and rights at work even if a country should not have ratified these Conventions.

For the complete text of these Conventions see: [www.ilo.org/ilolex/index.htm](http://www.ilo.org/ilolex/index.htm)

The legitimacy of representation is based on clear rules at national level which would allow identifying those participating in social dialogue. In regard to the representation of workers, the ILO

Convention No. 135 gives a clear indication of who is recognized under law and practice as workers' representatives.

### Box 7: Workers' Representatives according to ILO Convention No. 135

Article 3 stipulates:

"For the purpose of this Convention the term 'workers' representatives' means persons who are recognized as such under national law and practice, whether they are –

- (a) trade union representatives, namely, representatives designated or elected by trade unions or by members of such unions; or
- (b) elected representatives, namely, representatives who are freely elected by the workers of the undertaking in accordance with provisions of national laws or regulations or of collective agreements and whose functions do not include activities which are recognized as the exclusive prerogative of trade unions in the country concerned."

The representation of other social partners in the health services may not be as evident as that of the workers. In fact workers' representatives in this sector often deplore a lack of clear rules on the representation of their social partners. Employers in the 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 decentralization of health services to local and regional authorities, and the emergence of more independent public enterprises in the health sector, there is now a variety of public employers, with new representative organizations. At the same time, cooperation and coordination with other similar public or semi-public authorities are still lacking in many countries.

Employers in the non-profit sector of the private health services often maintain close links with public employers. In a number of countries, 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 personnel have become increasingly involved in negotiations with private health plans such as the Health Maintenance Organizations (HMO). Consequently,

they have been seeking representation in 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 about 11 million users.

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 have 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.

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 1990's has been developing social dialogue with a coalition of health workers' organizations. (See box 4 above) A relatively new challenge for many such employers is public-private partnerships, whereby the public health services purchaser establishes an agreement with private providers, as the National Health Service (NHS) in the United Kingdom did with the private multinational company BUPA. Under the agreement, BUPA will perform specified operations and bill the NHS. The target is to reduce waiting lists for these operations.

Against this background, it is often difficult to find social partners who would represent the employers in collective bargaining and other

social dialogue activities (see [Notes 4.1](#) below). At least in certain Nordic countries (Denmark, Finland and Sweden) and in some Member States of the European Union, 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 public nor private health services.<sup>6</sup>

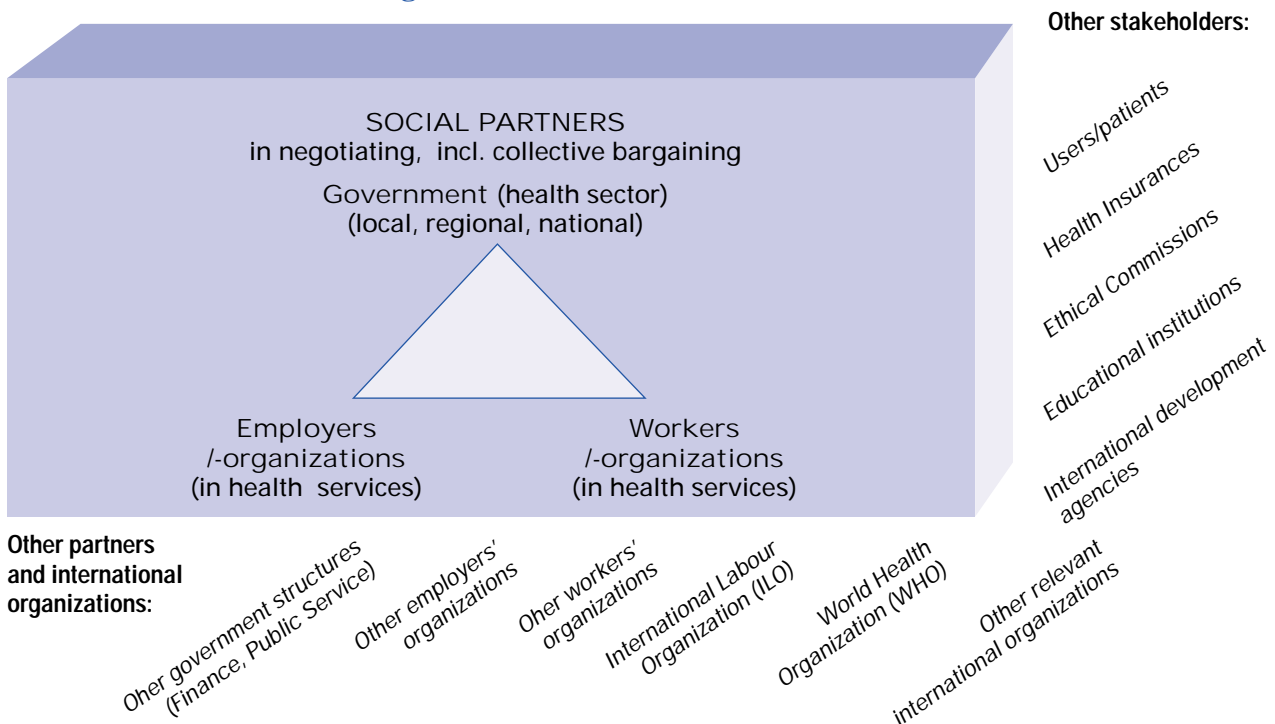
**Text of the conclusions**

*“6. The social partners in health services are in principle public authorities as regulators or as employers, private employers’ and workers’ organizations in the health sector. However, in view of the financial implications of the health sector for other government structures, employers and workers, other stakeholders beyond the health sector may also be involved in policy developments, except on matters properly the concern of negotiating and collective bargaining parties. The organizations or institutions which represent the groups in the health sector have changed over the past two decades. A greater variety of government levels are also involved. New private employers have entered the health sector and related services.”*

The above paragraph 6 of the conclusions describes a great variety of social partners in the health services who have to be carefully identified in a given situation. Figure 1 gives an overview of

the categories of social partners and of other stakeholders and partners in health sector development (see [Notes 4.2](#) below).

**Figure 1: Social partners, other stakeholders and partners in the health services and relevant international organizations**



<sup>6</sup> Excerpts from: ILO, *Social dialogue in the health services: Institutions, Capacity and Effectiveness, Report to the Joint Meeting*, Geneva 2002 pp. 32-34.

*Text of the conclusions*

***“7. Social dialogue can take many forms and can operate at various levels, from highly structured national institutions to relationships in the workplace. The legitimacy and level of representation should be suited to the context and issues concerned, bearing in mind the stakeholders involved. The representatives of the social partners should be recognized as equal partners by each other.”***

As the above paragraph 7 of the conclusions clarifies, setting the agenda and identifying the representatives for social dialogue in the health services are closely linked. In order to gain an overview, how the representation of the social partners is linked to the issues of a possible agenda, the following matrix can serve as an instrument to analyse this interlinkage. For the purpose of this Tool, the matrix (figure 2) only lists general issues and general categories of social partners and possible other stakeholders in

consultations. In a given situation, the matrix should be composed of the identified agenda items and the names of the relevant organizations representing the social partners. Other stakeholders may be listed separately for consultation beyond social dialogue as defined in this Tool. Inside the matrix, markings should indicate which organizations should be involved in which items. A completed matrix would be the result of a consultation process for the planning of the social dialogue.

**Figure 2: The right agenda with the right representatives** (see also Notes 4.3 below)

Agenda items Participants in social dialogue and others	<ul style="list-style-type: none"> <li>Reorganization of health care</li> <li>incl.</li> <li>- health care standards</li> <li>- finance</li> <li>- quality assurance</li> <li>- information systems</li> <li>- technology</li> <li>- drug management</li> <li>- disaster management</li> </ul>	<ul style="list-style-type: none"> <li>Human resource development,</li> <li>incl.</li> <li>- job opportunities</li> <li>- salaries and other benefits</li> <li>- management</li> <li>- training</li> <li>- staffing levels and mobility</li> </ul>	<ul style="list-style-type: none"> <li>Public health objectives, incl.</li> <li>good nutrition,</li> <li>environmental care,</li> <li>food security</li> </ul>	<ul style="list-style-type: none"> <li>Quality service delivery</li> <li>focused on users</li> </ul>	<ul style="list-style-type: none"> <li>Financial support</li> <li>to health sector reforms</li> </ul>
<ul style="list-style-type: none"> <li>Government:</li> <li>- local</li> <li>- regional</li> <li>- national</li> </ul>					
<ul style="list-style-type: none"> <li>Employers:</li> <li>- public</li> <li>- private (e.g. hospital, indiv. practice)</li> <li>- networks</li> </ul>					
<ul style="list-style-type: none"> <li>Workers:</li> <li>- various professions/ occupations (e.g. physicians, nurses, auxiliaries, admin. cleaning staff)</li> </ul>					
Consultation with others, e.g.:					
<ul style="list-style-type: none"> <li>- users</li> <li>- ethical commissions</li> <li>- technical experts</li> <li>- women's organizations</li> </ul>					

Source for the set of issues for the agenda of social dialogue in the health services (Headline row): ILO, *Joint Meeting on Social Dialogue in the Health Services, Note on the proceedings*, Geneva, 2003, p. 15, item 24.

## Checklist 4: Identifying the representatives for social dialogue

- **Which government levels are involved? Are they represented together?**

Decentralization which has taken place in many countries over the last two decades has devolved responsibilities from the Ministry of Health to lower governmental levels. However, while examining the representation of government structures in social dialogue a detailed analysis of the devolved responsibilities is required. In particular, it has to be distinguished whether the structure represents the government as the financing and regulating authority or as public employer. Also relevant is the agenda of the social dialogue, since different government levels may be responsible e.g. for primary, secondary and tertiary health care. Often it is unlikely that these various responsibilities are represented by one structure (like in the past the Ministry of Health). Therefore, it has to be asked carefully which structure can represent which responsibility. This analysis may make use of a matrix which list in the “head column” the various governmental structures responsible and in the “head row” the various responsibilities which would be taken up in the social dialogue.

- **Which private employers are involved – for-profit enterprises or non-profit organizations? Are the two types represented together?**

A corresponding method like in the case of the government structures could be applied for identifying the private employers and their representatives. Non-profit organizations operating for many years may have their representative bodies while private for-profit employers in the health sector are often only

emerging and may not yet have created their own representational associations or networks in the health sector and would have to be represented by other employers’ organizations or individually. Therefore, a table would also list the possible employers in the given situation and on the other side the issues or levels of the health services in which they operate.

- **How is the representativeness of workers’ organizations determined?**

Labour law in each country should provide rules by which the workers’ organizations that represent the various professional groups in social dialogue in the health services can be determined. In a number of countries, health workers may also be represented by their professional associations for the purpose of social dialogue. The international labour standard in accordance with national labour law which should provide for these rules of representativeness is ILO Convention No. 135 (see box 7 above).

- **Are these representatives of the social partners strong, independent and responsible and are they recognized as such partners by each other?**

The examination of this question has to be led in good faith and might initially be carried out separately among the social partners. In some situations, the partners may feel weaknesses of their own institutions or the legal frame in which they act. Therefore, strengthening of legal rules and institutions may be felt necessary and capacity-building required (training or advisory services) before or during the social dialogue process (see also paragraph 11 of the conclusions below).



## Three steps to establish representation

Establishing the right representation of the social partners in social dialogue events and processes is critical for the outcome. The following Notes will provide guidance on: (1) how the human and organizational capacity can contribute to the right representation, (2) how the legal provisions have to enable the right representation and (3) how matching the identified agenda items with the right representation can contribute to the achievement of social dialogue.

