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**SECTORAL ACTIVITIES PROGRAMME**

Working Paper

# Social dialogue in the health sector: Case study Ghana

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Working papers are preliminary documents circulated
to stimulate discussion and obtain comments

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# Preface

Concern about public health and the increasing cost of health care have made the subject of health one of the most debated political issues in many countries. The vital role of governments, employers' and workers' organizations and the importance of social dialogue 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, 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.

The Joint Meeting's recommendations for action led to a workshop held in 2003 on strengthening social dialogue in Ghana's health services as well as to the commissioning of this case study in order to research the existing capacity and institutions for social dialogue in this country.

As a sectoral working paper, the study is to be circulated in order to stimulate discussion and obtain comments. We hope that it will contribute to an understanding of how social dialogue presents a clear opportunity for governments, employers and workers to reach common ground in identifying and implementing solutions.

Norman Jennings,
Deputy Director,
Sectoral Activities Programme.

## *Contents*

*Page*

## *Appendices*

## Executive summary


The concept of social dialogue involves consultations, discussions and negotiations between the social partners on issues affecting their common interests. The three partners are the State (as regulator), the employers and the workers. In Ghana, the health sector has been through a turbulent period of health sector reform, sector-wide approaches to funding services, decentralization and the delegation of authority to district health services.

The terms of reference of this case study were to: *indicate positive examples of social dialogue creation in the health services, what benefit this has for the social partners concerned, and what impact can be observed with regard to quality health services.*

Qualitative methods were used to examine the organization and implementation of social dialogue: interviews were conducted with key informants representing each of the social partners.

Ghana is located in politically troubled West Africa, where it represents a relative oasis of peace. Since 1992 the country has operated a democratic multi-party constitution which led to the first transfer of power after peaceful elections in 2000. A vibrant and vocal press and the trade unions monitor every move of government. The country, with a population of about 20 million, has an annual per capita GDP of approximately $395. The country is implementing the HIPC initiative via a PRS.

The TUC is the largest labour organization in the country and for a while it was the only one. Organized labour within the tripartite process is currently represented by the TUC, the GFL, and "Associated Labour" which represents non-TUC/GFL workers. Associated Labour includes, for example, the Ghana Registered Nurses Association and the Ghana National Association of Teachers, which are not registered unions but which take part in negotiations and the tripartite system.

Some key social challenges in health include:

- the NHIS, its funding and operation;
- the human resources crisis and the emigration of health workers;
- the efficiency of the sector and performance management;
- managing change and the split between the MOH as policy-maker, the GHS and the THB as service providers;
- local government and the decentralized structures of the GHS.

The health system operates mainly at three levels – national, regional and district – which are linked to the political administration of the country. Three key components of the health service structure exist at each level – health administration and support services, public/preventive health services and clinical care services.

Financing health care remains a challenge. In 1985, Ghana started a drug costs recovery programme which reduced access to sections of the population. A new NHIS appeared to have general agreement but the policy development process erupted in some controversy in connection with using part of workers' social security contributions to fund premiums. The health labour market, especially for nurses, doctors and pharmacists, is highly mobile in Ghana. The number of medical training graduates each year is quite low, limiting supply into the labour market. This situation is exacerbated by the end of the medical training assistance received from the former Soviet Union and communist

countries. Then the supply-demand gap has been widened further by the emigration of doctors, nurses and, increasingly, of pharmacists and laboratory technicians.

The State is the major employer in the internal labour market for health professionals. The faith-based NGO sector employs some 20-25 per cent of health workers (who are paid by government subvention). The private for-profit sector is relatively small outside the two main cities.

Health sector reforms in Ghana are predicated on five premises:

- raising the efficiency of service delivery;
- providing effective interventions;
- developing linkages with all partners and providers;
- improving equity of access to health services; and
- improving the quality of care.

The GHS and Teaching Hospitals Law (Act No. 525, 1996) removes public sector employees from the civil service and offers new conditions of employment. The process of separating the executing agencies from the policy making Ministry has sometimes caused difficulties in defining their roles.

Ghana conforms to key ILO Conventions but has still not ratified some of them (such as the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144)). All partners agree that the labour laws were based on these Conventions and that non-ratification has not adversely affected industrial relations. A new labour law received presidential assent in October 2003. The process of developing this law was considered by all to be quite non-controversial and a good example of social dialogue at work.

A social dialogue initiative has been started by the MOH Human Resources Directorate, with the brain drain of health workers as its priority agenda item. It is proposed to set up a national social dialogue committee.

Several issues are emerging around the development of legislative instruments for the NHIS; developing a new national ambulance service; and tackling the brain drain through strategies identified during a Human Resources for Health forum in 2003. These will require intensive social dialogue between the partners.

Various forms of tripartite participation in policy development have occurred in Ghana. These include:

(a) disseminating information *(e.g. NHIS and water privatization)*;

(b) organizing educational seminars *(e.g. NHIS, ADHA management)*;

(c) consulting and reaching consensus *(e.g. the Brain Drain Forum, health sector reforms, legislative instruments for the Ghana Health Service Act)*;

(d) setting up technical committees to draft policy papers *(NHIS, health sector reforms)*.

## The way forward?

How can social dialogue in the health sector be strengthened?

The dialogue environment in Ghana's health sector is conducive and consultations have become a routine way of developing policies and strategies. However, this positive context needs to be refined through setting up recognized structures at all levels and reducing a somewhat ad hoc consultation process. In order to achieve more gains the following steps are suggested:

- greater advocacy is needed to bring the top management of the health sector and partners on board;
- the health sector will need to draft guidelines and systems aimed at reinventing and strengthening existing partnership structures. It will then need to integrate social dialogue processes into operations of these structures;
- the level of existing stakeholder involvement in policy development should be studied in order to increase the impact of social dialogue and ensure wider stakeholder participation;
- the relative industrial harmony continuing to exist in the health sector at present provides an opportunity to initiate or consolidate measures to enhance social dialogue.

## Abbreviations

| | |
|---|---|
| ADHA | additional duty hours allowance |
| AGI | Association of Ghana Industries |
| BMC | budget and management centres |
| CBO | community-based organizations |
| CHAG | Christian Health Association of Ghana |
| CSA | Civil Servants Association |
| DANIDA | Danish International Development Agency |
| DFID | Department for International Development UK |
| DHA | district health administration |
| GDP | gross domestic product |
| GEA | Ghana Employers' Association |
| GFL | Ghana Federation of Labour |
| GHS | Ghana Health Service |
| GMA | Ghana Medical Association |
| GNI, PPP | gross national income, purchasing power parity (US$) |
| GOG | Government of Ghana |
| GRNA | Ghana Registered Nurses Association |
| HIPC | highly indebted poor country |
| HIV/AIDS | human immunodeficiency virus, acquired immuno-deficiency syndrome |
| HRD | human resources development |
| HSWU | Health Service Workers' Union (of the TUC) |
| ILO | International Labour Office |
| IMR | infant mortality rates |
| ISODEC | Integrated Social Development Centre |
| JICA | Japan International Cooperation Agency |
| KATH | Komfo Anokye Teaching Hospital |
| KBTH | Korle-Bu Teaching Hospital |

| | |
|---|---|
| MMR | maternal mortality ratios |
| MOF | Ministry of Finance and Economic Planning |
| MOH | Ministry of Health |
| MOMD&E | Ministry of Manpower Development and Employment |
| MOTE | Ministry of Tertiary Education |
| NACL | National Advisory Council on Labour |
| NDPC | National Development Planning Commission |
| NGO | non-governmental organization |
| NHIS | National Health Insurance Scheme |
| NTC | National Tripartite Committee for Wages and Salary Negotiations |
| OHCS | Office of Head of Civil Service |
| PRS | poverty reduction strategy |
| PSGh | Pharmaceutical Society of Ghana |
| SD | social dialogue |
| SSNIT | Social Security and National Insurance Trust |
| THB | Teaching Hospitals' Boards |
| TUC | Trades Union Congress |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# I. Introduction

The concept of social dialogue involves consultations, discussions and negotiations between the Government, the employers and the workers on issues affecting their common interests. In Ghana, the health sector has been through a period of reforms which involved sector-wide approaches to funding, decentralization and the delegation of authority to district health services. The reforms also addressed the ongoing challenge of motivating and retaining professional staff. However, the most recent issue has been the introduction of the National Health Insurance Act, 2003, which sparked intense debate. This suggested that the partners had not reached understanding and consensus on key issues before the Act was passed (under a certificate of urgency).

This case study was carried out for the ILO and aims to "indicate positive examples of social dialogue creation in the health services, what benefit this has for the social partners concerned, and what impact can be observed with regard to quality health services". [1]

The study describes and analyses the structures and processes of social dialogue utilized in the health sector, with examples of effective social dialogue and the lessons learned to date. An attempt is also made to illustrate how social dialogue occurs at different levels of health service delivery and to provide recommendations on how it can be strengthened. This is a qualitative study which looked at the implementation of social dialogue through interviews with key informants selected from organized labour, employers, state agencies and NGOs using the basic analytical framework shown in table 1. The respondents were asked to describe the process of social dialogue in relation to specific issues and policies. The study also examined issues such as the recent Labour Act and the water privatization policy proposed by the Government.

Table 1. Analytical framework

| A. Social partners | B. Structures and systems | C. Processes utilized | D. Impact of SD/negotiations | E. Feedback and client involvement | Key issues discussed |
|---|---|---|---|---|---|
| State regulators: Employers: Public/state and private Worker groups: Others: Civil society, development partners, etc. | Committees, task forces, policy drafting committee, statutory negotiating boards, etc., arbitrators, etc. | Correspondence, consultations, memoranda, general meetings, negotiations, proposals and position papers | Agreements, laws, policy frameworks, strikes, demonstrations | Internal organizational meetings on subject, client positions on issues. Acceptance of feedback | NHIS Act, 2003, ADHA, health sector reforms – GHS/THBs, brain drain and retention of health workers' Labour Act, 2003 |

Relevant laws and documents on key social issues were reviewed as well.

[1] Terms of reference for the consultant, 2003.

# II. Social dialogue in the health services

## Context

Ghana is located in the politically troubled region of West Africa and represents a relative oasis of peace in the area. Since 1992 the country has operated a democratic multi-party constitution and in 2000 for the first time in the nation's history, power was transferred to the opposition after a peaceful election victory. The situation is quite stable, with a vibrant and vocal press and trades unions monitoring every move of government. Ghana has a population of about 20 million and an annual per capita GDP of approximately $395. The country is implementing the HIPC initiative via a PRS which includes a health policy component.

A sizeable section of the country's workforce is in the informal sector, with only about 850,000 workers in the formal sector enrolled with the SSNIT. There appears to be substantial underemployment of youth with an increasing number of street children.

