Social dialogue
in the health services :

A tool for practical guidance

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 among them 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 and 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. In its Conclusions, the Joint Meeting agreed on a framework for practical guidance to strengthen social dialogue in the health services. It further proposed action to be taken by the ILO. Among these recommendations was the request of the ILO constituents to make the Conclusions available as a practical tool.

Following the Joint Meeting's recommendations, the Sectoral Activities Department carried out several activities in 2003, including the commissioning of case studies in Brazil, Bulgaria, Ghana and Uganda; the organization of a workshop on strengthening social dialogue in health services

in Ghana; and the development of the present Tool for practical guidance. All activities have been carried out in close cooperation and with the support of the InFocus Programme on Strengthening Social Dialogue, Labour Law and Labour Administration (IFP/DIALOGUE).

This Tool for practical guidance has been developed based on the Conclusions of the Joint Meeting on Social Dialogue in the Health Services. It is intended to reach policy makers as well as those persons who plan and organize processes of social dialogue in the health services. It is meant to provide instruments to manage and to facilitate processes of social dialogue in the health services. It offers guidance on issues to be considered in processes of social dialogue in the health services in a comprehensive manner.

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.

Cleopatra Doumbia-Henry,
Director,
Sectoral Activities Department

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Introduction

The ILO commitment to tripartism and social dialogue and to health care 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 preconditions 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 for Practical Guidance

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, agreed in its conclusions on a framework for practical guidance to strengthen social dialogue in the health services. Following the decision of the Governing Body of the ILO 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 target group of the Tool for Practical Guidance

This Tool for Practical Guidance (hereafter called "the Tool") is intended to reach policy-makers as well as those persons who plan and organize processes of social dialogue in the health services. It is meant to provide instruments to manage and to facilitate processes of social dialogue in the health services, and it particularly targets those groups of persons who are already "initiated" and convinced of the usefulness of social dialogue in health services.[1] More basic and general information on social dialogue is already available in other guidelines and resource books of the ILO.[2] Furthermore, the Tool can also be used by trainers and facilitators who prepare and monitor the participants in social dialogue in the health services.

The structure of the Tool for Practical Guidance

The Tool for Practical Guidance 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 this Tool 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 at the end of each section endeavour to facilitate practi-

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[1] 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

[2] 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.

cal implementation. These checklists propose a number of questions to be examined in a given situation, knowing that these lists are not exhaustive and that they may have to be supplemented. While underlying basic principles were identified in the framework of the conclusions, each situation needs the development of tailor-made tools for implementation. The text is intended to assist dialogue on how to design such tools appropriate to each country and based on the agreed upon principles.

As the sections of the Tool are interrelated and need to make cross references, it is not recommended to work on individual sections of the Tool. The structure of the conclusions and therewith the structure of the Tool is intended to guide the reader step by step from preparatory analysis and action to the implementation and evaluation of the social dialogue process.

The terminology of the Tool for Practical Guidance

The terms used in the following text are taken from the conclusions of the above mentioned 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 the health services has to be distinguished from a wider dialogue on broader issues in health sector reforms which may also include consultations with "other stakeholders" beyond the social partners (e.g. the users of the health services). Such other stakeholders are not involved in what are properly the concerns of the social partners in collective bargaining.

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)

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/llubjana.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 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. 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 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).[3] Other relevant statements are contained in conclusions and resolutions of ILO sectoral meetings.[4] 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.[5] 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 to see whether they subscribe to the content and how a common vision could be formulated on this basis.

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[3] For the complete text of these and other ILO Conventions and Recommendations, see www.ilo.org/ilolex/english/index.htm

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

[5] For the complete text of the Declaration of Alma Ata in 1978, see www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Section 2: Health services and understanding social dialogue

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.

Box 2: Different elements of social dialogue

Negotiation

Negotiation is an integral – and one of the most widespread – forms of social dialogue. Parties can engage in collective bargaining at enterprise, sectoral, regional, national and international level.