### 4.1 Notes for the facilitator: Building capacity

**Objective: Develop key issues for the capacity building of participants in the social dialogue process.**

Strong, independent and responsible social partners are the prerequisites for effective social dialogue. However, participants selected for social dialogue events may not always possess these attributes, either as individuals or as representatives of their organizations. The organizer has to assess the situation before the social dialogue event and may decide to bolster capacity by staging preparatory events. Such events may have to be organized separately for or by the social partners and /or jointly with the social partners and should ideally involve the facilitators who would be present at the main event as well (see also Section 7 below). The following key issues may have to be considered for these capacity building exercises:

- management capacity of the organizations involved to put agreements of social dialogue into practice;
- cohesion of the members or institutional structures of the social partner;
- technical capacity in the area of health services;
- technical capacity in the area of labour relations;
- methodological capacity to communicate and dialogue;
- capacity to represent the organizations of the social partners.

### 4.2 Notes for the facilitator: Recognizing representation

**Objective: Compile background materials on the representation of the social partners.**

Before the social dialogue event and in cooperation with the social partners, the organizer should compile relevant legal texts which validate the legitimacy of each social partner. These texts should be made available at the social dialogue meeting in case of disputes over representation since the appropriate recognition has a formal and legalistic dimension.

#### Preparatory work before social dialogue events

The organizer should in particular:

- Identify texts from general labour law and the practice of its application in view of employers' representatives;
- identify texts from general labour law and the practice of its application in view of workers' representatives according to ILO Convention No. 135 (see Box 7 above);
- identify specific legal provisions or limitations for the health services (there may be distinct provisions for hospital and emergency services);
- identify other text from provisions of ministries of health, labour and consumer protection.

The process of compiling legal provisions for the representation of all social partners may also reveal that there is a lack of such provisions for some of the social partners. The organizer has to be prepared to address ambiguous situations in view of the representation of the social partners in the health services.

### **4.3 Notes for the facilitator: Matching the agenda with the participants**

***Objective: Develop the “agenda-participants” matrix in a given situation.***

Setting the agenda and finding the appropriate representation to discuss the agenda items are closely interrelated. It is therefore recommended to prepare a detailed list of the agenda items identified and to match each item with the existing representative bodies. For this purpose the matrix in figure 2 (see above in Section 4) was developed. It has to be noted, however, that this matrix only considers general categories of agenda items and general categories of representatives.

#### **Exercise during social dialogue events**

In a given situation, it is recommended that the organizer provide all names of relevant organizations. The facilitator should list the organizations’ names on flipcharts in a preparatory social dialogue event. If necessary, this list can be completed by the participants.

This list of organizations is then compared with the list of agenda items (see also Section 3 above) already developed, preferably in form of a visual matrix . In discussion with the participants, the agenda items are then matched with possible representative organizations. If the respective organization should be involved, a mark is put in the matrix at the intersecting box between the agenda item and the organization. Otherwise a zero or a dash should mark the non-involvement of the organization. At the end of the discussion an overview is produced indicating who should be involved in what item. This matrix can then be used at all stages of the social dialogue process (see Sections 8-12 below), from the planning to the evaluation and even in the process of mobilizing the required resources.

## Section 5: Social dialogue in situations of structural change

### *Text of the conclusions*

***“8. Social dialogue has proved particularly important in situations of structural change and reform in the health sector. 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 may not have the capacity and possibilities to participate to the full extent. Capacity-building should be promoted to equip social partners to participate in social dialogue. Difficult situations are 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. Regular discussion forums, effective means of communication, sensitization of media and continuous professional analysis of prevailing problems will facilitate necessary change. The social partners in a given situation should therefore, inter alia, decide the following: the mechanisms that will provide for a ‘early warning system’ when reforms of health services are needed; who will be involved in continuous consultations on reform processes; and who will provide professional analysis of prevailing problems.”***

Many countries have established mechanisms of social dialogue or are willing to establish such mechanisms. Beyond such basic mechanisms, the above paragraph 8 of the conclusions provides for a framework of social dialogue in situations of health sector reforms. Such complex situations of structural change require the involvement of a variety of social partners who have already contact with each other in situations of social dialogue and to establish a more continuous dialogue which would allow for early warning on structural problems in the health sector. For this purpose, it is helpful to first analyse the current situation of social dialogue (“mapping”), then decide how the

knowledge acquired in this social dialogue could be used for an “early warning system” for reforms and what further professional analysis of prevailing problems would be needed.

A possible tool for such “mapping” could be the following matrix which would allow an overview on where information on prevailing problems could be collected by already existing institutions of social dialogue. The matrix only lists examples of problem areas and possible social dialogue institutions; in a given situation the columns and rows have to correspond to the existing institutions of social dialogue and the prevailing problems.

**Figure 3: Information on various structural problems available in existing institutions of social dialogue** (see also Notes 5.1 below)

Existing institutions of social dialogue / Structural problem areas	Collective bargaining bodies	Commissions for quality standards	Institutions for health care finance	Institutions for public health
Health care delivery, incl. – health care standards – finance – quality of service – information systems – technology – drug management – disaster management				
Human resource development, incl.: – job opportunities – salaries and other benefits – management – training – staffing levels and mobility				
Public health, incl. good nutrition, environmental care, food security				
Quality service delivery focused on users				
Financial support to health sector reforms				
Demographic developments amongst users and workers				

Based on the information acquired through such a matrix, decisions could be taken which additional social dialogue forums or committees would have to be established in order to prepare for structural change and identify which external

professional expertise would be needed to progress with reform design and implementation. The following boxes show two examples in Brazil and Germany on how the health sector as a whole or parts of it were restructured through social dialogue.

#### Box 8: Health services and structural change in Brazil

For a number of years, Brazil has been undergoing a process of decentralizing government structures in the health sector. 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 the health system management to municipal authorities. Health councils were set up as part of the SUS under the decentralized health system reform in the early 1990s. Member of the councils were 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 these 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

Additionally, in 1997 a National Negotiating Committee was established by the Ministry of Health to address labour conflicts at the various levels of the SUS.

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 additionally the challenge of extending the dialogue to popular participation.

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 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 this 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 the health participation experiences during the 1960s and 1970s which continued with the reintroduction of democracy in 1982. These experiences shaped the health reform and legislation provided important preparation for setting up the municipal health councils.

*Source: ILO, Social dialogue in the health services: Institutions, Capacity and Effectiveness, Report to the Joint Meeting, Geneva, 2002, pp. 45-46.*

#### Box 9: Examples of using early warning systems in Germany

In the Joint Meeting on Social Dialogue in the Health Services 2002, "a worker member, noting that social dialogue in the health services had prevailed for a long time in Germany, provided recent examples of early warning system use, including: regulation of training at federal level and discussions over reform of legislation in which representatives of the Ministry of Health, professional associations and his trade union representing workers were involved; the creation of joint government/union working groups at the level of the Länder (provincial level) to review and develop strategies to combat nurses shortages based on indicators; and the establishment of round tables with government, private employers and trade union participation to review health-care reform and possible new laws ...".

*Source: ILO, Joint Meeting on Social Dialogue in the Health Services, Note on the proceedings, Geneva, 2003, p. 18.*

When social dialogue has been established to face the complex situation of structural change, there is a need for a number of measures to create also the continuity in which “early warning systems” can be developed (see also [Notes 5.2](#) below). Such measures could take different forms, including monthly social dialogue forums, effective and

repetitive communications, follow-up action plans, review of decisions already made in order to keep the dialogue on track, standard setting and monitoring of minimum standards and the establishment of indicators on the implementation of the decisions taken.

### **Checklist 5: Making social dialogue effective for structural change**

In order to make social dialogue effective in situations of structural change, the following questions have to be addressed in a given situation:

- **What mechanisms could provide an “early warning system” when reforms of health services are needed?**

Existing institutions of social dialogue should be examined as to whether the consultations could also serve to identify at an early stage forthcoming need for reforms. Such identification would require indicators to which the social partners agree. It should be examined whether such an “early warning system” would be the “by-product” of other consultations and negotiations or whether specific and regular forums have to be created.

- **Who should participate in continuous consultations on reform processes?**

In a given situation of structural change, employers and workers in the health services should contribute at an early stage their views on forthcoming deficiencies of the health system or possible labour conflicts. In regard to the quality of the health services, the users should certainly also have opportunities to contribute in a wider dialogue beyond social dialogue as defined in this Tool (see also [Notes 5.3](#) below).

- **Who will provide the professional analysis of prevailing problems?**

Academics and specialists may also have specific advice on up-coming problems in the health-care system, including those arising from current and likely demographic trends. If these groups are not involved in consultations of the social partners, other mechanisms have to be established to include their views (e.g. public hearings and surveys). Professional advice may come from among these independent specialists but also from among the social partners themselves.

## Three steps to address structural change through social dialogue

The existing knowledge and experience of the social partners can be harnessed in addressing structural change in the health services. The facilitator can play an important role in coaxing this knowledge and experience from participants. Three essential steps are recommended: (1) mapping the current situation of the social partners in the health services, (2) establishing an early warning system to initiate change and (3) consulting with other stakeholders beyond the social partners.

### 5.1 Notes for the facilitator: Mapping the current situation

**Objective: Gain an overview of the needs and ideas for structural change of the existing social dialogue institutions in the health services.**

In order to grasp the scope of existing social dialogue activities, the matrix in Figure 3 above was prepared for the use of the facilitator and of the participants. Figure 3 above gives examples of the type of social dialogue institutions that may exist.

#### Preparatory work before social dialogue events

In a given situation, the organizer has to gather as much information as possible for this matrix before the event. The organizer should therefore issue questionnaires and/or undertake structured interviews to obtain the following information at a minimum:

#### Questionnaire: Mapping of existing social dialogue institutions

Name and address of the social dialogue institution questioned	
Contact person and how to reach the person	
Stakeholders involved	
Mission of the institution	
Major areas of activities in the health services (incl. health care delivery, human and financial resources and quality standards)	
Procedures of communication and decision making	
Current ideas and needs for structural change in the health services (incl. health care delivery, human resource development, public health, quality service delivery, financial support, migration, demographic developments)	

Based on the information provided by the above questionnaire, the facilitator should prepare, preferably before the social dialogue event, a matrix similar to Figure 3 in the Section above. The “head row” will reproduce the names of the existing social dialogue institutions, and the “head column” will summarize the structural problem areas which have been raised by these social dialogue institutions.

The facilitator can initiate a discussion on the problem areas raised concerning the social dialogue institutions identified. The result will be a “mapping” of the existing social dialogue institutions in the health services, their concerns and their priorities for structural change.

## 5.2 Notes for the facilitator: Enabling early warning

**Objective: Establish an early warning system for structural change.**

Based on the mapping of the current situation and the need for change identified through the matrix, participants can agree to establish an early warning system for structural change. There are several options of how such early warning system may be established through a social dialogue process:

- In the first social dialogue event the participants agree to monitor a number of identified problem areas by discussing them in the regularly scheduled meetings of their organizations and giving feed back to a coordinating organizer either through meetings, in writing or electronic communication;
- If possible, the participants agree on ad hoc or permanent working groups with representatives of all social dialogue institutions with the aim of monitoring the identified problem areas.
- The organizer creates an electronic network in which the social dialogue institutions or the social partners give direct feed back on agreed upon problem areas and possible new developments.

No matter which options are chosen, it will be necessary to also have coordination meetings in which the social partners can (a) have a dialogue on the identified problem areas, (b) review decisions and changes made and (c) give the reform process new directions.

