

Note on the proceedings

Joint Meeting on Social Dialogue in the Health Services:
Institutions, Capacity and Effectiveness

Geneva, 21-25 October 2002

Contents

Introduction	1
Part 1. Consideration of the agenda item.....	5
Report of the discussion	7
Introduction	7
Composition of the Working Party	7
Presentation of the report and general discussion	8
General discussion	9
Health services and understanding social dialogue	13
Health services and participating in social dialogue	20
Consideration and adoption of the draft report and the draft conclusions by the Meeting	29
Conclusions on strengthening social dialogue in the health services: A framework for practical guidance	30
General considerations	30
Health services and understanding social dialogue.....	30
Agenda of social dialogue in the health services	30
Representation of the social partners	31
Social dialogue in situations of structural change	31
Identifying and enforcing quality standards.....	32
Establishing and strengthening institutions for social dialogue in the health services.....	32
Planning for social dialogue.....	32
Initiating social dialogue in the health services	33
Carrying out social dialogue	33
Monitoring and evaluating the process of social dialogue in the health services	33
Mobilizing the resources needed for social dialogue in health services	34
Proposed action by the ILO.....	34
Concerning practical guidance in strengthening social dialogue in the health services.....	34
Concerning the migration of health services workers.....	34
Part 2. Resolutions.....	37
Consideration and adoption by the Meeting of the draft resolutions	39
Resolution concerning health care as a basic human right.....	40
Text of the resolution adopted by the Meeting.....	41
Resolution concerning health care as a basic human right	41
Part 3. Other proceedings	43
Presentation on the Sectoral Activities Department one-stop window web site	45

Round table on workplace violence – A threat to quality health services.....	45
Part I: What is the problem?.....	45
Part II: Addressing the problem	49
Closing speeches	53
Evaluation questionnaire	55
List of participants.....	59

Introduction

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness was held at the ILO in Geneva from 21-25 October 2002.

The Office had prepared a report¹ issued in English, French and Spanish to serve as a basis for the Meeting's deliberations. It addressed the following topics:

- recent developments in the health sector, particularly in view of institutions and structures, the management, labour market development and the financing of health services;
- institutions, capacity and effectiveness of social partners in social dialogue analysing social dialogue as an approach to labour relations, categories and types of institutions in social dialogue, government structures, employers and their organizations in health services, health workers and their organizations, prerequisites and criteria for the capacity for social dialogue and indicators for the effectiveness of social dialogue;
- a possible framework for strengthening social dialogue in the health sector.

The Governing Body had designated Mr. V. Klotz, Government member of the Governing Body to represent it and to chair the Meeting. The two Vice-Chairpersons elected by the Meeting were: Mr. R. Tremblay (Canada) from the Government/Employers' group and Ms. D. Matebeni from the Workers' group.

The Meeting was attended by Government representatives from: Barbados, Brazil, Canada, Central African Republic, Chile, China, Colombia, Cyprus, Czech Republic, Egypt, Finland, France, Ghana, Hungary, Kenya, Republic of Korea, Luxembourg, Mauritius, Morocco, Nigeria, Panama, Philippines, Poland, South Africa, Switzerland, Syrian Arab Republic, Tunisia, United States and Venezuela as well as eight Employer representatives and 25 Worker representatives.

Four observers from the World Health Organization attended the Meeting and representatives from the following international non-governmental organizations also attended as observers: the International Confederation of Free Trade Unions, the International Council of Nurses, the International Federation of Employees in Public Services, the International Organisation of Employers, Public Services International and the World Confederation of Labour.

The two groups elected their Officers as follows:

Government/Employers' group:

Chairperson:	Mr. J. Wagner (United States)
Vice-Chairperson:	Dr. F.K. Anyah (Employer member)
Secretary:	Mr. J. Dejardin (International Organisation of Employers (IOE))

¹ ILO, Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness, Geneva, 2002: *Social dialogue in the health services: Institutions, capacity and effectiveness*, 67 pp.

Workers' group:

Chairperson: Mr. P. Green

Vice-Chairperson: Mr. M. Valera Corro

Secretary: Mr. M. Waghorne (Public Services International)

The Secretary-General of the Meeting was Mr. O. de Vries Reilingh, Director of the Sectoral Activities Department. The Deputy Secretary-General was Ms. C. Doumbia-Henry of the same Department. The Executive Secretary was Ms. G. Ullrich. The Clerk of the Meeting was Ms. S. Maybud. The Experts were: Ms. C. Foucault-Mohammed, Mr. B. Ratteree, Ms. T. Smout and Ms. A. Vere.

The Meeting held six plenary sittings.