Table 2. Basic health facts

| Basic health facts about Ghana (Engender Health Fact Sheet, 2003) | |
|---|---|
| Population | 20.2 million |
| Total area | 92,100 sq. m. |
| Population density | 220/sq. m. |
| GNI, PPP per capita (US$) | 1,910 |
| MMR (per 100,000 live births) | 590 |
| IMR (per 1,000 live births) | 56 |
| Literacy rate (male) | 80 per cent |
| Literacy rate (female) | 63 per cent |
| Percentage adult population with HIV/AIDS | 3 per cent |
| Life expectancy male (years) | 56 |
| Life expectancy female (years) | 59 |

Organized labour has had a long history in Ghana since independence and the formation of the TUC. The TUC is the largest labour organization and for a while was the sole umbrella group representing workers in the country. Organized labour in the tripartite process now consists of the TUC, the GFL, and "Associated Labour", which represents professional associations such as the GRNA, the Ghana National Association of Teachers, the CSA, etc., which are not registered unions but take part in negotiations.

The labour front is usually united, though recently a major group the Industrial and Commercial Workers Union (ICU) had left the TUC amid somewhat acrimonious circumstances. The introduction in 2003 of a NHIS that required the use of 2.5 per cent of workers' social security trust contributions as a general premium contribution, sparked widespread debate.

The key health sector union – the HSWU – is affiliated to the TUC. However, it does not represent the main professionals (doctors, nurses, pharmacists) or management groups, who have associations which negotiate on their behalf. Although the law permits registered unions with bargaining certificates to negotiate on workers' behalf, the associations are now an entrenched part of tripartite activities.

The Government delivers an estimated 60 per cent of health services (perhaps more in deprived rural areas); NGOs and faith-based organizations deliver about 30 per cent, and private allopathic practitioners deliver the rest. [1] By an Act of Parliament passed in 1996, [2] the Government devolved the running of services from the MOH to a semi-autonomous GHS and two THBs which provide the bulk of the services previously run by the MOH directly. The Ministry's role is now one of policy formulation, implementation and monitoring, as well as regulation and other special functions.

New local government structures were set up at about the same time as the GHS with elected district assemblies. However, the GHS structures at district level have rather loose statutory links with the local government structures and their employer remained the central GHS and public service rather than the local authorities. This means that there is some lack of clarity in delineation between the State, as employer, and the State, as regulator, of social partnerships in the health sector.

The HSWU represents health sector employees including allied health professionals and paramedical workers. The main health professionals are represented by their associations, such as the GMA, GRNA and the PSGh. As part of the wider civil service, previous health sector labour negotiations were held under the ambit of broader governmental structures, rather than solely between the health workforce and the MOH as the "employer". However, the HSWU does negotiate separately with the private agencies such as CHAG and with other government organs such as the Nurses and Midwives Council [3] on employee conditions. Similar arrangements may be used in future for the new MOH agencies, i.e. the GHS and the THB.

Some key and topical social challenges include:

- the NHIS, its funding, operation and benefits;
- the human resources crisis and the emigration of health workers with implications for salary negotiations and service provision;
- the efficiency of the health sector and performance management;
- managing change and the new roles split between the MOH (as policy-maker) and the GHS/THBs (as service providers);
- the relationship between local government and the decentralized structures of the GHS.

## National health system

The national health system operates mainly at three levels: national, regional and district, which are linked to the levels of the political administration of the country. Three key components of the health service structure exist at each of these levels, namely:

[1] Dr. F. Nyonator, Director, PPME, GHSs, personal communication.

[2] The Ghana Health Service and Teaching Hospitals Act, 1996, Act No. 525.

[3] The Nurses and Midwives Council (regulators of the profession) are also employers.

- health administration and support services;
- public/preventive health services; and
- clinical care services.

The district [4] and basic operational level consists of:

- the DHA – responsible for the overall management of health systems in the district;
- the district hospital (where available) which is independently run by a management team and provides clinical and referrals services for smaller units within its catchment area;
- the district public health services, including sub-district services, comprising health centres and posts, community-based health services, etc.

While these are all part of the GHS, they are expected to also answer to the "Social Services Sub-Committee" of the District Assembly which is responsible for health issues. The DHA, however, reports through the regional health administration to the GHS headquarters and receives its budget via the same route. The recruitment and employment of health workers takes place at national level: the central office assigns staff to the districts. Some of the resources for health especially those generated by HIPC debt relief are, however, channelled through the district assemblies/local government.

The regional level consists of:

- a regional health administration – responsible for management and the provision of logistical support to the entire political/administrative region;
- the regional hospital – serves as a referral centre for district hospitals and provides clinical specialist services;
- the regional public health services – including epidemic response units, reference laboratories and various other services.

The national level has several policy, technical and managerial units:

- the MOH is represented by the Minister and directors responsible for policy development and monitoring; they deal with human resources, planning, monitoring and evaluation, and technical advisory services;
- three major executing agencies of the MOH also serve as national institutions – the headquarters of the GHS and the two teaching hospitals and their boards;
- other MOH agencies include: professional regulation boards (medical and dental, nursing and midwifery, pharmacy, etc.), the Food and Drugs Board, the Private Hospitals and Maternity Homes Board, the National Public Health Reference Laboratory, as well as specialized institutions such as the national psychiatric and leprosy hospitals.

[4] Each district also has "sub-district structures, including health centres and posts".

The MOMD&E is responsible for labour and social welfare issues and it has a Labour Department which, until the passing of the current labour law, [5] was responsible for regulating industrial relations in the country. The MOF manages the economy and is a key player in salary negotiations and agreements on conditions of employment.

## Labour market issues

The labour market for professional groups, such as nurses, doctors, and pharmacists is characterized by highly mobile professionals. English is the medium of medical training and curricula are largely based on the British model; qualified health workers are thus readily employed in the United Kingdom and other countries. Health sector training schools produce most health worker cadres, except doctors, pharmacists, etc., [6] and the State employs almost all of them immediately after they graduate. Doctors, etc., trained within universities and in the education sector, are also almost assured of employment by the State once training is completed. The intake into all health worker schools was recently increased to address staff shortages.

Table 3. Training intake and output of some health worker categories

| Cadres | 2002 | | 2001 | | 2000 | |
|---|---|---|---|---|---|---|
| | Intake | Output | Intake | Output | Intake | Output |
| MOH state registered nurse *(est. requirement 712)* | 570 | 272 | 473 | 395 | 489 | 309 |
| CHAG state registered nurse | 89 | 85 | 46 | 91 | – | 77 |
| Doctor *(est. requirement 150)* | 193 | 63 | 238 | 116 | 223 | 116 |
| Dental surgeon *(est. requirement 10)* | 10 | 6 | 14 | 6 | 13 | 5 |
| Pharmacist (UST) (basic) *(est. requirement 70 )* | 175 | 96 | 106 | 106 | 111 | 99 |
| Graduate medical lab. technologist (UST) | 35 | 17 | 60 | – | 40 | – |

Source: Ministry of Health: *Programme of Work, 2002*. Report of the External Review Team, May 2003, p. 61.

It can be seen that the supply of professionals into the market is quite limited. Staff shortages have become worse because there is no longer a supply of health professionals trained in the former Soviet Union and the ex-communist countries. The problem has been further aggravated by the increased emigration of doctors and nurses, and increasingly of pharmacists.

The internal labour market also has interesting dynamics. The major employer of health professionals remains the MOH through its agencies, the THB and the GHS Council. CHAG employs some 20-25 per cent of health workers who are paid by government subsidy at the same levels as state employees. Some market forces exist between GHS and CHAG employment, caused by a more generous interpretation of ADHA – the extra duty allowances in the state sector and doctors are being lost from CHAG to the GHS because of this. [7, 8]

[5] Labour Act, 2003 (Act No. 651), Government printer, Assembly Press (Ghana Publishing Corporation, Accra).

[6] Doctors, pharmacists and physiotherapists are trained by the universities.

[7] Comments by Mr. Philbert Kankye, Executive Secretary, CHAG.

The private for-profit sector has a few sizeable hospitals but is mainly comprised of individual general practitioners employing five to ten staff each. The smaller private facilities tend to recruit few professional staff, possibly to avoid paying high salaries. Private clinics and hospitals, however, will hire state-employed professionals on a part-time basis, so that a significant amount of dual practice [9] (between private and public sectors) takes place. This double employment clearly has possible effects on performance, especially in the public facilities when workers spend more time moonlighting in the private clinics.

Generally, both local and international demand for health workers is high while supply has remained stagnant. A variety of other tangibles and intangibles influence the market, in addition to remuneration, but it is believed that morale among nurses and young doctors is still very low.

The influence of the external labour market means that more than twice the annual training output of nurses seek verification of their registration each year in order to work abroad. [10] The supply of new health workers remains stagnant in a context of rapidly increasing demand caused by expansion of access to health care and the brain drain. Another cause originated from the structural adjustment period policies that froze recruitment and slashed staffing levels.

A severe staff shortage exists (using MOH/GHS staffing norms) which is further worsened by huge differentials in staff distribution around the country, with the three northern regions having fewer qualified staff and very few specialists (see table 4 below).

The labour market situation the hands of the professional groups in pushing the Government to consider relatively large pay increases for health workers. The ADHA, for example, represented over a 100 per cent increase in real incomes for doctors (in US dollar terms) but only a 25 per cent increase for nurses already with lower base pay. [11] The agitation for higher pay from various health worker groups probably encouraged the creation of the Standing Committee on Negotiations involving the "Health Service Workers' Group" [12] which was an established forum for negotiations on conditions of employment but its meetings appear to have waned with divisions among the various professional cadres seeking separate negotiations. [13]

[8] Ministry of Health: *Programme of Work, 2002*. Report of the External Review Team, May 2003, p. 55 – 59 per cent of non-house-officer doctors hired by GHS were from the private sector in 2002.

[9] This practice is not legal but has happened widely over many years.

[10] Nurses and Midwives Council, unpublished data. In 2001, 923 nurses, or about 10 per cent of the public sector workforce, sought verification to work abroad.

[11] Ministry of Health: *Programme of Work, 2002*. Report of the External Review Team, May 2003.

[12] This group comprises all employees in the health services and includes the HSWU, which is the only true union in the health sector.

[13] Interview with Mr. G. Akoto, general secretary, HSWU, by Mr. P. Boni, May, 2005.