## 5.3 Notes for the facilitator: Consulting with other stakeholders

**Objective: Gain an overview of the needs and ideas for structural change of stakeholders beyond the social partners.**

### Preparatory work before social dialogue events

In order to consult on structural change with other stakeholders and partners beyond the social partners (see also Figure 1 in Section 4 above), the facilitator should undertake a mapping for other stakeholders by sending questionnaires on the following issues (see [Notes 5.1](#) above):

**Questionnaire: Mapping of stakeholders beyond the social partners.**

Name and address of the organization/institution	
Contact person and how to reach the person	



Stakeholders involved	
Mission of the organization/institution	
Major areas of activities in the health services (incl. health care delivery, human and financial resources and quality standards)	
Procedures of communication and decision making	
Current ideas and needs for structural change in the health services (incl. health care delivery, human resource development, public health, quality service delivery, financial support, migration, demographic developments)	

The facilitator should develop a mapping matrix similar to Figure 3 in the Section above. This matrix should be presented to the social partners and discussed with them so that a consensus can be reached on whom to involve. Consultative meetings with the other stakeholders on structural change could be organized separately or jointly with the social partners.

## Section 6: Identifying and enforcing quality standards

### *Text of the conclusions*

***“9. All structural changes and reforms in the health sector should be geared to the overall goal of improving efficiency and effectiveness as well as the quality of health services and, to this end, raising the quality of and access to health services. To identify quality standards for health services is, however, a particularly difficult task which has to be tackled carefully and realistically and which will have varied results for different countries. In the health sector which is highly labour-intensive, the standards have to realistically include the quality and capacity of the workers in each country, a question which is closely related to decent work and social dialogue itself.***

***10. In social dialogue it is necessary to identify quality standards which are shared by all the social partners. Such participatory approaches to performance management will facilitate that quality standards and indicators of outcomes can benefit from the particular knowledge and experience of all stakeholders. A common understanding of quality standards has to be reached which should also be shared by groups beyond the social partners such as the users of the health services. Governments should set the framework for the development and enforcement of quality standards for health services. These standards should be developed in consultation with the social partners and scientific or other relevant expert bodies. All parties should observe and implement these standards. In order to assess the reality in a given situation, the partners will have, inter alia, to consider the following: the type of quality standards that should be identified; who will decide on the choice of quality standards and their enforcement; and what mechanisms will be used to monitor their implementation.”***

The above paragraphs of the conclusions attribute an important role to the social partners in the identification of the quality standards in the health services. However, the conclusions also stipulate that governments should set the framework for the development and enforcement of such quality standards. Quality standards in health services relate to a number of complex issues. Quality standards in health services tend to change over

time, but they are also linked to basic principles of professional ethics. Their identification and implementation has to be seen against the background of the country’s prevailing situation and has to involve all parties concerned. The government has a specific responsibility to enforce such quality standards. The matrix below may help to “map” the different issues which warrant quality standards and the parties involved.

**Figure 4: Quality standards in the health services and the parties involved in their identification** (see also Notes 6.1 below)

Quality standards	Medical and hygiene standards	Quality of care and services standards	Quality of work standards	Safety standards (incl. violence)	Quality management systems
Social partners involved					
Government: - local - regional - national					
Employers: - public - private (e.g. hospital, individual practice) - networks					
Workers: - various professions and occupations (e.g. physicians, nurses, auxiliaries, admin. & cleaning staff )					
Consultation with others, e.g.:					
- users - ethical commissions - technical experts - women organizations					

The involvement of social partners and the consultation with other possible stakeholders on quality standards in the health services may be of a varied degree according to the type of quality standards. The highest degree of involvement for employers' and workers' organizations is required

in relation to quality of service, management and quality of work standards. The example of Kaiser Permanente's National Agreement of 2000 illustrates convincingly (see box 10 below) how such involvement may be conceived.

#### Box 10: Creating a service culture in Kaiser Permanente

“Partnership teams will be responsible for creating our service culture at the facility, department or work unit level. It is our intent that partner union employees in all departments/areas be included in the planning, development, and implementation of an improved service culture. Union partners should be integrated into any ongoing service initiatives, and subsequently be involved in the planning, design and implementation of any new initiatives from the onset.

Creating a service culture requires that certain organizational components be in place. We agree that these components include: knowledge of what constitutes an excellent care experience, modelling of excellent service behaviours, employee satisfaction and empowerment, skills and competencies, systems to support service quality, and a strategy for becoming an organization known for service excellence. We will create an organizational environment that encompasses these elements.

We also recognize that employee, physician, and patient satisfaction are achieved through an involved, multi-disciplinary, self-directed, trained team that focuses on meeting or exceeding the service expectations of our patients.

Essential components for creating high performance work teams include involvement and participation, information systems to share data with the work team, a sense of team and community, training and education, authority and accountability, and an organizational orientation to quality. Ultimately these work teams are self-directed, responsible for the entire, discrete processes, and in the best position to continuously improve their service to internal and external customers.”

Source: Kaiser Permanente, The Coalition of Kaiser Permanente Unions, *AFL-CIO National Agreement*, October, 1, 2000, pp. 8-9, <http://www.unac-ca.org/pdf/nationalagreement2000.pdf> and <http://www.kaiserpermanente.org>

Independently of the type of quality standards and the social partners involved, it is necessary to give transparency to the establishment and enforce-

ment of such standards. In some cases, this task was attributed by the government to independent institutions.

#### Box 11: Transparency in establishing and enforcing quality standards

In the Joint Meeting on Social Dialogue in the Health Services 2002, a Worker member agreed together with the Employers, notably with regard to the government's responsibility to establish and monitor quality standards, on the involvement of the maximum number of stakeholders in defining quality and effective means to enforce them, including sanctions where necessary. These criteria were the basis for the establishment of the independent National Institute for Quality Assurance in the Netherlands and for a similar system in Germany where the hospital associations and doctors' associations have developed a quality management system based on transparency. Quality also has to be measured in relation to economic criteria, but the latter should not be the major determinant, particularly where no uniform conditions exists for competitive health services.

Source: ILO, *Joint Meeting on Social Dialogue in the Health Services, Note on the proceedings*, Geneva, 2003, p. 20.

## Checklist 6: Identifying and enforcing quality standards

- **What type of quality standards should be identified?**

Quality in the health services may be related to a number of standards such as medical and hygiene standards, quality of care and service standards, quality of management systems, quality of work standards and safety standards. Relevant is not only whether the quality standard exists but also whether such quality health services are accessible. Quality standards may become a subject of tripartite or bipartite social dialogue and influence the economic performance and income of the social partner.

- **Who should decide on the choice of quality standards and their enforcement?**

The choice of quality standards should be made together with the social partners, however, the degree of their involvement depends on the type of standards. Modern technology and hygiene require additionally the involvement of specialists. However, there is a clear responsibility of the government to enforce such standards (see also [Notes 6.2](#) below).

- **What mechanisms should be used to monitor the implementation of quality standards?**

First condition for a possible monitoring of the implementation of quality standards is the development of respective indicators (see also the section on monitoring and evaluation below). Such indicators have to be developed jointly with the social partners, since this will ensure the commitment of all parties concerned to implementing and monitoring such standards (see also [Notes 6.3](#) below). Like in the case of an early warning system for the need of reforms, existing institutions of social dialogue could be used for monitoring quality standards. In some cases, it may even be possible to create independent institutions to monitor quality standards.

In these latter two questions, it is important to recognize the right of the users and community organizations to be involved in discussions on quality, so long as this does not impinge on what are properly the concerns of the social partners in collective bargaining.

## Three steps to identify quality standards through social dialogue

The facilitator should guide the participants of a social dialogue event to jointly (1) create shared quality standards, (2) choose the priority quality standards and (3) develop indicators for their achievement.

### 6.1 Notes for the facilitator: Creating quality standards

**Objective:** Introduce the use of matrix in Figure 4 for identifying quality standards in the health services by involving the social partners.

The matrix in Figure 4 above was developed in order to identify existing quality standards and the involvement of social partners. Figure 4, however, indicates only groups of quality standards which may exist (see “headline” of the matrix) and the social partners who may be involved with their identification and enforcement (see “head column” of the matrix). The participants may identify other standards or partners.

### Preparatory work before social dialogue events

The facilitator has to gather as much information as possible for this matrix before the event on existing quality standards in the health services. The facilitator should therefore issue questionnaires and/or undertake structured interviews to obtain from each organization or institution the following information at a minimum:

**Questionnaire: Overview of a social partner’s involvement in quality standards.**

	Nature of involvement in quality standards (e.g. identification, enforcement, monitoring)	Other social partners involved	Type of interaction (e.g. meetings, working groups, electronic communication)
List of existing quality standards: (1) ... (2) ... (3) ...			

**Questionnaire: Overview on social partner’s involvement in potential quality standards**

	Nature of involvement in potential quality standards (e.g. identification, enforcement, monitoring)	Other social partners to be involved	Type of interaction (e.g. meetings, working groups, electronic communication)
List of potential quality standards (proposals): (1) ... (2) ... (3) ...			

Based on the information from each social partner, the facilitator should fill in a matrix as in Figure 4 to gain an overview on quality standards in the health services in the country perhaps in one of the country's regions.

### Exercise during social dialogue events

The facilitator should initiate the plenary discussion on (a) any additional categories to be added to the matrix, (b) the current situation in implementing the quality standards and (c) the feasibility of proposed new quality standards.

Since the scope of quality standards in the matrix will be very extended, the facilitator should provide for working groups to deal with the details of the various quality standards. An alternative could be to organize separate events in which only one group of quality standards would be discussed.

The above exercise is particularly recommended for taking stock of quality standards in the health services of a country or of one of its regions. It is also possible to use this exercise for taking stock of quality standards at the enterprise level. In this case, the above questionnaire would be used to obtain information from (a) specific work units or (b) specific professional groups. The quality of care and services, the quality of work or the quality of management may be the standards for which the dialogue at enterprise level is the most appropriate.

#### Example case

Kaiser Permanente, USA, a member – based health organization, has established at enterprise level nine standards for quality of service and management. They are:

- (1) quality of assessment systems
- (2) continuity of care
- (3) quality of management of outside care
- (4) qualifications and competency of health practitioners
- (5) level of practitioners' performance
- (6) members' rights and responsibilities
- (7) capacity to assess performance
- (8) management of risks
- (9) utilization of facilities

Source: <http://newsmedia.kaiserpermanente.org/kpweb/quality>

## 6.2 Notes for the facilitator: Choosing quality standards

**Objective:** Enable a participatory choice of quality standards in order to benefit from the knowledge and experience of the social partners.

Once it is discussed, the matrix will provide the basis for the choice of quality standards by the social partners in a social dialogue event.

### Exercise during social dialogue events

The facilitator should encourage the participants to set priorities in discussing the individual quality standards and list these on a flipchart in order of priority. They should then formulate a text to describe the objective for each of the quality standards. It is advisable that the participants be assisted by expert resource persons for this exercise. This task can be done in groups or in plenary depending on the scope of quality standards discussed. In any event, the result should be reached by consensus.

It may be necessary to consult with other stakeholders and partners concerning certain quality standards (for example, quality of care and services). If agreeable to the social partners, representatives of the stakeholders should be invited to these specific discussions. Otherwise they should be consulted through questionnaires and interviews similar to those proposed in [Notes 6.1](#) above.

### 6.3 Notes for the facilitator: Developing indicators

**Objective: Develop indicators for quality standards and identify ways for implementation.**

Once a priority list of quality standards has been established, the facilitator should introduce to the participants the task to develop indicators for achieving the quality standards identified. Criteria to be respected in the formulation of indicators should be listed on a flipchart visible to the participants throughout the task.