The Chairperson of the Joint Meeting, Mr. Valentin Klotz, who was appointed by the Governing Body of the ILO, welcomed participants. It was heartening to see the increased interest of governments under the new format for government participation in sectoral meetings; more than 30 had sent representatives. This no doubt reflected the importance of the health services sector to all people and countries. Health services were essentially a public good provided in the public interest, even when delivered by private providers. The private/public mix was sometimes contested, but there was no denying the need for universal access to health services. The State and users of services spent billions of dollars each year on such services. The increasing costs and the concern for public health has made the issue a priority in public debate, as the ILO report underlined. Working and employment conditions in the sector were also highly topical, since the quality of services depended not only on financial means, availability of equipment and medicines, but especially on health service workers, their qualifications and job satisfaction. These workers had legitimate concerns regarding employment, safety issues, insufficient material, inadequate salaries, workload, stress and unsocial working hours, professional lifelong learning and their right to collective bargaining on such issues. Given the limitations on the right to strike in essential services, there was a particular need for social dialogue to avoid or resolve industrial action, based on open exchange of information, consultation and negotiation between the State, employers and workers and their representatives.

Reforms in health services had been initiated to contain costs, to ensure necessary financing, to improve the quality of health services and to create quality working conditions for health service workers. The process of reform was often accompanied by intensive social dialogue. The ILO had often underlined the need for such dialogue, notably in the conclusions of the 1998 Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, which stressed the importance of adopting social dialogue strategies and the fact that the best reforms were achieved through dialogue. An important objective of the Meeting would be to achieve a broad consensus on conclusions which could benefit participants and the ILO by strengthening approaches to social dialogue. Concluding, he noted the recent gift of a model health services ship for seafarers by the Government of Spain, illustrating the principle that access to health services had no borders.

On behalf of the Director-General of the ILO, the Executive Director of the Social Dialogue Sector, Ms. Sally Paxton, also welcomed participants to the first sectoral meeting for the health services since September 1998. During the last four years, the ILO had carried out a number of activities and programmes related to the sector, many of these in partnership with governmental and non-governmental organizations. Of particular importance was the ILO's 2001 Joint Meeting on the Impact of Decentralization and

Privatization on Municipal Services, which also included health services. The conclusions of this meeting set a certain framework for deliberations on social dialogue in services in the public interest.

To begin with, how did the theme of social dialogue match today's concerns in this sector, notably the increasing importance of health services, and the insurances which finance these services, in our daily lives. For example, a chronic shortage of nurses in a number of industrialized countries undermined governments' attempts to modernize the national public health systems, making the recruitment of nurses abroad vital to the operation of current services, and creating long waiting lists which made it necessary for patients to be treated in private hospitals and even abroad. In certain countries, massive nursing shortages would require the recruitment of thousands of nurses over the next decade, with international migration of health professionals creating consequences for "donor" and "recipient" countries. Furthermore, renewed concerns had recently been expressed over increasing health care and insurance costs for users, as well as over attempts to contain costs with improved performance management. News about the deteriorating quality of health services and working conditions, notably workplace violence and stress among health service workers and between workers and patients, was also cause for concern. When one looked closer, was not social dialogue part of the solution to these critical issues? The ILO believed that open and frank discussions between partners fostered social dialogue to help find solutions to economic and social problems, promoting transparency and accountability, themselves central elements of good governance and values that were of special importance in countering the uncertainties of globalization. Experience worldwide had shown that governments needed to take further measures to mainstream social dialogue in the formulation of their policies affecting the working conditions of millions of workers throughout the world, including those in the health services.

The ILO understood social dialogue to mean all types of negotiation, consultation and exchange of information between representatives of governments, employers and workers, on issues of common interest relating to economic and social policy. For these purposes, successful social dialogue not only needed a legal and/or institutional framework, but also required that the necessary parties have the capacity to be involved in a meaningful way. Social dialogue was a continuous process of consultation and negotiation, which did not end when a particular agreement was reached. Though time-consuming and difficult, the reward was sustainable results and ownership of the decisions by all stakeholders. Social dialogue processes were critical for public service workers, including those in the health services, in promoting and defending their rights. The exercise of the right of freedom of association and collective bargaining by public service officials and employees was now a reality in most industrialized countries and in many developing countries.

The ILO contributed to promoting these rights through various instruments, namely its standard-setting and supervisory process, research, advisory services, training and sectoral meetings for various public services, such as this Joint Meeting. Over the last decade, these sectoral meetings have strongly emphasized the role of public service workers in delivering quality public services and have provided very explicit conclusions on social dialogue's contribution to this objective. Future ILO work included a meeting in January 2003 to discuss public service emergency workers – a segment of the public service which has been even more visible since September 11 – and a meeting in May 2003 on the challenges and opportunities facing public utilities.

In September 2002, Miss Paxton participated in the launching of a worldwide campaign on quality public services at the congress of Public Services International (PSI), underlining in the process the role of the workforce in delivering such quality services, especially needed in the health sector for the well-being and productivity of society and

each individual. The workforce is the most valuable resource of any organization, particularly in highly labour intensive public services. The workforce both controlled the potential to deliver public services and accounted for a large part of the costs involved – in the health services as much as 70 per cent of the total. While it was obvious that improvements in the quality of public services were dependent on a competent and motivated workforce, concrete steps were needed to make such quality a reality. Recruitment and maintenance of a high-quality public service workforce required adequate education, lifelong learning, good working conditions and high ethical standards. Human resource development in the public service was an important part of the reform process, and needed to take place within a coordinated framework, through a process of social dialogue.