Table 4. Population per GHS doctor
(ratios by region)

| Region | GHS doctors | Population per GHS doctor |
|---|---|---|
| | | 1:16201 |
| Greater Accra | 179 | *Excludes teaching hospitals and large private sector* |
| Eastern | 85 | 1:24705 |
| Volta | 55 | 1:29090 |
| Central | 41 | 1:39024 |
| Western | 58 | 1:31034 |
| | | 1:40506 |
| Ashanti | 79 | *Excludes teaching hospitals and large private sector* |
| Brong Ahafo | 64 | 1:28125 |
| Northern | 28 | 1:66071 |
| UER (Upper East Region) | 30 | 1:30660 |
| UWR (Upper West Region) | 10 | 1:58000 |

Note: This table uses GHS distribution figures only.

Source: Ministry of Health: *Programme of Work, 2002*. Report of the External Review Team, May 2003, p. 54.

The gender distribution of the health workforce is a continuing issue. Between 85 and 90 per cent of nurses are female but they remain under-represented at national policy and decision-making levels as a cadre group. There are also very few women at the policy-making levels. [14] There is significant female representation at deputy-director and programme manager level but this over-represents women in fields such as maternal and child health and family planning.

## Health sector reforms

Health sector reforms in Ghana are predicated on five premises:

- raising the efficiency of service delivery;
- providing effective interventions;
- developing linkages with all partners and providers;
- improving equity of access to health services; and
- improving the quality of care.

Some of these goals should be realized through decentralization, and the creation of a semi-autonomous GHS and two Teaching Hospital Boards. The GHS and the THB are separate from the civil service; they are expected to improve performance management and to deliver a better quality of care. The GHS and Teaching Hospitals Law (Act No. 525, 1996) removes public health sector employees from the civil service and places them under the management of a new organization with different employment conditions.

[14] Only one in seven directors of the GHS was a woman in 2003, with no regional director being female. Currently, since 2004, one regional director is female but the national director had retired.

This separation of the main executing agencies – GHS (primary and secondary care), and the THB (tertiary care) from the Ministry has been slow, and has at times made it difficult to redefine the roles of the national level officers. The changes have probably reduced conflict between the social partners and the expected impact on health workers includes improved motivation and performance, better accountability, improved remuneration, and employment conditions. However, firm evidence is yet to be adduced to show gains arising from these organizational changes.

Key improvements brought about by health reforms include a higher share of health resources being allocated directly to the district level. The creation of BMCs in each viable unit with control over its own resources and planning has also created a "bottom-up" planning approach coordinated at regional level. Key difficulties remain, however, in linking the improved management environment to service delivery, especially as the performance of individual staff continues to be affected by low remuneration, lack of incentives and low morale.

## Challenges to reform

A recent review of the health sector reforms indicated that a fundamental challenge remains the difficulty of translating the success of the new structures and systems into quantifiably improved health outcomes. The past few years have seen increased (if sometimes irregular) resources for the health sector delivered utilizing the sector-wide approach (SWAP) of better coordinated and assured levels of financing. The 2003 Demographic and Health Survey (reported in 2004) showed stagnating or even slightly worsening indicators for child and infant mortality. [15]

Secondly, improvements in the performance of health workers cannot be ascertained as the utilization rates for health services have largely remained stable.

- The brain drain and low retention of health workers:

  Improvements in financing and health care brought about by the reforms are threatened by severe losses of health professionals to developed countries. The situation became more serious when incentives, in the form of ADHA-favoured doctors much more than nurses, creating adverse effects which may have led to much higher nurse emigration.

- Resources and health systems performance:

  Recent reviews of the GHS suggest that there is a need to enhance the performance of individual workers and also of units, and to relate this more closely to the enhanced resources and autonomy that the units have. Problems remain with linking the resources invested in the new BMCs to the results achieved.

- Health worker remuneration and motivation incentives:

  Remuneration has been a difficult issue in the sector. Ghanaian doctors and nurses have some of the lowest basic pay on the continent. Morale is also quite low and this is reflected in high rates of emigration and possibly low productivity, despite the increased investment in services. Other professional groups feel that doctors dominate the dialogue and have been overly favoured in the allocation of incentives, such as the

[15] Ghana Demographic and Health Survey, 2003. Noguchi Memorial Institute for Medical Research (NMIMR) and ORC Macro, 2004 (Calverton, Maryland).

ADHA and cars provided by the Government. [16] Doctors may sometimes receive ten times more ADHA than a senior nurse, further widening the gap in basic take-home pay.

## The private sector

A private sector unit has been established in the MOH and it liaises with the private subsector and is expected to contract some services from them in the future. CHAG is a confederation of non-governmental faith-based health service providers with close links to the MOH which pays its staff and, more recently, has provided some recurrent costs support. CHAG staff are unionized along the same lines as government health service staff with the HSWU representing allied health workers and mainly junior non-professional staff, while the professional associations represent the various professionals. The CSA usually represents the administrative and clerical staff.

Private for-profit facilities are usually small and the situation with these is unclear. However the HSWU usually represents their employees and deals with all types of employers, including private and parastatal health institutions.

## Other policy issues

Financing health care remains a challenge. In 1985 Ghana started a drug costs recovery programme (called *Cash and Carry*), which reduced the access of poorer sections of the population to health services. After the 2000 elections, one of the new Government's main platforms was to abolish *Cash and Carry* and to introduce alternative financing mechanisms. This resulted in the proposal for a new NHIS. Although there appears to be national agreement on changing *Cash and Carry* for pre-paid insurance systems, the policy development process erupted in controversy when the Government reallocated a proportion of the workers' contributions to a fund providing subsidies to the poor.

Ghana is currently implementing a PRS supported with HIPC debt relief funds. The health sector is a major area of intervention in the strategy paper. One indicator of the PRS is the redistribution of health professionals and improvements in the equity of access in the most deprived regions of the country – Northern, Upper Regions and Central Region.

Health-related PRS strategies include:

- bridging equity gaps in access to quality health services (Northern, Upper East, Upper West, and Central Regions);
- ensuring sustainable financing arrangements that protect the poor;
- containing the spread of the HIV/AIDS epidemic.

A major strategy of Ghana Government PRS is the community-based health planning and services initiative (CHPS) which aims to place nurses in rural communities and evolve greater access to services with increased community participation.

[16] Interview with the director, HRD, of the GHS.

# III. Conditions and elements of social dialogue

## Defining and interpreting social dialogue

The social partners interviewed knew the term "social dialogue" and felt that it was being practised in the country's labour systems. The labour law provides for structures and processes which may be considered in line with social dialogue principles, but which are not explicitly defined as such. Respondents were also aware of ILO concepts and Conventions on this subject and it was generally felt that debates, consultations and discussions between the partners have occurred in a cordial manner, especially at national level. However, application of the principles is variable, especially at enterprise and local levels, perhaps because less negotiation capacity exists. No clear and fixed definition of social dialogue was used by respondents, who simply referred to ILO documentation. The familiar and well-used general processes of consultation and dialogue that take place in various forums have been described by respondents as consistent with social dialogue.

## Legislative basis

In practice, Ghana conforms to the ILO Conventions on employment, although not all have been ratified, notably Convention No. 144. All social partners do, however, agree that the laws and processes used are based on these Conventions and that non-ratification has not adversely affected industrial relations.

A new Labour Law (Act. No. 651) was passed by Parliament and received presidential assent in October 2003. The process of developing this law was considered by all key informants to represent a very good example of social dialogue in practice. The new Law provides for a statutory labour commission, which is an institution for negotiation and social dialogue. It also seeks to enhance information sharing and contacts between various partners. The Labour Commission was formally appointed on 6 April 2005 and started operating taking over the role of neutral labour regulator from the Labour Department of the Ministry of Social Welfare and Employment.

Some labour relations structures had existed in the past. One example is the National Tripartite Commission which, in addition to its discussions on industrial and labour issues, has a wider mandate to include debates on general economic issues through an annual national economic forum. This forum looks at the economy in general and also debates national policy issues that impinge on labour relations. The TUC, however, felt that the Commission had not quite fulfilled this enhanced role. A variety of formal consultative bodies (committees, working groups, etc.) are set up to discuss policy issues. In some cases (e.g. the NHIS) worker representatives sat on the drafting committee of the Law.

The Labour Decree of 1967 (NLCD 157) and the Industrial Relations Act previously guided the conduct of labour and employer interactions in the country. The Industrial Relations Act mandated the creation of the NACL as the statutory body to oversee labour relations. The new Labour Act (Act No. 651, 2003) thus replaces the old 1967 Decree. In addition to the NACL, the NTC was constituted as a non-statutory body (the Committee is now a statutory body under the Labour Act 2003). Both of these organs are seen by the workers and employers as the main national structures for social dialogue.

The NACL and the NTC were concerned almost exclusively with determining the minimum wage and resolving public sector labour disputes. The key health issues used to trigger discussion in this study were apparently not discussed at either the NACL or the

NTC, which reflected the TUC opinion that their value for social dialogue was limited by the historical tradition of focusing on wage-related issues.

The new Labour Law (Act No. 651) does not explicitly use the term "social dialogue" in its text and appears to focus on the negotiation of minimum wages and the resolution of labour disputes. The law however enjoins the NTC to "consult with partners in the labour market on matters of social and economic importance; and perform such other functions as the Minister may request for the promotion of employment development and peace in the labour sector" in section 113(c) (see Appendix 3). This section of the Law is expected to provide the legal basis for social dialogue on key issues of national interest.

The Law is now in operation and the Labour Commission faced its first challenge in trying to deal with a strike by graduate teachers (who are not recognized as organized labour). The Commission is still in its formative stages and so far facilitating wage and benefits negotiations appears to be their main function. The role the Tripartite Committee can now play in enhancing social dialogue will need to be investigated further.

## The social partners in the health sector

The Government/public sector remains the largest single employer in Ghana. It is difficult to distinguish between the two roles of the Government as regulator and as employer, and there often seems to be interaction between both roles. The new and independent Labour Commission now takes up the role of neutral regulator from the State's Labour Department which should help separate the roles.

Previously, the key players in state regulatory mechanisms were: the Labour Department, which is responsible for implementing labour laws and policies; and the Factories Inspectorate, whose mandate is to ensure occupational safety and working environments, free from hazards. Both departments are part of the MOMD&E and come under the authority of the Minister. These departments and agencies continue with roles now limited to inspection for unfair labour practices and ascertaining occupational safety.

The MOF is the other major governmental agency and represents the Government as employer, as well as being a neutral manager of the country's economy. Individual ministries are seen as employers. The State thus plays both the employer and the regulator role to some extent. It is expected, however, that the Labour Commission, created by Act No. 651, will now take up some of these regulatory roles. The Labour Department and the Factories Inspectorate Department continue to provide some formal structures for supporting the Commission's functions through inspection reports, etc.

In the health sector, the structures described are used only for salary negotiations. Changes brought about by the new Labour Law mean that many health professions now belong to what is classified as "essential services" in the Law [1] which requires compulsory arbitration rather than resort to strikes.