<b>Indicators should be:</b>	
<ul style="list-style-type: none"> <li>• Factual</li> <li>• Verifiable</li> <li>• Linked to the objective concerned</li> </ul>	<ul style="list-style-type: none"> <li>• Specific in scope and time</li> <li>• Based on obtainable data</li> </ul>

### Exercise during social dialogue events

In addition to the formulation of indicators for each of the quality standards, the participants should specify the way in which the standard should be implemented or enforced. As a result, the issue of how implementation would be monitored and evaluated may also arise (see Section 11 below). The result of the discussion on these various aspects of quality standards can be summarized in a matrix. Using the example of quality standards in the case of Kaiser Permanente (see [Notes 6.1](#) above) such a matrix could have the following form:

**Example of overview on quality standards, their indicators and implementation**

	Indicator	Implementation/ enforcement	Monitoring & evaluation
(1) quality of assessment systems			
(2) continuity of care			
(3) quality of management			
(4) qualifications and competence of health practitioners			
(5) level of practitioners' performance			
(6) members' rights and responsibilities			
(7) capacity to assess performance			
(8) management of risk			
(9) utilization of facilities			



## Section 7: Establishing and strengthening institutions for social dialogue in the health services

### *Text of the conclusions*

***“11. Governments can facilitate and promote the process of social dialogue by laying down the framework to establish and strengthen institutions of social dialogue. 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 education and human resource development, which in turn will strengthen the institutions for social dialogue. Training programmes should create among the social partners awareness about the values of social dialogue systems and knowledge about procedures as well as negotiation and communication skills. Training programmes should be developed by all social partners who would have to decide in a given situation on a number of elements such as: who will be involved in such training; how can the individuals involved be prepared for social dialogue; and how can they be trained while continuing to carry out their professional activities.”***

As paragraph 11 of the conclusions stipulates, establishing and strengthening institutions of social dialogue in the health services is related to two aspects which complement each other: the legal and institutional aspect and the human aspect. The first aspect is the necessary condition, but only the second aspect can make the system of social dialogue operational and effective. Both aspects have to be examined in a given situation and measures have to be taken to develop the existing system of social dialogue into an effective tool. Box 12 summarizes the institutional setting of social dialogue for the health services at different levels using the example of Bulgaria. Subsequently, an example from the United States illustrates the possibilities of how the human capabilities at enterprise level can be developed in order to make institutional settings of social dialogue operational.

The discussions about the development of human capabilities in social dialogue has to be undertaken at sectoral and at enterprise levels. At sectoral level, benchmarks for training could be set which would facilitate reaching agreements on the type of training required. Also, model curricula and training modules on social dialogue could be developed which identify the basic ideas on knowledge, skills and behaviour in social dialogue situations in the health services. The government may be willing to support such developments. Bipartite agreements at enterprise level would help to establish the details of the content of training for social dialogue, the trainees to be selected, the situations in which such training takes place and also the investment to be undertaken for the training by the different parties involved, including finance and time used for the training. The National Agreement of Kaiser Permanente established how education and training in this area would be developed and monitored. (See box 13 below)

Box 12: Framework for social dialogue in the health sector in Bulgaria

	Social Partners	Agendas	Social dialogue institutions	Social dialogue elements, instruments and mechanisms
National*	<p>Government: Vice-president, Ministers, Deputy Ministers</p> <p>Employers' organizations: BIA, BCCI, UPEB, UEI</p> <p>Workers' organizations: CITUB and Podkrepa CL</p>	<ul style="list-style-type: none"> <li>- Labour and social legislation</li> <li>- Socio-economic policy and reforms</li> <li>- Overall policy for social dialogue and collective bargaining</li> <li>- Wage policy in the public sector</li> <li>- Minimal wage</li> </ul>	<ul style="list-style-type: none"> <li>- National Council for Tripartite Cooperation (NCTC)</li> <li>- Commissions at NCTC</li> <li>- Specialized tripartite bodies</li> <li>- Expert working groups on different issues (e.g. labour legislation)</li> </ul>	<ul style="list-style-type: none"> <li>- Negotiation</li> <li>- Information</li> <li>- Consultation</li> <li>- Framework agreements</li> <li>- National agreements</li> <li>- Action plans</li> </ul>
Sectoral/branch	<p>Government: Ministry of Health</p> <p>Employers' organization: National Employers Association in Health</p> <p>Workers' organizations: Federation of Unions in Health-CITUB, Medical Federation "Podkrepa"</p>	<ul style="list-style-type: none"> <li>- Specific labour and social legislation</li> <li>- Health policy and reforms</li> <li>- Collective bargaining</li> <li>- Industrial and labour conflicts</li> </ul>	<ul style="list-style-type: none"> <li>- Sectoral Council for tripartite cooperation in the health sector</li> <li>- Ad hoc &amp; permanent working groups</li> </ul>	<ul style="list-style-type: none"> <li>- Negotiation</li> <li>- Information</li> <li>- Consultation</li> <li>- Sectoral/branch collective agreements</li> <li>- Conflict resolution procedures</li> </ul>
Region/municipal	<p>Government: Mayor or representative</p> <p>Employers' structure (if any)</p> <p>Territorial Coordinating Council-CITUB Medical Regional Council "Podkrepa"</p>	<ul style="list-style-type: none"> <li>- Collective bargaining</li> <li>- Health reform in the municipality</li> <li>- Restructuring &amp; Privatization</li> <li>- Labour disputes in the establishments</li> </ul>	Municipal council for tripartite cooperation	<ul style="list-style-type: none"> <li>- Bargaining</li> <li>- Information</li> <li>- Consultation</li> <li>- Collective agreement</li> <li>- Conflict resolution</li> <li>- Control over the implementation of collective agreements</li> </ul>
Health care institution/enterprise (bipartite)	<p>Employer</p> <p>Workers' organization</p>	<ul style="list-style-type: none"> <li>- Collective bargaining</li> <li>- Internal rules</li> <li>- Health and safety at work</li> <li>- Pay system</li> <li>- General policy</li> <li>- Labour disputes</li> </ul>	Bargaining group	<ul style="list-style-type: none"> <li>- Information</li> <li>- Consultation</li> <li>- Collective bargaining</li> <li>- Collective agreement</li> <li>- Code of conduct</li> </ul>

\* The national level is relevant in view of pay systems in the public sector and legislation on health reforms which are negotiated at that level. Source: Tomev, L. et al, *Social Dialogue in the Health Services – Case Study Bulgaria*, ILO Sectoral Working Paper, forthcoming.

### Box 13: Example of Kaiser Permanente's Agreement on Education and Training

"We recognize that in order to achieve the Kaiser Permanente Promise, the vision of the Pathway to Partnership, and enhanced organizational performance, a significant commitment must be made to invest in the training and education of the workforce. Furthermore, most of the policies, commitments and plans described in this Agreement cannot be successfully accomplished without the committed efforts of Kaiser Permanente employees. Meaningful participation requires a level of knowledge and understanding of the business of health care, the operations of Kaiser Permanente and the principles of the Labor Management Partnership. Therefore, we share the goal of comprehensive, jointly-administered education and training effort with joint design and oversight teams.

#### **National support**

The Bargaining Task Groups (BTGs) identified a variety of educational requirements necessary to advance the partnership and transition into high performing, committed work teams. To address these recommendations, the Strategy Group will establish a national education task force to evaluate the BTG educational recommendations and develop a plan for integrating the recommendations into the organizational structure. The committee will consider:

- Development of a uniform and consistent tracking mechanism for all National Labor Management Partnership and regional employee education and training.
- Methods to secure and coordinate funds from external resources.
- Jointly administered educational funds for partnership training.
- Integrating education into current processes and funding mechanisms.
- National templates for employee education.
- Providing national guidance and coordination to regions including the collection and dissemination of best practices in training design and content.
- National support for the development of partnership activities.
- Support for educational requirements of Partnership teams including: partnership orientation; business education (root learning maps); interest based problem-solving; consensus decision making; union education; issue resolution and corrective action and understanding institutional unions.
- Support includes program development, train-the-trainer programs, partnership team orientation and consultation.

#### **Joint employee education design and teams**

Joint oversight of local Partnership and other joint training will be provided under the guidance of the Regional Partnership Teams. The national education committee will provide guidance for local/regional teams concerning:

- National and regional oversight/administration.
- Process to inventory current employee education activities.
- Audit current spending (total and percentage of payroll).
- Create/implement a funding tracking system.
- Determine feasibility of a National Education Resource Center."

Source: Kaiser Permanente, The Coalition of Kaiser Permanente Unions, AFL-CIO, October, 1, 2000, pp. 13-14, <http://www.unac-ca.org/pdf/nationalagreement2000.pdf> and <http://www.kaiserpermanente.org>

## Checklist 7: Strengthening institutions of social dialogue

In order to strengthen in particular the human aspect of social dialogue, the following questions have to be addressed in a given situation:

- **How should training programmes for social dialogue be designed in a given situation?**

Model curricula and modules on social dialogue in the health services may provide the basic ideas on the required knowledge, skills and behaviour in this area. The details in a given situation have to be designed jointly by the social partners. To limit the expenditures on training, it is important to identify already existing programmes and training materials. Training programmes may be designed for the enterprise or for groups of enterprises and professions.

- **Who will be involved in such training?**

The need for involving all staff and management in training on social dialogue may be discussed. However, it should be made certain that all actual and potential representatives in social dialogue receive such training since a small group of trained persons cannot ensure large scale participation and commitment in implementing the results of the social dialogue (see also [Notes 7.2](#) below).

- **How can the individuals involved be prepared for social dialogue?**

Additional to the general design of training for social dialogue, mechanisms have to be established which examine the individuals' need for such training which might be stronger in one field than the other. Also, the potential of following the training and applying the acquired knowledge and skills should be included in such evaluation of training needs and the possible support needed. Specific attention may have to be paid to trainees who face limitations through their family responsibilities, in particular women (see also [Notes 7.3](#) below).

- **How can individuals be trained while continuing to carry out their professional activities?**

The question whether training in social dialogue should be counted as working time is related to financing of training costs and the returns of such investment. This question might be even more pronounced in times of staff shortages. The clarification of such questions may require a careful audit of spending and potential returns. Such an audit might be easier to apply in private than in public institutions (see also [Notes 7.4](#) below).

## Four steps to strengthen social dialogue institutions in the health services

The following four steps will focus on the human resources capacities of the social partners. The steps include (1) strengthening the understanding of social dialogue, (2) the auditing of resources spent, (3) the selection of participants and (4) the identification of their training needs.

### 7.1 Notes for the facilitator: Strengthening the understanding of social dialogue in the health services

**Objective: Develop a standard module to acquire an understanding of social dialogue in the health services.**

The most effective training method in acquiring understanding of social dialogue is through “learning by doing”. It is therefore recommended that the facilitator develops a sample module in which the social partners plan for their activities. One example which was already introduced in Section 3, could be to plan a module for setting the social dialogue agenda. A simplified version of a standard module is outlined below:

#### Standard module on knowledge of social dialogue (1 day example)

Time	Topic	Method	Materials	Responsible	Observations
9:00-10:30	What is social dialogue?	Role play (several groups) (see Notes 2.3)	Instructions for the groups in the role play		
10:30-11:00	Break				
11:00-12:30	Current situation in the health services	SWOT (see Notes 3.1) in working groups	Prepared flipcharts		
12:30-14:00	Break				
14:00-15:30	Analysis of the current situation in the health services	SWOT matrix (see Notes 3.1) in plenary	Prepared matrix on flipchart		
15:30-16:00	Break				
16:00-18:00	Identifying and setting priorities for the agenda of social dialogue	Plenary discussion and listing of agenda items; prioritisation	Flipchart		

By using interactive methods which involve the participants as much as possible, such a module can provide not only understanding but also practice in acquiring the necessary skills and behaviour for social dialogue. This standard module should be developed at the sectoral level by the teams of organizers/facilitators and then adapted for training at the enterprise level.