Consultation

Consultation requires an engagement by the parties through an exchange of views which in turn can lead to more in-depth dialogue. The parties participating in tripartite or bipartite bodies can engage in negotiations and the conclusion of formal agreements. Some of them are only consultative and information bodies, others are empowered to reach agreements that are binding on the parties.

Information-sharing

Information sharing is one of the most basic and indispensable elements for effective social dialogue. In itself, it implies no real discussion or action on the issues but it is nevertheless an essential part of those processes by which dialogue and decisions take place.

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. 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. This phase of social dialogue is essential and should ensure that social dialogue does not break down at such early stages.

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. 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. 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 government 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. 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.

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.

Section 4: Representation of the social partners

> *Text of the conclusions*
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> *"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

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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.

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. 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 organ- ized 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. [6]

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 devel- opment.

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

Other stakeholders:
Users/patients
Health Insurances
Ethical Commissions
Educational institutions
International development agencies

SOCIAL PARTNERS
in negotiating, incl. collective bargaining
Government (health sector)
(local, regional, national)

Employers /-organizations
(in health services)

Workers /-organizations
(in health services)

Other partners and international organizations:
Oher government structures (Finance, Public Service)
Other employers' organizations
Oher workers' organizations
International Labour Organization (ILO)
World Health Organization (WHO)
Other relevant international organizations

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

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

Agenda items ⟍ Participants in social dialogue and others	Reorganization of health care incl. – health care standards – finance – quality assurance – 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 objectives, incl. good nutrition, environmental care, food security	Quality service delivery focused on users	Financial support to health sector reforms
Government: – local – regional – national					
Employers: – public – private (e.g. hospital, indiv. practice) – networks					
Workers: – various professions/ occupations (e.g. physicians, nurses, auxiliaries, admin. cleaning staff					
Consultation with others, e.g.:					
– users – ethical commissions – technical experts – women's organizations					

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).

Section 5: Social dialogue in situations of structural change

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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."

</div>

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

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 govern-ment 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 addition-ally 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 Con-ference 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 par-ticipate 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 expe-riences 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 repre-sentatives 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. 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.

● **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.

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

Quality standards / Social partners involved	Medical and hygiene standards	Quality of care and services standards	Quality of work standards	Safety standards (incl. violence)	Quality management systems
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 enforcement 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, J*oint 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.

● **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. 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.

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

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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)

	Social Partners	Agendas	Social dialogue institutions	Social dialogue elements, instruments and mechanisms
National*	Government: Vice-president, Ministers, Deputy Ministers Employers' organizations: BIA, BCCI, UPEB, UEI Workers' organizations: CITUB and Podkrepa CL	– Labour and social legislation – Socio-economic policy and reforms – Overall policy for social dialogue and collective bargaining – Wage policy in the public sector – Minimal wage	– National Council for Tripartite Cooperation (NCTC) – Commissions at NCTC – Specialized tripartite bodies – Expert working groups on different issues (e.g. labour legislation)	– Negotiation – Information – Consultation – Framework agreements – National agreements – Action plans
Sectoral/ branch	Government: Ministry of Health Employers' organization: National Employers Association in Health Workers' organizations: Federation of Unions in Health-CITUB, Medical Federation "Podkrepa"	– Specific labour and social legislation – Health policy and reforms – Collective bargaining – Industrial and labour conflicts	– Sectoral Council for tripartite cooperation in the health sector – Ad hoc & permanent working groups	– Negotiation – Information – Consultation – Sectoral/branch collective agreements – Conflict resolution procedures
Region/ municipal	Government: Mayor or representative Employers' structure (if any) Territorial Coordinating Council-CITUB Medical Regional Council "Podkrepa"	– Collective bargaining – Health reform in the municipality – Restructuring & Privatization – Labour disputes in the establishments	Municipal council for tripartite cooperation	– Bargaining – Information – Consultation – Collective agreement – Conflict resolution – Control over the implementation of collective agreements
Health care institution/ enterprise (bipartite)	Employer Workers' organization	– Collective bargaining – Internal rules – Health and safety at work – Pay system – General policy – Labour disputes	Bargaining group	– Information – Consultation – Collective bargaining – Collective agreement – Code of conduct

* 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.