The health sector reforms in general generated a need for consensus building and agreement on changes within the system. The experience gained in this process (though not formal "social dialogue") helped to strengthen the systems of communication and consultation within the sector and this has become almost a routine process in developing new policies and systems. New policy development in health will involve the sector's social partners as indicated in the table below.

[1] Labour Act, 2003 (Act No. 651), Part XVIII, Sub-Part II 162.

Table 5. The social partners in health

| State/Government | Employers | Workers | Other stakeholders |
|---|---|---|---|
| ■ MOH – policy generation<br>■ MOF – funding source for the sector and wages<br>■ NDPC<br>■ MOTE – trains doctors, pharmacists, some nurses and allied professionals<br>■ MOMD&E – the Government's labour regulators | ■ GHS Council<br>■ Teaching Hospital Boards [1]<br>■ professional regulating bodies - medical & dental, nurses and midwives, pharmacy<br>■ special institutions - e.g.; training schools, leprosy hospitals<br>■ CHAG<br>■ private practice hospitals<br>■ NGOs and CBOs involved in health | ■ HSWU<br>■ GMA<br>■ GRNA<br>■ PSGh<br>■ allied health workers' groups - radiographers, laboratory technicians physiotherapists, etc.<br>■ health students' groups<br>■ Private Practitioners Society<br>■ Ghana Hospital Pharmacist Association (GHOSPA) | ■ Private Practitioners Society<br>■ NGOs in health, (international and local)<br>■ external development partners (USAID, DANIDA, DFID, Netherlands Aid, JICA, World Bank, UNICEF, UNFPA, WHO, etc.)<br>■ civil society organizations – e.g. Coalition against Privatization of Water<br>■ Concerned Citizens Association |

[1] KBTH and KATH.

# IV. The social dialogue process in the health sector

The social dialogue issues that study respondents alluded to had varied origins and utilized differing methods. All the social partners interviewed had initiated action on issues for dialogue. Some felt that they were ignored by the Government and that their proposals were not acknowledged. The debate on privatization of water and sanitation was initiated by the ISODEC and sustained through a "coalition against the privatization of water". This involved labour and local NGOs working with international support to challenge the policy, despite the fact that their original petitions to the Government had received no response.

## Initiating dialogue

The NHIS, for example, was initiated by the MOH and the new Labour Law by the government regulatory agency for labour, the MOMD&E. CHAG tried to initiate a dialogue on health insurance but failed to get an audience before the NHIS law was passed.

The brain drain problem was addressed through a national forum initiated and sponsored by the GHS, the main employer. The GHS and the MOH invited a wide array of social partners and stakeholders to the forum to discuss and agree strategies to solve the human resources crisis, including the brain drain.

Discussions on ADHA for health workers was initiated by a section of "organized labour" – the GMA – whose actions eventually led to the formation of the multi-cadre "standing negotiating committee" and the "Health Services Workers' Group" which, at the time, met monthly.

All the initiatives mentioned above originated in the absence of any formal social dialogue structure. Some were successful in that they resulted in agreement or they started useful processes, but others failed to make any significant input into new policies and laws. The MOH in 2002 began a process to institutionalize social dialogue. This initiative is led by the Director of HRD and other country representatives who attended the ILO Joint Meeting on Social Dialogue in the Health Services at ILO headquarters, Geneva, in October 2002. The MOH has so far held two workshops, in 2002 and early 2003, and produced an action plan, along with a list of priority items to be discussed. A memo was sent to the Minister of Health seeking his agreement to the possible establishment of the social partners' forum. There has not been any further follow-up to the process that was initiated and a new minister is now in charge of health since January 2005 and is yet to be briefed. The Human Resources Directorate in the Health Ministry proposes to initiate the formation of a "National Dialogue Commission" after consultations with the new Minister of Health. [1] There has been little other action to initiate dialogue and to start the previously agreed work plan.

Despite the absence of formal social dialogue structures, to a large extent, the health sector appears to follow the principles in developing policies and regulations. However, some partners find that actors outside the sector are not included sufficiently in the dialogue as indicated by the impasse with the TUC over the health insurance scheme.

[1] Information from interview with Dr. Y. Antwi-Boasiako, Director, HRD, MOH, May 2005.

Internal communication difficulties also exist within the sector. The reforms appear to have created communication gaps between the headquarters units of the MOH and the GHS arising from the definition of roles and the control of resources. The Human Resources Directorate of GHS (the main employer of health workers), for example, appeared not to have been fully involved in the social dialogue initiative organized by the MOH.

## The social dialogue agenda

The MOH initiative made the brain drain and its effects the priority question to be tackled through social dialogue. It was also decided to set up a social partners committee (Social Dialogue Committee) which will formally address the priority issues identified. However, none of the proposed agenda has been tackled. Several questions continue to be discussed in the sectors which are completely outside the purview of the proposed Social Dialogue Committee. Some emerging issues centre around the following:

- developing legislative instruments for the NHIS;
- developing a new national ambulance service which is now in a piloting phase;
- tackling the brain drain through the strategies identified during the national forum (initiated separately by GHS).

No common agenda for dialogue has been formally drawn up and the social partners are brought together on an ad hoc basis to contribute to policy development and to debate various issues. There also appears to be a divorce between the formal social dialogue process initiated by an arm of the MOH and the various procedures and structures already involved in dialogue.

## Purpose of social dialogue

The main objective of social dialogue is to ensure the practical implementation of the reform mandate. The health sector is a peripheral player in matters such as the water privatization debate. Issues at the core of the health system are:

- the NHIS, where the main purpose of dialogue was to fulfil election pledges to replace a cash-for-service health financing system, generally acknowledged to be flawed;
- applying and modifying ADHA and distributional incentives for health personnel;
- arresting the brain drain of health professionals and devising strategies to deal with it;
- implementing Ghana's health sector reforms and the five-year plan of work.

Recent discussions have taken place on new proposals, such as:

- the national ambulance service – funding will include the NHIS and sources derived from the road tax/vehicle licensing system;
- the reintroduction of auxiliary nurse training is being discussed and is expected to be initiated soon to help address the staff shortages caused by the mobility of professional nurses;

- public/private collaboration in the health sector: this would involve new ways of involving NGOs and for-profit service providers through contracting mechanisms, but also privatizing aspects of hospital services such as pharmacies, security, catering.

There are indications that senior health sector managers and policy-makers see social dialogue as a consultative and deliberative process needed to reach consensus or agreement on certain policy issues and to ensure the future cooperation of critical groups once the plans have been put into effect. However, some partners have a more cynical view – that the meetings and workshops cover up for the absence of true consultation and negotiation on the details of policy. The Government saw these processes as defusing potential controversy and enabling implementation of the outcomes without much dissent and difficulty. Some of the forums and consultations seem to have petered out in the opinion of some respondents and the absence of a planned set of actions is felt by both the unions in health and the employer organizations.

Sometimes, as in the NHIS debates, the Cabinet and Parliament require thorough consultation and discussion with sponsors before bills are laid before them. Policy evolution in the health sector also involved the social partners in workshops, policy formulation and drafting committees.

The purposes of dialogue in health may be described as follows:

(a) to disseminate information (e.g. on aspects of the NHIS and water privatization);

(b) to educate through seminars and debates (e.g. the NHIS; ADHA management for local managers);

(c) to consult and build a consensus (e.g. the Brain Drain Forum and aspects of health sector reforms);

(d) to set up technical committees responsible for preparing documents/policy papers (NHIS, health sector reforms).

In reality, social dialogue combines these four purposes in ways which depend on the circumstances and the time available. The procedures adopted may depend on the degree of controversy and the political value gained by carrying out a thorough investigation.

## Participation

Participation in one form or another by the social partners in decision making has become fairly routine in the health sector with lists of partners from various stakeholders. These include:

(a) governmental agencies and departments such as the MOF, the OHCS; the NDPC; the MOMD&E; the MOTE; and the Ministry of Local Government;

(b) service delivery agencies such as CHAG, GHS, teaching hospitals' boards, private service providers and regulatory bodies;

(c) organized labour groups such as HSWU, GMA, GRNA, PSGh, allied health professions, the Health Students Association;

(d) related agencies such as training schools/medical schools, nursing and pharmacy training, as well as basic health-worker training schools, research institutes;

(e) a variety of other groups – health journalists, development partners in health, members of the Parliamentary subcommittee on health.

There have been complaints about the inability of participants at various forums to play an effective role in the deliberations. Policy briefing papers and other preparatory documents were only made available at the time of the meeting which did not allow the partners to read and consider the issues before discussions. Partners may lack the knowledge and capacity to grasp the full implications of the issues tabled, and this creates unequal influences in the dialogue.

A TUC complaint in relation to the NHIS is that, despite having had a representative on the drafting committee of the bill, the final text was not made available to the partners for full internal discussions and concurrence. The NHIS secretariat assumed that the presence of a representative on the committee amounted to consultation and thus agreement with the final product.

At the national level, the partners' capacity to negotiate was considered to be significantly stronger, as a result of long experience of using similar structures for negotiations and consultations. At a lower level, the capacity tends to be weaker and often local labour representatives request better trained and more experienced colleagues from the national level to assist with negotiations. This is also the case with employers who may call on the Ministry or on the GEA to assist with negotiations at the local or enterprise level.

The KBTH provides an example of local process. This is the nation's largest hospital in terms of beds, complexity of services and staff numbers. The discussions between partners are related to local management issues and other matters impinging on staff welfare such as ADHA, HIV/AIDS prevention, disciplinary actions and decisions made by the hospital board. A fairly structured system of regular meetings exists within the administration, as well as with organized labour. The local HSWU wing also has a regular system of feedback to its members, with the frequent involvement of the hospital administrator. Disputes are now rare between the HSWU and the hospital administration. However, there is a less congenial relationship with Associated Labour representing the health professionals, where regular feedback and consultations are not well established and dialogue appears to take place on an ad hoc basis.

The teaching hospitals have their own staff and the medical school is a separate employer (under the MOTE). The lecturers practice as clinicians in the hospital and are appointed as heads of clinical departments without the Board's involvement. This tends to complicate the dialogue, as the school expects to be consulted by the hospital but the reverse does not occur.

## Methodologies

The mechanisms for social dialogue in the health sector are not well structured. There is no formal agreement on the procedures to be used and the outcomes to be expected from meetings. Interview respondents indicated that it was also not clear how issues were selected, prioritized and tackled and no agreements were made on "fall-back" positions should the partners fail to reach consensus. Perhaps the National Dialogue Commission (previously designated as the Social Dialogue Committee) proposed by the HR department of the MOH will set out these mechanisms in a much clearer way. Similarly, the way in which their interests and positions are to be communicated by the social partners is not clearly spelt out. For example, some organizations complain that at certain forums, key partners do not have an opportunity to deliver proposals or to share their experience, and are often not given sufficient time to study and comment on a document before the discussion. A number of informants talked of being invited to forums where they receive

copies of long documents and policy papers and are expected to state their position immediately. CHAG and some other partners felt slighted by being asked to participate only in large one-day public forums on the subject of the NHIS.