## 7.2 Notes for the facilitator: Selecting participants for social dialogue training

**Objective: Apply rational criteria for the selection of social dialogue participants.**

Ideally the staff of all social partners in the health services should be trained in social dialogue. In the long run this could be achieved by introducing the subject into the educational curricula of the relevant professions in the health services. However, to initiate short-term courses, a selection of participants for social dialogue training should be established. The following sequence of selection is recommended:

- (1) participants familiar with social dialogue processes who could serve as facilitators (select together with the social partners);
- (2) participants familiar with social dialogue processes who would not be candidates for facilitation (selection with the social partners; to be started in pilot areas);
- (3) participants who are not currently active in social dialogue processes but have potential (select with the social partners; public announcement of the courses through health facilities).

## 7.3 Notes for the facilitator: Identify training needs and potential

**Objective: Identify the training needs in social dialogue for individuals and develop their potential to apply the training.**

Besides identifying the general training needs in social dialogue (see [Notes 7.1](#) above), the facilitator has to identify the training needs of the individual participants before the course. In designing the course, it is also important to determine the potential of the participants to apply the training. The facilitator has to bear in mind the needs and potential of participants in view of the three main aspects of training: knowledge, skills and behaviour.

### Preparatory work before social dialogue events

It is recommended that questionnaires be sent to the participants for training courses which would include the following questions and the possibility of multiple answers per question:

**Example of questionnaire to identify training needs** (providing several answers per questions giving priority (1), (2), (3) ...)

	(1)	(2)	(3) ....
What do you have to know about social dialogue in the health services?			
What skills do you feel you need most for social dialogue?			
What attitudes do you consider most important for social dialogue?			
How could you use what you learned in the training in your work?			
What role would you like to play in social dialogue?			

	(1)	(2)	(3) ....
What would be the most convenient dates/ times for you to attend a training course?			
How long would you be available for a training course?			
What facilities would you require for the course' (e.g. child care facilities)			

The results of the answers to such questionnaires should be analysed for the course design and also presented to the participants in order to explain the objectives and the programme of the course.

### Exercise during social dialogue events

Experience has shown that it is indispensable to ask the participants at the beginning of the course about their concerns and expectations of the course. Such an exercise could be conducted by asking participants to spontaneously write each their concerns and expectations on 2-3 cards (one idea per card). These cards should be structured on a pin-board in two clusters marked “concerns” and “expectations” which will help in fine-tuning the programme. These clusters can also serve as a basis for evaluation at the end of the course.

## 7.4 Notes for the facilitator: Auditing the resources

**Objective: Audit spending on social dialogue training and gauge its potential returns.**

The facilitator should prepare a budgetary forecast and keep a record of the actual spending in view of the financial and human resources involved (see also Section 12 below). This “auditing” should be done irrespective of the possible sources of finance. In fact, such a record will be useful in mobilizing funds and in distributing the expenditures. For this purpose the facilitator may use the following table:

### Resources involved in a social dialogue event:

	Budgetary forecast	Actual spending
Participants (workdays): • Preparation • Participation • Follow-up		
Facilitator (workdays): • Preparation • Participation • Follow-up		
Specialists (workdays): • Preparation • Participation • Follow-up		

	Budgetary forecast	Actual spending
Materials		
Equipment		
Facilities <ul style="list-style-type: none"> <li>• Conference rooms</li> <li>• Board and lodging</li> </ul>		
Other expenses		
Total		

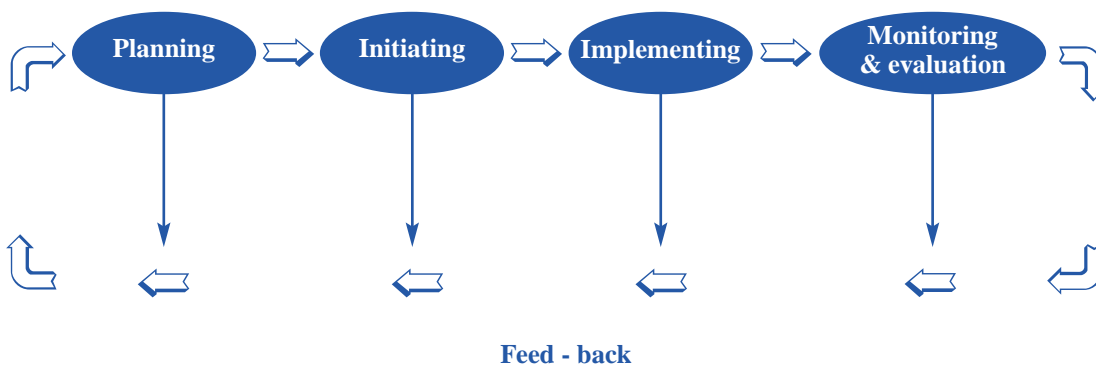
The possible returns on the investments are difficult to quantify since very often they are not easily measurable, and it may be necessary to meet separately on this issue with the social partners. The purpose of the exercise is to identify problems areas where costs could be reduced through social dialogue at the workplace. Examples could be: costs incurred through absenteeism when working time schedules are not established; costs incurred through demotivation when reorganization is conducted in the absence of dialogue; costs incurred through violence at work when prevention measures are not discussed through dialogue.



Second part:

## The Process of social dialogue in the health services

Social dialogue is not a single event but a continuous process of planning and implementing. The monitoring of the implementation will be used to revise the current process and as a feed-back into the planning of future stages of social dialogue. The details of such process are described in the following sections. Even though the various stages of social dialogue are overlapping, they will be described separately for the purpose of a clear analysis.



## Section 8: Planning for social dialogue

### *Text of the conclusions*

***“12. All stages of a process of social dialogue are interrelated and depend on each other. The stage of planning is, however, of particular importance and should be carried out through social dialogue itself. Planning for social dialogue in health services has to be based on the continuing analysis of the current situation in the health sector and has to be closely related to general processes of health sector reform. Planning has to anticipate the process of reaching a common understanding, of recognizing the social partners and of identifying indicators for the effectiveness of social dialogue. This planning process has to be designed in advance and depends on the issues and the elements of social dialogue chosen for a given situation. Therefore, the social partners have to consider, inter alia, the following: who will 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; and how should the time frame and different phases for social dialogue be determined.”***



As the above paragraph 12 of the conclusions sets out, planning social dialogue should be an integral part of the whole process, since it is the only way that the social partners will take ownership of the whole process. This approach, however, makes the result of the planning not necessarily predictable. The result may be different from a plan that would be developed by specialists based on well-informed analysis of the current situation and problems. Notwithstanding, the social partners need objective and detailed information on such specialized analysis. The process which develops based on this analysis can already be the first stage of social dialogue. The resulting plan will be more acceptable to all parties concerned even though it will be a compromise between different approaches.

There is no uniform model for planning social dialogue in the health services. A number of questions like those in the checklist below have to be

answered simultaneously. They cannot always be answered in a given sequence; in fact the answer found to one question has to be matched against those to other questions. In many cases, the only feasible approach is that of trial and error. Also the resulting plan should have built-in mechanisms which allow for revision if the social partners wish to do so jointly. Monitoring is therefore a very important element in all stages of social dialogue. The plan also has to set out a time frame for implementation. Even if the time required is often underestimated, such a time frame provides an important reference for monitoring the whole process. The time requirements for planning a national health sector reform might be different from planning for restructuring and reorganizing at enterprise level. However, the examples of New Zealand, Brazil and Kaiser Permanente (USA) in sections 3 and 5 of this Tool show that several years may be needed to come to agreements on a plan.

#### Box 14: Planning for a social dialogue institution in the health sector – an example from Ghana

At the initiative of the Ministry of Health (MOH), a tripartite planning process was started in 2003 to establish an institution for social dialogue in the health sector. As the result of two workshops, the following first steps for action were proposed in March 2003:

Objective	Target	Activity	Action by
To constitute national dialogue committee	National social dialogue committee constituted	Identification of national social dialogue committee members	Director HRHD, MOH
To notify identified members	Identified members informed	Writing letters to identified members then inviting them to a meeting	Minister or Director HRHD
To invite identified members for first meeting	Identified members invited	Writing letters to invite at a fixed date: – briefing – TOR	Director HRHD
Committee members to meet Minister of Health	Committee members met Minister of Health	Arrange meeting between committee members and Minister or interaction, familiarization and purpose statement	Director HRHD
To inaugurate Committee	Committee inaugurated	Arrangements, invitations for inauguration	Minister MOH
To plan quarterly meetings	Quarterly meeting planned	Arrangement to hold planning meeting	Chairperson, National SD Committee

Source: Dovlo, D., *Social Dialogue in the Health Services – Case Study Ghana*, ILO Sectoral Working Paper, forthcoming.

At an ILO tripartite workshop on strengthening social dialogue in the health services in Ghana in November 2003, the discussion of this activity plan generated proposals on how to enhance the planning process and the functioning of the future social dialogue institution. Participants suggested to include as additional components activities of awareness raising and to develop an advocacy strategy. The need of capacity building at an early stage of the planning process was felt to be crucial for this country. Further it was suggested to identify monitoring mechanisms for the planning process.

Source: Strengthening Social Dialogue in the Health Services, ILO Workshop, Accra, Ghana, 25-26 November 2003

## Checklist 8: Planning social dialogue in the health services

- **Who should be involved in the planning process?**

Identifying the parties to be involved in planning also means to give them recognition as equals in social dialogue. The organizations chosen must be representative for the group of persons concerned with the agenda item chosen. Hence these questions are interdependent. The matrix of figure 2 might help to match the right representatives against the right agenda items. If the agenda relates to broader issues in the health services and to health sector reforms, consultation with other stakeholders might be included in a wider dialogue beyond social dialogue as defined in this Tool.

- **Who should set the goals to be achieved through social dialogue?**

The initiator of social dialogue in the health services is often the government which may pursue its own goals of public health and health sector reforms. However, the joint planning process with the social partners might set less ambitious goals in the beginning. This first phase of social dialogue may be used to build a culture of trust and a common understanding of the situation. Building on such initial goals, the social dialogue may be expanded. Important is the explicit formulation of the goals to be achieved in the forthcoming phase of social dialogue.

- **How should the agenda of social dialogue be set?**

The agenda items for the social dialogue in the health services should be identified through social dialogue and formulated clearly in an agreed upon plan. Checklist 3 might be helpful for this exercise. Each agenda item chosen should be examined for its gender implications.

- **How should the type of social dialogue be selected?**

The type of social dialogue in the health services could be chosen at enterprise, regional and national level and may be bipartite or tripartite. This decision of the social partners depends on the agenda set in the planning phase. Further, the main elements of social dialogue have to be selected depending on the targeted outcome. They are described in box 2 and include information, consultation and negotiation. The agreed upon plan should make explicit which type and which elements of social dialogue were chosen for which phase of the social dialogue.