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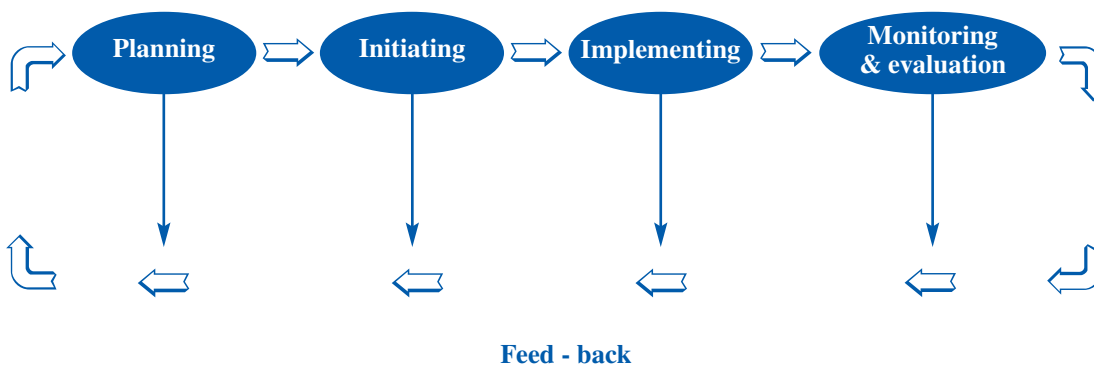
● **How can individuals be trained while continuing to carry out their professional activities?**

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.

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.

Planning ⇒ Initiating ⇒ Implementing ⇒ Monitoring & evaluation

Feed - back

Section 8: Planning for social dialogue

Planning → Initiating → Implementing → Monitoring & evaluation

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						

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."

Planning → **Initiating** → Implementing → Monitoring & evaluation
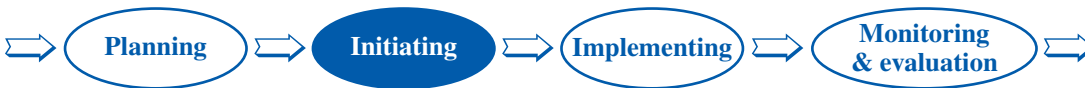
As the above paragraph 13 of the conclusions underlines, social dialogue is a continuous process of consultation, negotiation and exchange of information. The phases of social dialogue are overlapping and what is called "initiating" in one case might already be phase 1 of implementing social dialogue 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.

● **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.

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 reinitiate 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."

⟹ **Planning** ⟹ **Initiating** ⟹ **Implementing** ⟹ **Monitoring & evaluation** ⟹

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 not wide-spread. 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. 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).

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). The National Agreement of Kaiser Permanente provides for a bipartite review process which 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.

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."

Planning ⟹ Initiating ⟹ Implementing ⟹ **Monitoring & evaluation** ⟹
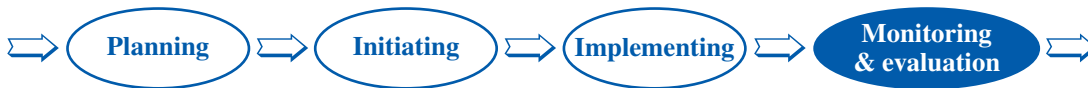
Paragraphs 15 and 16 of the conclusions set out the importance of monitoring and evaluation in relation to the goals to be achieved. The mechanism of monitoring and evaluation presents itself as complex and multifaceted. This mechanism is meant to monitor and evaluate progress of the process of social 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.[7] For this purpose, the overview matrix in Figure 4 might be expanded in order to attribute indicators to the goals to be achieved.

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[7] 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

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, continuous 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.

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.

● **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[8] 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.

● **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.

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

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.[9] 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.

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[9] 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.

Readings and information

For the complete text of all International Labour Conventions and Recommendations see: 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/

For statements and standards of the World Health Organization see: www.who.int

For international codes of ethics of the International Council of Nurses see: www.icn.ch

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