The Labour Department describes a standard set of agreed procedures which generally govern industrial relations (rather than just social dialogue). There is an initial process of consultation which may lead to an agreement. If there is no agreement, the next step is either pre-arranged conciliation (if the talks degenerate into a dispute and hardened positions) or binding arbitration (when agreement seems beyond the partners). The official who was interviewed contends that strikes only become part of the process when the MOMD&E, who has the statutory responsibility to appoint an arbitrator, delays in this responsibility and the workers become impatient.

While a number of matters may be addressed at various operational levels of employer-employee partnerships, the issues deliberated under this arrangement are labour disputes, collective agreement negotiations, disciplinary procedures and discussions on new regulations and arrangements affecting staff. Thus, there was very little experience of using this process to deliberate on matters of common interest that go beyond the usual wage negotiations. This was confirmed by the secretary-general of the TUC, who felt that the intention to expand the role of the NTC into a forum for consultation on economic and social issues had not been realized.

Another point is whether representation on a committee or attendance at seminars amount to full consultation with the partner. The National Health Insurance Secretariat felt that having a TUC representative on the drafting committee opened a channel of consultation, and that the onus was on the TUC to hold regular discussions with their contact. The TUC, however, contends that the product of the committee should be formally tabled before each partner for discussion with their members.

## Results: Achievements and failures

It is difficult to attribute specific results to social dialogue in Ghana. The institutionalization of social dialogue within the health sector is continuing at a rather slow pace constrained by the recent elections and change in ministers. However, elements of processes recognized as “social dialogue” have been with the sector for some time, probably as a result of the consultations held to prepare for health reforms in the mid-1990s.

There are many examples of policies, technical guidelines and debates on other issues that have gone through processes akin to social dialogue between the health partners. This means that almost no major decision is taken without recourse to some form of partner/stakeholder consultation and deliberations via working groups, steering committees, advisory groups or a task force.

Despite the tensions of the brain drain and agitation for better remuneration, negotiations within the Health Services Workers’ Group and health sector employers (as well as the Government in its role as regulator) have been drawn out for more than two years. This reflects a collegial negotiation atmosphere and no sense of urgency by respondents representing employers, government and workers all agree that the cordiality of dialogue is sometimes seen by ordinary workers as a lack of commitment and effort on the part of their leaders – herein lies a danger if adequate feedback is not taking place.

A key failure is that, whilst there is an awareness of the value of social dialogue in the health sector, the process is on an ad hoc basis with no agreed structures or procedures. However, some argue that utilizing existing labour processes may well be the best way of introducing social dialogue in a sustainable way without completely displacing the

institutions and processes which have engendered remarkable experiences in labour relations and stakeholder involvement.

## Analysis of the process

The elements of social dialogue in Ghana were reviewed with key informants from various partner organizations as well as with reference to documents regarding the legal framework. The status of social dialogue is summarized in table 6 below.

An important question is whether the process of consultation between partner representatives is linked to feedback and consultation with the general public (clients) as well as with the rank and file membership of the social partner organizations.

A second point is that the influence of donors or development partners, both multilateral and bilateral, is quite strong and represents an important force field in issues concerning reform, financing and privatization. This is relevant to controversial matters such as the NHIS and privatization of water.

Table 6. Social dialogue in the health sector

| Key issues | Social partners | Structures and systems | Processes | Feedback and client involvement | Impact of social dialogue |
|---|---|---|---|---|---|
| NHIS | Government: Parliamentary Committee on Health, MOH, NHIS<br>Secretariat: NTC, NACL<br>Labour: TUC, HSWU,<br>Employers: CHAG, THB, GHS, GEA | Drafting committee membership, 2 workshops with partners, 3 public forums, Parliamentary committee meetings, TV, radio appearances, regional forums/meetings | Drafting meetings, information at workshops, comments at public forums, internal information dissemination to identified agencies, e.g. TUC, submission of memos to Parliament | Not clear. Health sector employers' (CHAG, GHS, THBs) feel they are not involved enough; GEA is quite satisfied<br>TUC – poor consultations, no consensus on key issues | Bill passed, appears to have public support despite some institutions' concerns about consultations<br>Further consultations needed, TUC has produced a paper on its stand |
| ADHA | Government: MOH, MOF, MOMD&E<br>Employers: GHS, THB, CHAG<br>Labour: HSWU, GMA, GRNA, PSGh, Allied Group | Standing Negotiating Committee, Health Service Workers' Group,(HSWU, GRNA, GMA, etc.) "operational committees" at local level | Ongoing bargaining, negotiations, consultations – on consolidation of ADHA into pay – also improving retirement options | Local allocation meetings at institutional level<br>Policy level negotiations with government partners.<br>No wider partners involved outside sector | Doctors' strikes averted but nurses rather dissatisfied. Reduced emigration of doctors but higher number of nurses leaving due to disparities in level of allowance. New rural allowances now in place for certain categories of staff |
| Health sector reforms (GHS and THB) | Government: MOH, NDPC, MOF<br>Employers: CHAG, MOH<br>Labour: TUC, GMA GRNA, etc<br>NGOs: CHAG | Working groups with social partners, several forums with social partners, policy drafting teams and consensus-building meetings and workshops | Debates and discussions<br>Submissions to parliamentary committee<br>Public forums | Discussion meetings and workshops held by various interest groups with attendance by MOH<br>Position papers submitted to MOH | Some clarity as to the reforms. Difficulties in delineating roles between new GHS and old MOH. First five years successful implementation of reforms completed |
| Retention and brain drain | Government: MOF, MOTE, MOH, MOMD&E, NDPC, OHCS*<br>Employers: GHS, THB<br>Regulatory bodies: CHAG<br>Private sector, training institutes, military/police, hospitals.<br>Labour: GMA, GRNA, PSGh, Allied Health Workers' Group, medical students, GRMA<br>Others: development/donor partners | National HR stakeholders forum held by GHS. Further consultative actions planned<br>Separate MOH forums held (e.g. MOH, social dialogue workshops)<br>Discussed in HSW group meetings | Memos from CHAG to Minister of Health<br>Bargaining and negotiations for better service conditions<br>Committee for distribution of cars | Not clear – apart from regular organized labour groups' meetings. Government partners not clear. Monitored by government and development partners group as part of PRSP indicators for redistribution | Assured ADHA payments, cars for HWs now targeted to deprived locations and all health workers, not only doctors. Several new allocations of cars for all health workers completed late 2004<br>Still some distrust from groups such as pharmacists, nurses about fairness of processes<br>Doubling of intake into health training schools. (CHAG says not consulted) |

| Key issues | Social partners | Structures and systems | Processes | Feedback and client involvement | Impact of social dialogue |
|---|---|---|---|---|---|
| Labour Act 2003 | Government: MOF, MOMD&E, NDPC, OHCS<br>Parliamentary committee: NTC, NACL<br>Labour: TUC, GFL, "Associated Labour", CSA<br>Employers: GEA, AGI, Chambers of Commerce and Mines | NACL<br>NTC<br>Social partners group meetings<br>"Bill Drafting Committee" of partners. | Start-up workshop to explore interests and positions of social partners<br>Strong deliberative and consultative process<br>Negotiations and bargaining on positions<br>Involvement in Drafting Committee, thorough individual review of draft bills by partners | Regular meetings of organized labour groups for feedback | "Most peaceful" labour legislation ever developed. Bill passed without much dispute and fanfare but well accepted by all social partners |
| Water privatization | Social dialogue not really planned (not really a "dialogue" at beginning, but TUC, NGOs, employers, etc., involved<br>Government: MOF, Ministry of Works<br>Others: World Bank, IMF, DFID | Workshop on water privatization by ISODEC, demonstrations and other advocacy tools. Publicization of the policy, "Coalition against privatization of water" | Workshop by NGO initiative inviting the Government and the IMF to improve public awareness<br>Formation of the coalition<br>Invitation by the Government (information only)<br>Still no real consultation took place<br>Soliciting international pressure and partnership to mitigate effects on the poor. | Public forums<br>Coalition meetings<br>Newspaper articles, media alliances *(not quite a "dialogue")* | Fairly drastic revision of government proposals from 30-year lease of water services to external companies to ten years and then to new management contracts only. Discussions continuing about government guarantee of profits to external companies and loan burden on Ghanaians. Also lack of sanitation and sewerage arrangements in the agreements |

* Source: MOF – Ministry of Finance, MOTE – Ministry of Tertiary Education, MOMD&E – Ministry of Employment, NDPC – National Development Planning Commission, OHCS – Office of Head of Civil Service.

## Factors contributing to the success or failure of social dialogue

A key factor revealed by this study is the feeling of trust and sincerity generated by government agencies and other partners in the process. Indeed, the difficulties with the NHIS appear not to have arisen from major disagreements about the principles and policy framework, but from a feeling on the part of organized labour that political imperatives led to rushing the Bill through Parliament in a way that bypassed the usual consultations (Parliament was recalled from recess to read and pass the Bill).

In the health sector in particular, all parties agree that a healthy level of consultation and debate takes place on many issues. This does not mean that there is complete harmony on the issues but that interests and positions are stated and discussed.

Problems arise when partners feel they have been ignored. In a recent case, KATH inadvertently angered the Pharmaceutical Society by deciding to establish a commercial pharmacy service in the hospital. The Society wrote to the Minister of Health but received no response; they then sued the Ministry in the High Court for contravening the food and drugs law. At the time of this case study, a meeting had been held where it was agreed to negotiate the issue out of court.

Such difficulties arise from the absence of a formally agreed process of social dialogue known to all parties. The partners currently rely on appeals to the Minister, who has no statutory forum to deal with these matters. The social dialogue process initiated in the MOH will need to go beyond the "workshop phase" into establishing advocacy with the Minister and senior health managers which will lead to its acceptance.

A number of parallel and possibly duplicated events are also occurring. The Health Service Workers' Group [1] and its joint Standing Committee on negotiations represents one such effort. Various agencies and technical programmes also set up their own committees, sometimes leaving out certain partners (deliberately or inadvertently). The GHS (HR directorate) held a successful forum on human resources for health in 2003 and the brain drain involving a very wide selection of relevant social partners and stakeholders. At the same time, the MOH's HR department was separately developing the social dialogue process touching on the same issues. A coordinated and synchronized approach is more likely to have stable stakeholder involvement and can be better sustained.