- **How should the time frame and different phases for social dialogue be determined?**

Once the above questions have been answered and the answers have been matched against each other, the plan should also provide a time frame for implementing the plan in the different phases of social dialogue. The matrix below might help to formulate an overview of the plan agreed upon which responds to the above questions:

**Figure 5: Overview on agreements reached for a plan of social dialogue**

Phase	Goal	Agenda	Representatives	Type of social dialogue	Elements of social dialogue	Time
Initiating						
Phase 1						
Phase 2						

## One step to arrive at a mutually agreed plan

### 8.1 Notes for the facilitator: Agreeing on a plan

**Objective:** Arrive at a mutually agreed plan by bringing together the decisions made on various aspects of a social dialogue process in the health services.

The goal of arriving at a negotiated plan is achieved by bringing together the decisions already made on various aspects of a social dialogue process. For this purpose, the facilitator should compile the information already gained for the social dialogue process, in particular on:

- (1) the goal and agenda (*see Section 3 above*)
- (2) the representation (*see Section 4 above*)
- (3) type and elements of social dialogue (*see Section 2 above*)

The break-down of the timing into various phases should be undertaken in a planning workshop.

### Exercise during social dialogue events

At the beginning of a planning workshop the facilitator should present a matrix similar to *Figure 5* above which outlines the relevant information already available. The matrix should be presented on a pin board with mobile cards. The plenary of the workshop should then be distributed in working groups. Each group will receive the same matrix on a sheet of paper and will be entrusted to fill in one or several columns in this matrix. The group discussion will be based on the information already gained in the social dialogue process. The results of the working groups will be presented in the plenary by pinning mobile cards unto the presented planning matrix on the pin board. Mobile cards are convenient for such an exercise since they can be replaced if the discussion in the plenary requires change. For each goal, one matrix should be developed.

In order to make the start of the social dialogue manageable, in the beginning a goal should be chosen which is relatively limited in scope, e.g. reorganization of work. The resulting planning matrix for the “reorganization of work” could be as follows:

**Example: Overview on a plan to reorganize work at a health facility through bilateral social dialogue:**

	Goal	Agenda	Representatives Dialogue	Type of social dialogue	Elements of	Time
Initiating	Reorganization of work	Taking stock	– Management – Staff representatives	Enterprise level	Exchange of information	2x1 week
Phase 1	Reorganization of work	Proposals by unit	– Representatives of management – all staff by unit	Enterprise level	Consultation	5x3 days
Phase 2	Reorganization of work	New work organization	– Management – Staff representatives	Enterprise level	Negotiation	1 week

## Section 9: Initiating social dialogue in the health services

### *Text of the conclusions*

*“13. Social dialogue is not a time-limited event but a continuous process of consultation, negotiation and exchange of information aimed at agreed improvements of health services and public health within the framework of financial possibilities and affordability. Nevertheless, the process or reform needs to be initiated by persons, organizations, institutions, or following an event. In the health services, structural adjustment, public sector reforms or crisis situations have often prompted a process of social dialogue. However, there are also success stories of social dialogue in certain areas of the health services which may encourage social dialogue to be expanded to other areas or to other levels. This process may start in an informal, limited and ad hoc way with the aim of building long-term relationships of increasing trust. The initiative for social dialogue depends on the issues chosen and requires addressing issues such as: who will take the initiative to enter into social dialogue; whether social dialogue should start as an informal or formal process; and what the agenda for this initial stage of social dialogue should be.”*



As the above paragraph 13 of the conclusions underlines, social dialogue is a continuous process of consultation, negotiation and exchange of information. The phases of social dialogue are overlapping and what is called “initiating” in one case might already be phase 1 of implementing social dialogue in another case. As can be seen in the example of Kaiser Permanente which is a case of bipartite social dialogue at enterprise level, the initial phase ended in a formal National Agreement which outlined reorganization and the future organizational culture. In the cases of health sector reforms in Brazil and in New Zealand, the

social dialogue process went step by step and needed long phases of preparation and initiation. In these cases, the initiative was taken by the governments with many informal consultations before any formal forums and bodies were created. Ideally, the planning process would already identify the way in which the social dialogue should be initiated. Also, the respective body which invites others to the first meeting whether bipartite or tripartite, would have already discussed the details of such a meeting in the planning phase (see e.g. example of Ghana in box 14).

## Checklist 9: Initiating social dialogue in the health services

- **Who will take the initiative to enter into social dialogue?**

The government as regulator of health services takes often the initiative to enter into social dialogue in order to find solutions to prevailing problems in the sector. If the initiative does not come from this side, it would be appropriate that the social partners agree beforehand in the planning process by whom and how this initiative may be taken (see also Notes 9.1 below).

- **Should social dialogue start as an informal or formal process?**

If a long-term process of reforms is envisaged and there has been little tradition of social dialogue, it may be appropriate to start in an informal way in order to build up trust among the social partners. However, there should be provisions on how and when such informal

exchange of information and points of view can be turned into a formal negotiation. All steps have to be made explicit in a transparent way.

- **What is the agenda for this initial stage of social dialogue?**

It might be helpful to start off with a small and light agenda. The agenda for the initial stage could be to take stock of current health-care problems at national and enterprise level and to set out the necessary steps to address these problems through social dialogue. Another scenario may also be that collective bargaining on partial but important aspects of health services (e.g. negotiations on pay) can trigger a more general discussion on reforming health services. Section 5 on “early warning systems” provides some ideas to this approach.

## One step to start the social dialogue

### 9.1 Notes for the facilitator: Choosing the right entry point

**Objective: Prepare the initiative and invitation to social dialogue.**

The facilitator should choose between several possibilities to prepare the initiative and invitation to social dialogue in the health services. Each of the following options is (a) matched with the specific goal and agenda, (b) based on the existing relations between the social partners, (c) adapted to the type of social dialogue, and (d) requires different procedures:

- (1) *The authority in charge of the health service calls for a tripartite planning workshop at the sectoral level:* this option is indicated when (a) a general reform of the health services is under consideration (b) the health authority is not in a continuous exchange with the social partners and (c) the health authority wishes to consult the social partners in the health services at the national level. Such a case requires that the health authority should take the initiative to invite the social partners to a national event on health services or a planning workshop for social dialogue in the health services (see also Sections 1-7 above). The planning workshop could then establish the agenda, the representation and other details of the following social dialogue process (see Section 8 above).
- (2) *The social partners at the sectoral level agree on a procedure and on when to organize a tripartite meeting:* this option is appropriate for situations where (a) a specific issue in the health services needs to be addressed (e.g. staff shortages), (b) tripartite social dialogue institutions exist and routine meetings are functional, and (c) the social partners wish to exchange information and consult with each other. Such a case requires the social partners to agree in a regular meeting on a planning matrix (see Section 8 above) which the facilitator can then use to initiate the specific social dialogue event.
- (3) *The management of a health enterprise calls for a bipartite meeting with representatives of the staff:* this option is appropriate for a situation where (a) structural changes in the health enterprise are under consideration (e.g. a merger with another health enterprise), (b) social dialogue institutions at enterprise level do not yet exist, and (c) the management wishes to consult and negotiate with the workforce regarding structural changes. Such a case requires management to take the lead in calling for a bipartite social dialogue planning workshop ((see also Sections 1-7 above). The planning workshop could then establish the agenda, the representation and other details (see Section 8 above).
- (4) *The social partners at enterprise level agree during their routine discussions to organize a bipartite meeting in order to find a solution to a specific problem in the health enterprise:* this option is appropriate for a situation where (a) a specific problem in the enterprise warrants a solution (e.g. reorganization of work), (b) bipartite social dialogue exists at enterprise level and (c) the social partners wish to consult and negotiate with each other. Such cases require the social partners to agree in a routine meeting on a planning matrix (see Section 8 above) which the facilitator can then use to initiate the specific social dialogue event.



## Section 10: Implementing social dialogue

### *Text of the conclusions*

***“14. Social dialogue is a process to be carried out in good faith. 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. However, in health services the implementation of the plan is often difficult and dependent on factors which may be beyond the complete control of the social partners. Therefore, to sustain support for these efforts, continuous attempts have to be made to adjust or reinstate social dialogue. To this end, the social partners should adopt a consensual approach to implementation. For a given situation the following should, inter alia, be considered: who will manage and facilitate the process of social dialogue; and what mechanisms should be provided to match the plan against reality.”***



The above paragraph 14 of the conclusions stresses the importance to sustain support for the implementation of the agreed upon plan. If the social dialogue is well prepared in the planning phase and appropriately initiated, the major tasks in the implementation phase are the management and the facilitation of the dialogue. These tasks require persons who are explicitly nominated for these functions and who have the necessary skills and behaviour to fill such functions. Often there is a need to first train such facilitators as the specific skills and behaviour of mediation between groups with different interests are normally no wide-spread (see also [Notes 10.1](#) below). The example of Kaiser Permanente where 300 employees and management staff were involved in the dialogue for the National Agreement, illustrates how many facilitators must have been needed in the various discussion groups.

The other major task in the implementation phase, is to keep the social dialogue “on track”, i.e. to match the agreed upon plan against reality but also to keep the interest and the willingness to participate alive. This is often also seen as a task of the facilitator, but the social partners themselves have to provide mechanisms to move the

implementation of the plan forward. Modern information technology seems to offer here considerable possibilities (see also [Notes 10.2](#) below). In the UK, in the social dialogue on the reform of the pay system in the National Health Service – NHS (through the “Agenda of Change”), the leading trade union UNISON offers permanent up-to-date information to the public and its members on their website ([www.unison.org.uk/healthcare](http://www.unison.org.uk/healthcare)).

However, there should also be provision for mechanisms which allow the review of social dialogue while the plan is being implemented. This task is closely linked to or overlapping with the phase of monitoring and evaluation which will be treated in section 11. In the implementation phase, the focus should be on monitoring of the implementation as this gives a major input into the evaluation of the whole social dialogue process. Depending on the agenda of social dialogue, monitoring the implementation will be bipartite (public/private employers and workers) or tripartite (governments, public/private employers and workers) (see also [Notes 10.3](#) below). The National Agreement of Kaiser Permanente provides for a bipartite review process which

### Box 15: Kaiser Permanente Partnership Agreement Review Process

“After sharing information and fully discussing and exchanging ideas and fully considering all views about issues of interest and concern to the parties, decisions should be reached that are satisfactory to all. However, it is understood that the parties may not always agree. Disagreement at the facility (hospital) which arises out of the interpretation and/or implementation of section 1 [see box 4 in this Tool], should be referred to the local level Partnership Team for discussion in an attempt to reach a consensus decision. If it is unresolvable at the local level, the Regional Partnership Team must address and attempt to resolve the issue at its next scheduled meeting but not later than 30 calendar days following its referral. The Regional Partnership Team will, after careful review of all facts and interests, craft a consensus decision designed to resolve the issue. If consensus proves impossible, the matter may then be referred to a national panel comprised of two union and two management members of the Labor Management Partnership Strategy Group, along with a predetermined neutral designee selected by the Strategy Group ...”

Source: Kaiser Permanente, The Coalition of Kaiser Permanente Unions, AFL-CIO, *National Agreement*, October, 1, 2000, p. 23, <http://www.unac-ca.org/pdf/nationalagreement2000.pdf> and <http://www.kaiserpermanente.org>

involves, at enterprise level, the private employer and the workers. This provision is summarized in the box below.

Such a review process may be sufficient for cases in which persons notify explicitly disagreement; however, provisions may also be needed to monitor the implementation of social dialogue in a more general way where deviations from the plan are noted even, if there is no explicit disagreement. The most evident aspect of deviation is the timing. In the example of New Zealand’s health reform (see box 3), the timing of the plan had to

be revised, as certainly in a number of other cases. Monitoring of the time schedule is, however, critical in reform processes since one step builds on the next and hence “early warning” is needed if the first step cannot be achieved. Other aspects of deviation may occur in cases where the structure of a social partner changes, e.g. through corporate transaction (like contracting out or acquisitions) or mergers of unions. The National Agreement of Kaiser Permanente provides for such cases in a specific section.