## Impact of social dialogue

It is too early to assess the impact of the social dialogue process initiated in 2002. However, as stated earlier, the use of consultation and dialogue has a long history in the health sector and, if managed well, can be readily transformed into true social dialogue.

Secondly, a variety of factors arising from the health reforms itself and the changes in the way the sector is organized may in themselves have influenced the effects seen in practice, making it difficult to attribute any impact to a specific intervention. Positive results are clearly suggested by the success of specific issues, laws and policies. These outcomes may well be attributed to the use of social dialogue processes. A few, mentioned previously, are discussed here.

[1] A grouping of the union and other employee representatives in the health sector.

The Health Service Workers' Group and the Standing Committee on Negotiations have stabilized the payment of ADHA and extended it to cover all health workers, not only doctors. Industrial action has declined considerably despite some concerns among health workers about the long-standing negotiations. However, doctors have resisted government attempts to reform ADHA and link it more closely to extra hours actually worked. The CHAG applies the terms of ADHA to the letter, to the financial disadvantage of some of its employees. [2]

Another area where social dialogue seems to have had a positive impact is in the allocation of incentives to staff based in deprived districts. Over the past few years the MOH has been providing cars mainly for doctors as part of an incentive system aimed at retaining health workers in the country. In 2003, however, after negotiations with the social partners, a new system was agreed whereby cars are provided for doctors and other professional staff working in remote, deprived or unpopular locations. These, and forthcoming allocations, seem to have been agreed without the usual tensions. Indeed the GMA, which had been the controlling beneficiary of the cars, accepted that incentives should be distributed to deprived areas.

In other areas, dialogue has been less smooth. Both CHAG and a teaching hospital (KATH) have complained about changes in the management of scholarships (fellowships) by the MOH. The selection of candidates has been recentralized and staff are selected without reference to the institution. In the case of CHAG, the agreed allotment of scholarship funds did not materialize at all in 2002. This is said to be the result of a lack of consultation and decisions made outside the usual framework dialogue.

Basically, the terms and conditions of service for workers have not changed much beyond the introduction of ADHA to all health sector workers. There are continuing negotiations by the Health Services Workers' Group on salaries and conditions of employment which workers think have gone on for too long. In a sense, the ongoing negotiations appear to have brought some industrial peace to the sector, which has had no recent strikes on account of pay. [3]

## Health system performance and social dialogue

The *World Health Report 2000* defines a health system as "including all activities whose primary purpose is to promote, restore or maintain health". This excludes other sectors whose primary purpose is not health but whose actions can create positive effects for health. Examples would include education, or good housing. The *World Health Report 2000* describes the following main functions of health systems:

- stewardship;
- creating resources (investments, training, etc.);
- financing (pooling, insurance, etc.); and
- delivering services.

[2] CHAG maintains strict timing of additional hours, whilst GHS and TH facilities effectively pay ADHA as a salary supplement.

[3] Junior doctors have threatened to strike because of delays in payment of the regular ADHA.

These functions, managed well, should result in health systems responding to needs and demands, equity in access and contribution; all these together should result in good health. [4]

Does the social dialogue process in Ghana contribute to improvements in the health system? From the responses of the key informants, the answer will be a qualified yes.

The dialogue processes have brought on board most of the partners and stakeholders involved in health. They meet in a regular and almost routine way and have a sense of involvement. There is now a private sector unit in the MOH and a traditional/herbal medicine unit which is also involved in all levels of policy dialogue. Where there is inadequate consultation, partners are quick to raise their concerns, and this is usually taken on board by the Government and employers. The quality and the depth of consultation and debate appears limited, however, when the questions involved are outside the scope of remuneration and conditions of service.

The review of the health sector in 2002 raised issues about accountability and about linking the changes to improved performance of the system in meeting its health objectives.

The levels of contact between various stakeholder groups suggest that it may be desirable for the MOH, as a regulator and employer, to improve stewardship and feedback to constituents. Significant and more assured resources have become part of the health system, although there was some instability in 2002 caused by rises in ADHA and delays in releasing donor outflows into the pooled health fund. The issue of financing services has been addressed through the National Health Insurance Law, although some partners feel that the level of consultation has fallen short of what was anticipated.

social dialogue appears to have improved the information and communication between partners in health. Despite a disparity in opinions about the methods for improving health services, a conciliatory mood appears to prevail, to some extent because of the partners' involvement (even when limited) in policy development and in setting national health goals.

The Ghana PRS includes measures aimed at equity of access to health services. The goals include the following:

- to bridge equity gaps in access to quality health care services (Northern, Upper East, Upper West and Central);
- to ensure sustainable financing arrangements that protect the poor;
- to reduce the spread of the HIV/AIDS epidemic.

The first objective on equity gaps is being tackled by attracting professional staff to the deprived areas. The recent incentive package that ties the provision of cars to deprived zones is one such action that was accepted by all partners.

The second objective of sustainable financing will be facilitated by the NHIS which includes, as a major component, a network of district-based mutual schemes partially subsidized through a social solidarity system. This was part of the reason for the TUC opposition to government use of workers' social security contributions. The dialogue here has not been very convincing and some respondents see it as an attempt by the

[4] The *World Health Report 2000,* health systems: Improving performance, WHO, Geneva, 2000.

Government to get an important manifesto promise into law before the elections next year, hence the unusual speed and fast-track consultation. The *Health Sector Review 2002* had also recommended slower and more careful deliberations on the complicated issue of health insurance.

HIV/AIDS and its impact on health workers is one of the agenda items agreed for the proposed MOH Social Dialogue Committee. The Ghana AIDS Commission, which is in the President's office, now oversees the HIV/AIDS programme in the country. A key gap here concerns the development of programmes to educate, protect and support health workers; the decision to make this one of the issues for the proposed Social Dialogue Committee will create an environment for tackling this need.

The PRS appears to be an area that many partners feel could have benefited from more in-depth and detailed consultation. The rush is seen as the result of pressure from donors, such as the IMF, to meet deadlines.

# V. Conclusions and recommendations

What lessons can be learned from social partner interactions in general and from the limited social dialogue process in health?

It is clear from experience in Ghana that social dialogue needs a well-structured institutional home, and it may need to be integrated into the existing processes for managing industrial relations. Currently, social dialogue is dominated by salary and wage negotiations which tend to marginalize other social and economic issues that can contribute to industrial peace and productivity.

Good examples of social interaction between partners exist at local level – the KBTH hospital is one example of successful interaction between organized labour and the hospital administration. However, it is sometimes difficult to attract health professionals (doctors and nurses) into dialogue because of the lack of a framework and insufficient capacity to structure social dialogue effectively.

The utilization of social dialogue has been ad hoc and unstructured, or even unconscious in the health sector. This means that policy-makers and other actors approach the discussion with a variety of procedures, some of which may not be appropriate for the specific question. For example, it would have been useful for the partners to decide together and in advance on the consultative approach to be used in the NHIS discussion so that the resulting process would not be misconstrued. Significant capacity exists in the sector from previous experience, and this needs to be harnessed.

The perception of honest dealing and open and clear information is vital to the success of social dialogue. This has been mentioned by many respondents. One factor in the difficulties with the NHIS must have come from the perception (right or wrong) that the process was driven by a political rather than a technical imperative. This was reinforced by different messages given at different times as to how workers' social security contributions were going to be used. [1]

When communication difficulties exist among key partners, social dialogue leads to duplication and other complications. There appear to be tensions between the national offices of the GHS and the MOH in assigning roles and functions between similarly defined departments. [2] Thus, the GHS initiated a dialogue process with a forum on HR, while the Ministry simultaneously initiated a social dialogue committee with the same priority issue but with minimal involvement of the GHS.

A key example, though from outside the health sector and proclaimed by all as an instance of successful social dialogue in Ghana, is the new Labour Law 2003. The partner respondents all agree that the process was very inclusive, very consultative and deliberative. Workers, employers and state respondents all applauded this. Table 7 below describes the process as derived from discussions with respondents.

[1] It was acknowledged by the NHI secretariat in an interview that SSNIT funds were used as a premium, as start-up funding, and simply as a loan to fund the scheme.

[2] Both the MOH and the GHS have HR directorates with overlapping functions.

Table 7. Schematic social dialogue process – from the Labour Bill 2003

| |
|---|
| Stage 1: |
| A comprehensive stakeholder workshop to table interests and positions and to agree on a process. |
| Stage 2: |
| Several workshops, meetings and seminars of the social partners to develop the proposed content of the Bill. |
| Stage 3: |
| Formation of a representative "drafting committee" to prepare the draft Bill. The text was referred back to the partners for discussion and agreement. Several changes were made at this stage. |
| Stage 4: |
| Draft Bill sent together with specific drafting instructions agreed by the partners to the Attorney-General's Department for the final draft of the Bill to be prepared. After feedback and deliberations, the Bill goes to the Cabinet for approval and is then laid before Parliament. |
| Stage 5: |
| Parliamentary Committee stage – the social partners still made representations to the Committee and wording and perceptions were refined again at this stage. The Bill was finally passed. |

This process lasted for over four years and survived a change of government during the 2000 election. Respondents emphasize that this Bill on labour was unusual in that it did not provoke any well-publicized strikes or conflicts. This is a positive lesson, but can all issues be debated utilizing this rather lengthy process? What process could be used for matters that require more urgency?

Clearly, the success factors include an agreed process of consultation and sufficient time for negotiation using conciliation and consultation, with a prior declaration of interests. Another factor is said to be the open sharing of information by partners.

A formal structure for social dialogue would appear to be a useful tool. The health sector's attempt to create such structures seems to have stalled and will need advocacy with government ministers and senior managers. The process may also benefit from integrating social dialogue structures into existing forums between the state, employers and the Health Services Workers' Group. The proposal for a parallel social dialogue committee may tend to delay its introduction. The benefits or otherwise of integrating existing structures need to be explored.

## The way forward?

How can social dialogue in the health sector be strengthened? The environment is conducive in that inter-partner consultations and discussions have become a tradition of the sector. The process needs to be refined and scaled up to allow true dialogue through recognized structures.

- A greater advocacy strategy is needed to bring the principles of social dialogue to the top management of the health sector and partners. It is not clear whether the workshops held by the MOH have achieved this level of participation and agreement. The process may benefit from a high-level meeting on social dialogue chaired by the Minister and drawing in all partners. The HR department of the Ministry may then follow up on this with the wider national forums.

- The key managers of social dialogue in the health sector, such as the HR directorate in the MOH, will need to develop draft guidelines and systems aimed at reinventing existing partnership structures that already appear to be working well. They need to

integrate social dialogue processes and structures into the operations of these existing arrangements (such as the Health Service Workers' Group meetings).