## Checklist 10: Implementing social dialogue in the health services

### ● Who will manage and facilitate the process of social dialogue?

Persons nominated to these tasks have to be carefully selected and trained as the skills and behaviour required for mediation between groups with different interests are very specific. Their role is very decisive for the process of social dialogue; however, the social partners themselves have to prepare their representatives in a manner which is adequate to keep the process alive and “on track”.

### ● What mechanisms should be provided to match the plan against reality?

The plan or the initial agreement should provide for review mechanisms which monitor the implementation of the plan. Such review mechanisms should not only examine any disagreement of one of the social partners but also provide for general and periodic matching of the plan against reality. Moreover, it may be necessary that each of the social partners establishes some basic review mechanism on their own.

## Three steps to ensure the implementation of social dialogue in the health services

The implementation of social dialogue in the health services requires competent organizers and facilitators who have to (a) guide the individual social dialogue events, (b) ensure the continuity of the overall process of social dialogue throughout a sequence of events and (c) prepare the basis for possible adjustments of this process. The following three steps are recommended:

### 10.1 Notes for the facilitator: Preparing guidance

**Objective: Select and train the persons to manage and facilitate the process of social dialogue.**

Section 1 of the Handbook provided practical tips on the profile of the persons who manage and facilitate social dialogue events. The text explained how to select and train these persons and how to create facilitators' teams. (see [Notes 1.1](#) above) It should be noted from these explanations that the roles of the organizer and facilitator are distinct but that the same person may be able to play both roles. Therefore, throughout the Handbook the practical notes address "the facilitator". The training for both roles should be provided in the same training courses. Bearing in mind the large scope of tasks in guiding social dialogue processes, it would, however, be more convenient to create teams of several persons to cover the various tasks.

The training of organizers and facilitators should be done in a sequence of short courses interspersed with opportunities in which the persons can apply the training learned under the supervision of a coach. The sequence of short courses could take the following form:

#### Training sequence for organizers and facilitators:

3 days group training in methodology	Organizing and facilitating a social dialogue event (supervised by a coach)	2 days group training with feed back from the coach on the application	Organizing and facilitating a social dialogue event	1 day group training to exchange and to evaluate the experiences gained
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The first training workshop could have the following programme:

**Programme for initial training workshop of organizers and facilitators:**

Day 1	Day 2	Day 3
Introduction of participants, expectations and context of the training event	Presentations of the role play by the different groups in plenary	Conceptual introduction of methods and rules for social dialogue events with reference to the experiences gained in the simulations
“Icebreaker” exercise to prepare participants for cooperation in groups	Evaluation of the role play after each presentation	Discussion, questions and answers on methods for social dialogue events
Simulation of the planning for a social dialogue event in health services (role plays to be prepared in groups for presentation in plenary)	Reflection on methodological lessons learned in the simulations: presentation by the facilitator and discussion with the participants	<ul style="list-style-type: none"> <li>– Evaluating the workshop and matching against the expectations</li> <li>– Getting prepared for the next steps in the training sequence</li> </ul>

**10.2 Notes for the facilitator: Ensuring continuity**

**Objective: Implement social dialogue events in a long-term process.**

The facilitators have to not only guide social dialogue in individual events but also oversee the social dialogue processes on a continuum. The main task in guiding such a process is to ensure continuity. This continuity is related to the representation of the social partners and the agenda identified in the beginning of the process. The sequence of individual events in a social dialogue process is normally spaced with periods of consultation of the social partners with their own members, periods of information collection and periods of evaluating the negotiated agreements. After a social dialogue event, the facilitator should endeavour to secure the participation of the representatives in future meetings. If that is not possible, the facilitator should ensure that new persons are briefed on the previous decisions taken and are aware of the goals ahead. This briefing could be assisted by availing reports of previous meetings and by informing the participants in the beginning of new meetings through a summary session. Also, the planning matrix (see figure 5 in Section 8 above) and the matrix matching the agenda with the representatives (see figure 2 in Section 4 above) should be made available to the participants at that new meeting. If information technology is available to the social partners, they should also post earlier agreements on their internal websites.

**10.3 Notes for the facilitator: Preparing for the adjustment**

**Objective: Develop a review mechanism for monitoring the implementation of the social dialogue process.**

The above task of ensuring continuity is closely related to the task of reviewing the implementation of social dialogue. Reviewing the implementation of individual social dialogue events and of the whole social dialogue process is the basis for monitoring and evaluation (see Section 11 below) and the basis for necessary adjustments. Such review mechanisms should be built in each individual event by keeping a record of achievements and problems. The facilitator should introduce standard questions to the participants at the beginning and at the end of each meeting (e.g. about concerns and expectations) which can then be analysed and compared during the course of the social dialogue process.

## Section 11: Monitoring and evaluating the process of social dialogue in the health services

### *Text of the conclusions*

**“15. Planning and implementation are closely related to mechanisms of monitoring and evaluating the process of social dialogue in relation to 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. Indicators have to be set for this purpose. Substantial deviations from the plan need to be examined and evaluated in the light of the goals to be achieved. If the results are not satisfactory, corrective action has to be taken by the social partners.**

**16. Social partners have to be trained in methodologies for the monitoring and evaluation of the process of social dialogue. All social partners should participate in such process and appropriate institutional arrangements should be foreseen for this purpose. The initiative for the process may come from the Ministry of Health or other appropriate competent authority; other stakeholders such as users, experts and international agencies may be included if so requested by the social partners. The following elements need to be taken into account: 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.”**



Paragraphs 15 and 16 of the conclusions set out the importance of monitoring and evaluation in relation to the goals to be achieved. The mechanism of monitoring and evaluation presents itself as complex and multifaceted. This mechanism is meant to monitor and evaluate progress of the process of social dialogue and yet is often also taken to monitor and evaluate the progress in the substance of the agenda of social dialogue. As social dialogue is also a means to forward this

agenda, it is unavoidable to also include the substance into monitoring and evaluation. The review bodies described in boxes 15 and 16 reveal this “dilemma”. It is, however, important to distinguish explicitly among both aspects. The precise formulation of indicators will help to solve this problem.<sup>7</sup> For this purpose, the overview matrix in Figure 5 (should read 5 and not four as in original) might be expanded in order to attribute indicators to the goals to be achieved.

<sup>7</sup> For the development of indicators on the impact of human resources on the health system performance, see K. Diallo et al., *Monitoring and evaluation of human resources for health: an international perspective*, WHO, 2003, <http://www.human-resources-health.com/content/pdf/1478-4491-1-3.pdf>

**Box 16: Monitoring in the Proposed Agreement “Agenda for Change” (United Kingdom)**

In 2003, after many years of preparation, the UK Health Departments, NHS Confederation, Unions and Professional Bodies proposed an agreement to modernise the NHS pay system in a Partnership Approach to Pay and Service Modernisation. It provides for monitoring as follows:

“Monitoring of implementation will be carried out, in the first instance by the national implementation steering groups (or equivalent bodies) in England, Scotland, Wales and Northern Ireland. Issues of common concern will also be discussed in the Pay Modernisation Implementation Steering Group (UK), and its successor, which under this agreement will be the sub-group of the NHS Staff Council, responsible for coordinating and monitoring the implementation of this agreement. Any issue requiring amendment or reinterpretation of any part of this agreement must, however, be endorsed by the NHS Staff Council.

The initial criteria against which progress will be monitored in the early implementers (12 selected NHS Trusts which are piloting the Agenda of Change since spring 2003) in England, together with suggested measures, are attached in Annex E. (This list of 15 success criteria and the approach on how to measure them includes also quality standards for patients and staff.) These may be modified for national roll out in the light of experience in the early implementers, subject to the approval of the NHS Staff Council. During the early implementation period arrangements will be made to allow the wider NHS to learn from experience in the early implementers ...”

Source: *Agenda for Change, Proposed Agreement*, 2003, p. 6, at: [www.unison.org.uk/healthcare](http://www.unison.org.uk/healthcare)

Another complexity arises from the fact that monitoring has to take place continuously, also during the phases of planning, initiating and implementing while the analysis of the acquired data, the evaluation, takes place in periodic stages and is often commissioned to advisers outside the social dialogue process. Ideally, both aspects, continu-

ous monitoring and periodic evaluation, should be accommodated throughout the process of social dialogue. The monitoring process may be facilitated if tools, like the matrices outlined for planning in earlier sections of this Tool, are continuously matched against reality (see also [Notes 11.1](#) below).

**Box 17: Monitoring and evaluation of partnership agreements in Canada (Province of Saskatchewan)**

“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, the Saskatchewan Department of Intergovernmental and Aboriginal Affairs (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. ...”

Source: ILO, *Social dialogue in the health services: Institutions, Capacity and Effectiveness, Report to the Joint Meeting*, Geneva 2002, pp. 50-51.

## Checklist 11: Monitoring and evaluating social dialogue in the health services

- **Who should identify deviations from the planned process of social dialogue in terms of substance, timing, methodology and other aspects agreed upon?**

The planned process of social dialogue is multi-faceted and hence the identification of any deviation is complex when implementing the process. Already in the planning phase, bipartite or tripartite bodies should be established which are given the task to monitor and evaluate according to agreed upon mechanisms. The planning phase needs already to develop clear indicators which would allow objective identification of any deviation by such review bodies. External expertise may be required for setting up the mechanisms, for periodic evaluations and for complex assessments. However, overall responsibility should remain with the review bodies (see also Notes 11.2 below).

- **Who should evaluate the impact on the health services?**

While deviations within the process of social dialogue are being monitored, the impact of social dialogue on the health services in general terms should also be evaluated. Quality standards as described in section 6 can serve as indicators. The assessment of health systems performance as developed by WHO<sup>8</sup> should be a relevant goal. However, there is a need to further identify the role of social

dialogue on the impact on health system performance. Other initiatives may also come from the government as regulator or from the users of the health services.

- **Who should set the indicators for this impact?**

The development of clear and over time comparable indicators on the impact of health system performance is a joint task for the social partners in preparing an agreement for social dialogue. In fact, the text of the agreement should list such indicators in order to make the process of monitoring and evaluation transparent. Such indicators should include those for the progress of social dialogue as well as those for its impact on the health system performance (see also Notes 11.3 below).

- **Who should initiate the action required?**

Procedures for initiating monitoring and evaluation should be agreed upon by the social partners in the planning stage. The initiative should lie with the review bodies; however, there should also be provision in the agreement for other initiatives which the social partners wish to undertake for the purpose of monitoring and evaluating progress in the process of social dialogue. Other initiatives may also come from the government as regulator or from the users of the health services.

<sup>8</sup> C. Murray, J. Frenk: "A framework for assessing the performance of health systems", *Bulletin of the World Health Organization*, 2000, 78(6).

## Three steps to monitor and evaluate

To monitor and evaluate (m&e) the social dialogue process in health services, it is necessary that a variety of methods and of persons be involved. In order to arrive at a practical assessment of the achievements of the plan for a social dialogue process, the facilitator should (a) standardize the m&e instruments, (b) involve all participants of the social dialogue process and (c) analyse the results of monitoring and evaluation in view of possible adjustments to the plan.

### 11.1 Notes for the facilitator: Standardizing m&e instruments

**Objective: Prepare questionnaires and other instruments to monitor and evaluate the process of social dialogue.**

The central reference for monitoring and evaluating is the planning matrix for the social dialogue process as agreed by the social partners (Figure 5 above). All m&e mechanisms should collect information on the issues listed in this planning matrix.

#### Preparatory work before social dialogue events

For continuity and comparison, it is recommended that the facilitator standardize the questions raised in questionnaires and other m&e instruments. They should at least include the following questions to which ratings can be attributed:

- (1) Was the plan itself developed through social dialogue? (1-5)
- (2) Is the social dialogue process implemented according to plan? (1-5);
- (3) Is the planned agenda adapted to the goal? (1-5)
- (4) Is the representation of partners adapted to the agenda? (1-5)
- (5) Is the guidance of the social dialogue process adapted to the plan? (1-5)
- (6) Will social dialogue have an impact on the health service issue under discussion? (1-5)

Additional questions on each issue could be: Can you identify any problems? What proposal do you have to solve the problems?

For individual social dialogue events the questions at the end of each event could be formulated in a similar fashion:

- (1) Did the social dialogue event correspond to your expectations? (1-5)
- (2) Did the social dialogue event advance the overall social dialogue process? (1-5)
- (3) Will the results of the social dialogue event help you in your day-to-day work? (1-5)

In order to provide a solid basis for monitoring and evaluating, the same questions should be raised periodically and at each individual social dialogue event. The facilitator can then calculate average scores from the ratings.

### 11.2 Notes for the facilitator: Involving the social partners in m&e

**Objective: Prepare the participants of the social dialogue process to take part in m&e**

All social partners should participate in monitoring and evaluating the social dialogue process. Therefore, m&e mechanisms have to be established which include as many participants as possible. The facilitator should continuously involve the participants through the following mechanisms:



- All participants of social dialogue events should be involved through questionnaires and evaluation exercises at the end of each event.
- Persons nominated by the social partners to follow m&e should be involved through questionnaires and structured interviews.
- Tripartite or bipartite review bodies established by the social partners should organize specific m&e meetings or workshops in which the representatives are involved in regular discussions.
- Organizers and facilitators of social dialogue events and processes should themselves be involved by keeping records of the social dialogue events and by analysing questionnaires and other m&e mechanisms.

### 11.3 Notes for the facilitator: Analysing m&e results for possible adjustments of the plan

**Objective:** Present and discuss the monitoring and evaluation of results and provide feed back for the planning of future social dialogue.

In order to analyse the results of monitoring and evaluation it is necessary to match the results against the plan. The measurement for this matching of results are indicators which have to be developed when the m&e mechanisms are established. Where review bodies of the social partners exist, indicators can be developed in the meetings of these review bodies. In other cases, the facilitator has to introduce a session to identify indicators into the planning workshop. The most appropriate way would be to introduce an additional column for “indicators” into the planning matrix of Figure 5 (for developing indicators see also [Notes 6.3](#)).

During the course of the social dialogue process, the facilitator should structure periodical assessments of monitoring and evaluation according to the

- indicators developed in the planning matrix;
- standardized questionnaires and structured interviews which are sent periodically to the contact persons nominated by the social partners;
- standardized questionnaires and other evaluation exercises which were answered by the participants of the social dialogue events;
- standardized questionnaires and other evaluation exercises which were answered by the review bodies and other tripartite/bipartite structures.

The results of these assessments should be presented by the facilitator at the m&e meetings of the review bodies or at special m&e sessions at other social dialogue events. After such a presentation the facilitator should open the discussion on the following questions:

- How do you assess the advancement of the social dialogue process?
- How do you assess the impact of the social dialogue process on the health services?
- Where do you feel adjustments of the plan are necessary?

Convenient methods to start such a discussion could be (a) that the facilitator lists the answers of the participants to each of the questions on separate flipcharts or (b) that the participants write their ideas on cards which would be structured in clusters on a pin board. In both cases, an in-depth discussion has to follow.

The questions can be first treated separately in subgroups of each of the social partners if they wish so and then be finalized in the tripartite/bipartite plenary. If the plenary can come to an agreement on the question where adjustments of the plan are necessary, a revised planning matrix should be formulated. This draft could then be fed back into the social dialogue process.

## Section 12: Mobilizing the resources needed for social dialogue in the health services

### *Text of the conclusions*

***“17. Social dialogue is often seen as a positive and helpful instrument to activate understanding and facilitate the implementation of new, improved approaches to health services. The process of social dialogue is complex and lengthy and requires financial and human resources. To work effectively, social dialogue institutions and the partners engaged in them should be provided with the resources required in terms of budgetary resources, time, facilities and training for participants. All partners have a proportionate responsibility to invest in these resources depending on the given situation. Analysis is required on issues such as the following: what financial and human resources are needed for the process of social dialogue; who should contribute to mobilizing these resources; and how can resource mobilization be maintained throughout the process of social dialogue in health services.”***

Paragraph 17 of the conclusions points out that the process of social dialogue requires financial and human resources. The major costs incurred by social dialogue are generated by training and the time needed to participate in the social dialogue. Further costs may arise through required facilities and external expertise which may be needed to keep the social partners well informed on the current situation of health services and possible solutions to occurring problems. Relatively realistic estimations of the costs involved may convince social partners to participate in social dialogue when sometimes they may argue in general terms that social dialogue is too costly and lengthy.

Another question which may divide participants in social dialogue, is, how to mobilize required funds. Estimations have to be made as to the needed investment and in addition it is necessary to estimate the returns on such investments. The returns on such investment could be derived from the impact on the performance of health systems in general and on the quality of health services delivery at national and enterprise level. WHO has established methodologies to assess the per-

formance of health systems as a whole.<sup>9</sup> Such performance assessments may justify government investment in funds which promote the development of social dialogue in the health services. Indicators which assess changes in the quality of health-care delivery, such as shortened waiting lists or increasing numbers of patients, may make investments in social dialogue plausible at enterprise level. Investment in social dialogue in the health services can also be guided by more general development goals and lead to spending on technical cooperation programmes in this area. Since all social partners should contribute in a proportionate way to the resources needed for social dialogue, some argue in favour of establishing joint funds out of which social dialogue activities could be financed at enterprise level. At national level in the UK, the Employment Relations Act 1999 aimed to change the culture of relations at work through partnership and consequently, the Department of Trade and Industry set up a fund to award grants to organizations, also in the health services, in order to encourage this approach.

<sup>9</sup> C. Murray; J. Frenk, op. cit

### Box 18: Investments in social dialogue

At the Joint Meeting on Social Dialogue in the Health Services 2002, a Worker member added that it was the responsibility of all partners to invest in the funding, time, facilities and training costs required. It was particularly important for employers and governments to assist the social partners so that they could operate from a position of strength and independence. In some situations, frontline workers might be needed while plenary representation might be needed in others. Therefore, legitimacy and the level of representation are important considerations. The speaker provided an example of the Danish Technical Cooperation Agency (DANIDA) which based technical advisers in the United Republic of Tanzania for the purpose of developing trade union bargaining skills among workers and trade union representatives. Social dialogue funding agencies would also be effective with the added advantage that no party was solely reliant on the resources provided by another.

Source: ILO, Joint Meeting on Social Dialogue in the Health Services, Note on the proceedings, Geneva, 2003, p. 22.

### Checklist 12: Mobilizing resources for social dialogue

- **What financial and human resources are needed for the process of social dialogue?**

The planning process should foresee estimates of the additional financial and human resources incurred by social dialogue. Even if estimates can only be very basic, this assessment is important to prevent arguments about a too “costly” process of social dialogue and should be undertaken jointly by the social partners.

- **Who should contribute to mobilizing these resources?**

Since the financial capacities of the social partners may be different, the shares and ways of contributing should be discussed and agreed upon in the planning process. Such agreement should distinguish between finan-

cial and human resources and make provisions for the time used to participate in social dialogue.

- **How can resource mobilization be maintained throughout the process of social dialogue in health services?**

Expenditures and the use of time should be carefully monitored during the process of social dialogue. Contributions from external supporting funds may be available only for a limited period of time. Planning of resource mobilization should take this limitation into consideration. Early evidence on the impact of social dialogue on the quality of health services may be decisive in encouraging continuous contributions to the resources required.

## Two steps to prepare for the mobilization of resources

The organizers and facilitators are not necessarily responsible for the mobilization of resources in a social dialogue process. However, they should prepare the social partners for resource mobilization. The two recommended steps are to (a) prepare for the cost estimates and (b) determine methods to be undertaken in the mobilization of resources.

### 12.1 Notes for the facilitator: Preparing cost estimates

**Objective:** Prepare an overview of cost estimates for the financial and human resources involved in the social dialogue process and to introduce the estimates to the social partners.

In order to arrive at an overview of estimated costs, the human resources involved should be attributed a financial value (e.g. costs/per work day). For the use of the overview in the implementation phase of the social dialogue, a table with the overview should also foresee a column on the actual spending. The overview could be presented as per the following table (see also [Notes 7.3](#) above).

#### Estimated cost and actual spending in a social dialogue process

	Estimated costs for activity (1)	Estimated costs for activity (2)	Estimated costs for activity (3)	Estimated costs for activity (4)	Total estimated costs in SD process	Actual spending
Participants (workdays): • Preparation • Participation • Follow-up						
Facilitator (workdays): • Preparation • Participation • Follow-up						
Specialists (workdays): • Preparation • Participation • Follow-up						
Materials						
Equipment						
Facilities • Conference rooms • Board and lodging						
Travel						
Other Costs						
Total						

The facilitator should foresee the introduction of such cost estimates and their use in special sessions in planning workshops, in m&e workshops and in training workshops for facilitators and representatives of the social partners. Introducing a standardized form of such overviews would help to audit the expenditure for social dialogue and to use the information for monitoring and evaluation. Even though filling in such a standardized table might appear simple and evident to the participants, the facilitator should introduce the use of the table through exercises with simulated or real examples.

## 12.2 Notes for facilitator: Launching the discussion on resources

**Objective:** Discuss and decide on the estimated costs and the mobilization of the resources.

The overview of the estimated cost will allow the facilitator to launch the discussion on the resources involved in a social dialogue process. The discussion should include the possibility that the available resources will not be enough to completely cover the costs of social dialogue. In such cases there should be consideration that the adequate investment in social dialogue will produce returns by reducing other costs (e.g. incurred through absenteeism, demotivation, stress and violence, or accidents at work). This discussion could be launched by an exercise to list possible returns on the expenditures on social dialogue (see also [Notes 7.3](#) above). The quantitative assessment of such returns and reduced costs is difficult and would require an in-depth study for the preparation of a social dialogue event.

### Exercise during social dialogue events

The facilitator could launch a discussion on the mobilization of the adequate resources by creating an exercise in which the participants of a planning workshop would outline the possible sponsors for the planned activities. An overview could be gained through the following table:

#### Possible sponsors for the social dialogue process

	Total estimated costs for activity (1)	Total estimated costs for activity (2)	Total estimated costs for activity (3)	Total estimated costs for activity (4)	Total estimated costs for in the SD process
Sponsor 1					
Sponsor 2					
Sponsor 3					
Sponsor 4					
Total					



## Additional information

For the complete text of all International Labour Conventions and Recommendations see:  
[www.ilo.org/ilolex/index.htm](http://www.ilo.org/ilolex/index.htm)

For ILO sectoral information and publications on the health services sector see:  
[www.ilo.org/public/english/dialogue/sector/sectors/health/](http://www.ilo.org/public/english/dialogue/sector/sectors/health/)

For statements and standards of the World Health Organization see: [www.who.int](http://www.who.int)

For international codes of ethics of the International Council of Nurses see: [www.icn.ch](http://www.icn.ch)

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