- The established patterns of stakeholder involvement in policy development and in deliberations should be studied by the HR management of the MOH with a view to amending these systems to permit more effective social dialogue.

- The relative industrial harmony existing in the health sector at present makes it possible to take measures to ensure that good relations will continue. Several thorny issues can then be seen to be tackled before they develop into industrial conflict.

# Appendix 1

## Key informants

### *Government/state regulators*

- Mr. Kwamina Amoasi-Andoh – OHCS, Decent Work Coordination Secretariat, former Chief Executive of SSNIT Health Insurance project
- Mr. J.Y. Amankrah – Director, Research Statistics and Information Ministry of Manpower, Development and Employment
- Mr. Asiedu-Nyarku – Assistant Chief Labour Officer and head of Legal and International Affairs Unit, Labour Department
- Dr. Yao Antwi-Boasiako – Director, HR, MOH
- MOH – National Health Insurance Secretariat
  - Mr. J.K. Adusei
  - Dr. Addae Munukum
  - Dr. Sam Akor – Director, PPME and head of the NHIS

### *Employers*

- Mr. Chris Nartey – Director of Administration, Korle Bu Teaching Hospital
- Mr. Alex Frimpong – Industrial Relations Officer, GEA
- Dr. Ken Sagoe – Director, HRD, GHS
- Mr. Philbert Kankye – Executive Secretary, CHAG
- Dr. Frank Nyonator – Director, Policy Planning, Monitoring and Evaluation, GHS

### *Workers*

- Dr. Adu-Ababio – Vice-President, GMA
- Mr. Peter Segbor – Executive Secretary, PSGh.
- Mr. Alex Kesseh – Health Service Workers' Union, TUC
- Mr. Kwasi Adu-Amankwa – secretary-general, Ghana TUC

### *NGO/CBO clients*

- ISODEC
  - Mr. Tay Awoosah Ag. Deputy Executive Director
  - Mr. Ibrahim Akalbila Programme Officer
  - Mr. Gabriel Sosu Finance Department
  - Mr. Yakubu Zakaria Programme Officer
  - Ms. Victoria Adongo Advocacy and Campaigns Officer

  Mr. Philbert Kankye – Executive Secretary, CHAG [1]

  Mr. Austin Gamey – former Deputy Minister of Employment and Social Welfare, Labour and Mediation Consultant

[1] CHAG is a core partner as an employer of health workers but is also considered an important NGO representing faith-based interests.

# Appendix 2

## Documents reviewed/consulted

### *National documents*


*Agenda for social dialogue – Problems/issues of common interest*. MOH-HRD, undated paper.

Meeting on Social Dialogue in the Health Service – Kumbaya Hotel, Achimota, 27-28 March 2003. Summary of Meeting.

*Action plan for implementation of programme for National Committee*. MOH, March 2003.

*Policy framework for the establishment of health insurance in Ghana*. MOH/GOG, October 2002.

*The position of organized labour on the National Insurance Act*, pamphlet issued by the TUC of Ghana, GNAT, CSA, GRNA, Judicial Services Staff Association of Ghana (JUSSAG), 8 September 2003.

Civil Service Law 1993 (PNDCL 327).

Labour Decree 1967 (NLCD 157).

Labour Act 2003, Act No. 651, Ghana Publishing Corporation, Assembly Press, Accra.

Ghana Health Service and Teaching Hospitals Act 1996: 525.

Korle-Bu Teaching Hospital: *Annual report* 2002.

Minutes of meeting of Heads of Agencies held on 15 July 2003 in Hon. Minister's office, MOH.

*Partnership for progress: Improving Christian Health Association of Ghana, Ministry of Health and Ghana Health Service Relations,* Memorandum submitted to the Minister of Health by CHAG, 22 March 2002.

*Establishing health insurance in Ghana: Comments and contributions to the national effort*, Memorandum submitted to the Minister of Health by CHAG, 22 March 2002.

Health Services Workers' Union: *A brief on social dialogue,* undated paper.

Ministry of Health: *Programme of work* 2002, report of the External Review Team, May 2003.


### *International documents*


Amankrah, J.Y.: *Ghana*: *Decent work statistical indicators – Fact-finding study,* report prepared for the ILO Policy Integration Department (Geneva, August 2003).

Fashoyin, T.: *The contribution of social dialogue to economic and social development in Gambia*, Working Paper No. 6 (Geneva, ILO, InFocus Programme on strengthening social dialogue, January 2002).

ILO: *Social dialogue in the health services: Institutions, capacity and effectiveness*, document JMHS/2002 (Geneva, 2002).

—: *Note on the proceedings: Joint Meeting on social dialogue in the health services – Institutions, capacity and effectiveness*, Geneva, 21-25 Oct. 2003 (Geneva, 2003).

Lethbridge, J.: *Social dialogue in health services:* Case studies in Brazil, Canada, Chile, United Kingdom, Working Paper (Geneva, ILO, Sectoral Activities Programme, August 2002).

Perez, J.L.D.: *Social dialogue in the public services*, Working Paper No. 11 (Geneva, 2002).

WHO: *The World Health Report 2000: Health systems – Improving performance* (Geneva, 2000).

# Appendix 3

## Excerpts from Labour Act No. 651, 2003 [1]

*Part XIII: National Tripartite Committee*

*Establishment of National Tripartite Committee*

112. There is hereby established a National Tripartite Committee which shall be composed of:

– the Minister who shall be the chairperson;

– five representatives of the Government;

– five representatives of employers' organizations; and

– five representatives of organized labour.

*Functions of the National Tripartite Committee*

113. (1) The National Tripartite Committee shall determine the national daily minimum wage:

…

(b) advise on employment and labour market issues, including labour laws, international labour standards, industrial relations and occupational safety and health;

(c) consult with partners in the labour market on matters of social and economic importance; and

(d) perform such other functions as the Minister may request for the promotion of employment development and peace in the labour sector.

(2) The Minister shall publish in the *Gazette* and in such public media as the Minister may determine, a notice of the national daily minimum wage determined under subsection (1).

(3) The Ministry shall provide the National Tripartite Committee with such secretarial services as the Committee may require for the effective performance of its functions.

*Meetings of the National Tripartite Committee*

114. (1) The National Tripartite Committee shall meet at times and at places determined by the members but shall meet at least once in every three months.

(2) The quorum for a meeting of the National Tripartite Committee shall be nine members with at least two members each representing the Government, organized labour and employers organizations.

(3) The National Tripartite Committee may invite any interest group to attend any of its meetings.

(4) Except as otherwise provided in this section, the National Tripartite Committee shall regulate its proceedings.

*Regional and district tripartite committees*

115. (1) The National Tripartite Committee may set up subcommittees of the Committee in such regions and districts as it considers necessary for the effective performance of its functions.

[1] These sections describe the structures that can arguably be used for social dialogue under the new law.

(2) The composition of a regional or district subcommittee of the National Tripartite Committee shall be determined by the Committee, except that there shall be equal representation of Government, organized labour and employers' organizations.

(3) The Ministry shall provide a subcommittee with such secretarial services as the subcommittee may require.

*Part XVIII: National Labour Commission*

*Sub Part 1: Establishment and functions of the National Labour Commission*

*Establishment of Commission*

135. There is established by this Act a National Labour Commission referred to in this Act as the "Commission".

*Composition of the Commission*

136. (1) The Commission shall consist of the following persons —

(a) a chairperson who shall be nominated by the employers' organization and organized labour except that where there is failure to nominate a chairperson within 60 days as provided, the employers' organization in consultation with organized labour shall submit the matter to a mediator agreed by them;

(b) six representatives, two each nominated by the Government, employers' organizations and organized labour.

*Functions and independence of the Commission*

138. (1) The functions of the Commission are as follows:

(a) to facilitate the settlement of industrial disputes;

(b) to settle industrial disputes;

(c) to investigate labour-related complaints, in particular unfair labour practices, and take such steps as it considers necessary to prevent labour disputes;

(d) to maintain a data base of qualified persons to serve as mediators and arbitrators;

(e) to promote effective labour cooperation between labour and management; and

(f) to perform any other function conferred on it under this Act or any other enactment.

*Committees of the Commission*

141. (1) The Commission may appoint:

(a) a standing committee consisting of members of the Commission; or

(b) an ad hoc committee consisting of non-members or both members and non-members of the Commission

as the Commission considers necessary for the efficient discharge of its functions.

(2) The Commission shall assign to any of its committees such of its functions as it may determine.

# Appendix 4

## Action plan for programme implementation for the National Committee [1]

(as developed at a National MOH Social Dialogue Workshop, March 2003)

| Objective | Target | Activity | Action by | Achievement dates | Resources |
|---|---|---|---|---|---|
| To constitute a national Social Dialogue Committee | National Social Dialogue Committee constituted | Identification of National Social Dialogue Committee members | Director HRHD, MOH | 31 March 2003 | MOH |
| To notify identified members | Identified members informed | Writing letters to identified members inviting them to a meeting | Minister or Director, HRHD | 7 April 2003 | MOH |
| To invite identified members for a first meeting | Identified members invited | Writing letters to invite members at a fixed date:<br>– Briefing<br>– TOR | Director, HRHD | 29 April 2003 | MOH |
| Committee members to meet the Minister of Health | Committee members met Minister of Health | Arrange meeting between Committee members and Minister for interaction, familiarization and purpose statement | Director, HRHD | 13 May 2003 | MOH |
| To inaugurate the Committee | Committee inaugurated | Arrangements, invitations for inauguration | Minister, MOH | 10 June 2003 | MOH |
| To plan quarterly meetings | Quarterly meeting planned | Arrangement to hold planning meeting | Chairman, NSD Committee | 17 June 2003 | MOH |

[1] A criticism of the action plan is that it omits advocacy and capacity building as part of the process of building social dialogue.

# Sectoral working papers [1]

| | *Year* | *Reference* |
|---|---|---|
| The Warp and the Web<br>Organized production and unorganized producers in the informal food-processing industry: Case studies of bakeries, savouries' establishments and fish processing in the city of Mumbai (Bombay)<br>(Ritu Dewan) | 2000 | WP.156 |
| Employment and poverty in Sri Lanka: Long-term perspectives<br>(Vali Jamal) | 2000 | WP.157 |
| Recruitment of educational personnel<br>(Wouter Brandt and Rita Rymenans) | 2000 | WP.158 |
| L'industrie du textile-habillement au Maroc: Les besoins des chefs d'entreprise et les conditions de travail des femmes dans les PME<br>(Riad Meddeb) | 2000 | WP.159 |
| L'évolution de la condition des personnels enseignants de l'enseignement supérieur<br>(Thierry Chevaillier) | 2000 | WP.160 |
| The changing conditions of higher education teaching personnel<br>(Thierry Chevaillier) | 2000 | WP.161 |
| Working time arrangements in the Australian mining industry: Trends and implications with particular reference to occupational health and safety<br>(Kathryn Heiler, Richard Pickersgill, Chris Briggs) | 2000 | WP.162 |
| Public participation in forestry in Europe and North America: Report of the Team of Specialists on Participation in Forestry | 2000 | WP.163 |
| Decentralization and privatization in municipal services: The case of health services<br>(Stephen Bach) | 2000 | WP.164 |
| Social dialogue in postal services in Asia and the Pacific: Final report of the ILO-UPU Joint Regional Seminar, Bangkok, 23-26 May 2000<br>(Edited by John Myers) | 2000 | WP.165 |
| Democratic regulation: A guide to the control of privatized public services through social dialogue<br>(G. Palast, J. Oppenheim, T. McGregor) | 2000 | WP.166 |
| Worker safety in the shipbreaking industries: An issues paper<br>(Sectoral Activities Department and InFocus Programme on Safety and Health at Work and the Environment) | 2001 | WP.167 |
| Safety and health in small-scale surface mines – A handbook<br>(Manfred Walle and Norman Jennings) | 2001 | WP.168 |

[1] Working Papers Nos. 1-155 are not included on this list for reasons of space, but may be requested from the Sectoral Activities Department.

| | *Year* | *Reference* |
|---|---|---|
| Le rôle des initiatives volontaires concertées dans la promotion et la dynamique du dialogue social dans les industries textiles, habillement, chaussure<br>(Stéphanie Faure) | 2001 | WP.169 |
| The role of joint voluntary initiatives in the promotion and momentum of social dialogue in the textile, clothing and footwear industries<br>(Stéphanie Faure) | 2001 | WP.170 |
| La situation sociale des artistes-interprètes de la musique en Asie, en Afrique et en Amérique latine<br>(Jean Vincent) | 2001 | WP.171 |
| The social situation of musical performers in Asia, Africa and Latin America<br>(Jean Vincent) | 2001 | WP.172 |
| Guide sur la sécurité et hygiène dans les petites mines à ciel ouvert<br>(Manfred Walle and Norman Jennings) | 2001 | WP.173 |
| Seguridad y salud en minas de superficie de pequeña escala: Manual<br>(Manfred Walle and Norman Jennings) | 2001 | WP.174 |
| Privatization of municipal services: Potential, limitations and challenges for the social partners<br>(Brendan Martin) | 2001 | WP.175 |
| Decentralization and privatization of municipal services: The perspective of consumers and their organizations<br>(Robin Simpson) | 2001 | WP.176 |
| Social and labour consequences of the decentralization and privatization of municipal services: The cases of Australia and New Zealand<br>(Michael Paddon) | 2001 | WP.177 |
| 1st European Forest Entrepreneurs' Day, September 16, 2000<br>(European Network of Forest Entrepreneurs ENFE) | 2001 | WP.178 |
| The world tobacco industry: trends and prospects<br>(Gijsbert van Liemt) | 2002 | WP.179 |
| The construction industry in China: Its image, employment prospects and skill requirements<br>(Lu You-Jie and Paul W. Fox) | 2001 | WP.180 |
| The impact of 11 September on the aviation industry<br>(Peter Spence Morrell and Fariba Alamdari) | 2002 | WP.181 |
| The impact of 11 September on the civil aviation industry: Social and labour effects<br>(Prof. Peter Turnbull and Geraint Harvey) | 2002 | WP.182 |
| Employment trends in the tobacco sector in the United States: A study of five states<br>(Maureen Kennedy) | 2002 | WP.183 |
| Tobacco: An economic lifeline? The case of tobacco farming in the Kasungu Agricultural Development Division, Malawi<br>(Michael Mwasikakata) | 2002 | WP.184 |
| A study of the tobacco sector in selected provinces of Cambodia and China<br>(Yongqing He, Yuko Maeda, Yunling Zhang) | 2002 | WP.185 |

| | *Year* | *Reference* |
|---|---|---|
| Child performers working in the entertainment industry: An analysis of the problems faced<br>(Katherine Sand) | 2003 | WP.186 |
| Informal labour in the construction industry in Nepal<br>(Kishore K. Jha) | 2002 | WP.187 |
| The construction labour force in South Africa: A study of informal labour in the Western Cape<br>(Jane English and Georg Mbuthia) | 2002 | WP.188 |
| Social dialogue in health services – Case studies in Brazil, Canada, Chile, United Kingdom<br>(Jane Lethbridge) | 2002 | WP.189 |
| Teachers and new ICT in teaching and learning modes of introduction and implementation impact<br>implications for teachers<br>(Chris Duke) | 2002 | WP.190 |
| Best practice in social dialogue in public service reform: A case study of the Norwegian Agency for Development Co-operation (NORAD)<br>(Torunn Olsen) | 2002 | WP.191 |
| Best practice in social dialogue in public service emergency services in South Africa<br>(Bobby Mgijima) | 2003 | WP.192 |
| Case studies in social dialogue in the public emergency services – Argentina<br>(Laura El Halli Obeid and Liliana Beatriz Weisenberg) | 2003 | WP.193 |
| Employment trends in the tobacco sector: Selected provinces of Bulgaria and Turkey<br>(Roska Ivanovna Petkova and Nurettin Yildirak) | 2003 | WP.194 |
| How to prevent accidents on small construction sites<br>(Illustrated by Rita Walle) | 2003 | WP.195 |
| Sectoral trends: A survey<br>(Katherine A. Hagen) | 2003 | WP.196 |
| The impact of the restructuring of civil aviation on employment and social practices<br>(Bert Essenberg) | 2003 | WP.197 |
| Raising awareness of forests and forestry. Report of the FAO/ECE/ILO Team of Specialists<br>on Participation in Forestry and the FAO/ECE Forest Communicators Network | 2003 | WP.198 |
| Teaching and the use of ICT in Hungary<br>(Eva Tót) | 2003 | WP.199 |
| Violence and stress at work in the postal sector<br>(Sabir I. Giga, Helge Hoel and Cary L. Cooper) | 2003 | WP.200 |
| Violence and stress at work in the performing arts and in journalism<br>(Sabir I. Giga, Helge Hoel and Cary L. Cooper) | 2003 | WP.201 |
| Making ends meet: Bidi workers in India today. A study of four states | 2003 | WP.202 |
| Civil aviation: The worst crisis ever?<br>(Bert Essenberg) | 2003 | WP.203 |

| | *Year* | *Reference* |
|---|---|---|
| Informal labour in the construction industry in Kenya: A case study of Nairobi<br>(Winnie V. Mitullah and Isabella Njeri Wachira) | 2003 | WP.204 |
| Violence and stress at work in the transport sector<br>(Bert Essenberg) | 2003 | WP.205 |
| The impact of Severe Acute Respiratory Syndrome (SARS) on health personnel<br>(Christiane Wiskow) | 2003 | WP.206 |
| How we work and live. Forest workers talk about themselves<br>(Bernt Strehlke) | 2003 | WP.207 |
| Workplace violence in service industries with implications for the education sector: Issues, solutions and resources<br>(Richard Verdugo and Anamaria Vere) | 2003 | WP.208 |
| International migration of health workers: Labour and social issues<br>(Stephen Bach) | 2003 | WP.209 |
| Violence and stress at work in financial services<br>(Sabir I. Giga, Helge Hoel and Cary L. Cooper) | 2003 | WP.210 |
| Violence and stress in hotels, catering and tourism sector<br>(Helge Hoel and Ståle Einarsen) | 2003 | WP.211 |
| Employment and human resources in the tourist industry in Asia and the Pacific<br>(Travel Research International, London) | 2003 | WP.212 |
| Democracy and public-private partnerships<br>(Jerrold Oppenheim and Theo MacGregor) | 2003 | WP.213 |
| Social dialogue in the public emergency services in a changing environment (Bulgaria)<br>(Pavlina Popova) | 2003 | WP.214 |
| Training of machine operators for mechanized wood harvesting. A study carried out under the EU-funded ERGOWOOD project<br>(Bernt Strehlke and Kristin Warngren) | 2004 | WP.215 |
| Social dialogue in the public emergency services in a changing environment (Bulgaria) – pdf, 150k<br>(Pavlina Popova) | 2004 | WP.216 |
| Public emergency services: Social dialogue in a changing environment: A study on Japan<br>(Minawa Ebisui) | 2004 | WP.217 |
| Academic tenure and its functional equivalent in post secondary education<br>(Donald C. Savage) | 2004 | WP.218 |
| Study of the Kerala Construction Labour Welfare Fund<br>(R.P. Nair) | 2004 | WP.219 |
| The Joint FAO/ECE/ILO Committee: Fifty years of international cooperation in forestry<br>(T.J. Peck and E.G. Richards) | 2004 | WP.220 |
| La permanence et son équivalent fonctionnel dans l'enseignement postsecondaire<br>(Donald C. Savage) | 2004 | WP.221 |
| Academic employment structures in higher education: The Argentine case and the academic profession in Latin America<br>(Garcia de Fanelli) | 2004 | WP.222 |

| | *Year* | *Reference* |
|---|---|---|
| An introduction to labour statistics in tourism<br>(Dirk Belau) | 2004 | WP.223 |
| Labour implications of the textiles and clothing quota phase-out<br>(Hildegunn Kyvik Nordas) | 2005 | WP.224 |
| Baseline study of labour practices on large construction sites in Tanzania<br>(coordinated by the National Construction Council, Dar es Salaam) | 2005 | WP.225 |
| Informal construction workers in Dar es Salaam, Tanzania<br>(Arthur Jason) | 2005 | WP.226 |
| Prospects for micro, small and medium enterprises in the food and drink industries in Guyana<br>(Abdul Rahim Forde) | 2005 | WP.227 |
| Alimentation et boisson au Burkina Faso: au delà de la survie<br>(Dié Martin Sow) | 2005 | WP.228 |
| Social dialogue in education in Latin America: A regional survey<br>(Marcela Gajardo and Francisca Gómez) | 2005 | WP.229 |
| Good industrial relations in the oil industry in the United Kingdom<br>(Dr. Chris Forde, Dr. Rob MacKenzie, Dr. Mark Stuart, Dr. Rob Perrett) | 2005 | WP.230 |
| The future of civil aviation in Africa: Restructuring and social dialogue<br>(Bert Essenberg) | 2005 | WP.231 |
| The issues of fatigue and working time in the road transport sector | 2005 | WP.232 |
| Privatization of energy in the Argentine Republic | 2005 | WP.233 |
| Social dialogue in the health sector: Case study Ghana<br>(Dr. Delanyo Y. Dovlo) | 2005 | WP.234 |