The cross-sectoral meeting in October 2001 on the impact of decentralization and privatization on municipal services asked the ILO to promote social dialogue at all levels in the context of public service reform, particularly the need to evaluate the factors in public service reform that contribute positively to the efficiency and quality of services. These factors were the security and terms of employment, compliance with ILO standards, eradication of corruption, the promotion of high standards of professional ethics and gender equity. Consequently, the report to this Meeting examined areas in which social dialogue assists in finding solutions to problems prevailing in the sector, such as the nursing shortage and increased health costs. The report also outlined various approaches to social dialogue, the institutions necessary for social dialogue to take place, prerequisites for improving the capacity for social dialogue, indicators for assessing social dialogue's effectiveness, and the ILO approach to strengthening social dialogue in general. She hoped that this Meeting would be a vehicle for social dialogue at the international level, resulting in useful conclusions for action by the social partners and by the ILO in order to strengthen social dialogue in the health services.

Part 1

Consideration of the agenda item

Report of the discussion ¹

Introduction

1. The Meeting met to examine the item on the agenda. In accordance with the provisions of article 7 of the Standing Orders for sectoral meetings, the Officers presided over the discussion.
2. The spokesperson for the Government/Employers' group was Ms. Bogen Behrens and the spokesperson for the Workers' group was Mr. Green.
3. The Meeting held five sittings devoted to the discussion of the agenda item.

Composition of the Working Party

4. At its fifth plenary sitting, in accordance with the provisions of article 13, paragraph 2, of the Standing Orders, the Meeting set up a Working Party to draw up draft conclusions reflecting the views expressed in the course of the Meeting's discussion of the report. The Working Party, presided over by the Government/Employer Vice-Chairperson, Mr. Tremblay, was composed of the following members:

Government/Employer members

Ms. Bogen Behrens (Employer member)

Ms. Chiffoleau (Employer member)

Ms. Mafubelu (South Africa)

Ms. Porschwitz (Philippines)

Mr. Wagner (United States)

Worker members

Mr. Gravel

Mr. Green

Ms. Mbatia

Mr. Ndi

Mr. Nicholas

¹ Adopted unanimously.

Presentation of the report and general discussion

5. Introducing the report prepared by the Office, the Executive Secretary summarized the main points of the chapters and the points for discussion. Chapter 1 on “Recent developments in the health sector: Setting the context for social dialogue” dealt with four main areas:
- **Institutions and structures in health services:** a current situation characterized by decentralized public health systems with more autonomy, changed conditions of employment, different treatment of staff and loss of economies of scale, and a private sector composed of for-profit or non-profit organizations.
 - **Management of health services:** marked by exploration of performance and quality management, influencing factors were human and financial resources and work organization; top management needed to be trained, committed and accountable; staff required material and non-material incentives to redress them; the report indicated both the high percentage of employment in health services as a percentage of the workforce and the important share of women as a percentage of the health workers.
 - **Labour market development in health services:** slow adjustments on the supply side and institutional and regulatory restrictions on the demand side made market mechanisms difficult to operate; staff shortages fostered international recruitment and migration.
 - **Financing of health-care delivery:** financing was conditioned by countries’ GDP, but the amount allocated did not indicate the quality of services, equity of access and the health outcomes; distribution between public and private expenditure was important as well as the system of payment; remuneration of staff was central for financing.
6. Chapter 2, “Institutions, capacity and effectiveness of social partners in social dialogue”, concerned the following main themes and points:
- **Social dialogue as an approach to labour relations:** social dialogue went beyond collective bargaining; it was a continuous process of participation among social partners and helped in the prevention and resolution of disputes.
 - **Categories and types of institutions in social dialogue:** there were formal, informal and virtual institutions, cross-sectoral and sectoral and national, local, enterprise and international levels; social dialogue in health services was embedded in wider health policy and supported by dialogue with users.
 - **Government structures:** in health services the government was employer and regulator; the central issue for social dialogue was how to initiate and to sustain reform processes which lead to quality and cost-effective health services.
 - **Employers and their organizations in health services:** there were decentralized public employers, private non-profit employers, private for-profit employers, as well as partnerships across various types of employers; sectoral employers’ organizations were now emerging; central issues for social dialogue included: recruiting and retaining qualified staff and cost containment.
 - **Health workers and their organizations:** in some countries there were no public service unions, in other countries a high degree of unionization; there were also

challenges to union unity; central issues for social dialogue included: lifelong learning, work organization, pay systems and gender equity.

- **Capacity for social dialogue:** Prerequisites and criteria included: ability to engage in social dialogue; political will to engage in social dialogue and mutual respect among the social partners; a concrete agenda on economic, social and labour issues; various interrelated levels of social dialogue.
 - **Indicators for effectiveness of social dialogue:** a degree of satisfaction for all stakeholders; improved health outcomes; the indicators to be developed through social dialogue.
7. In closing, the Executive Secretary reiterated the 11 questions which the Office proposed as the basis for the Meeting's points for discussion, which were contained at the end of Chapter 3 of the report.

General discussion

8. The spokesperson for the Government/Employers' group observed that many different views were held on the definition of social dialogue in terms of who were the partners and what were the essential elements which constituted such dialogue. Too wide a focus, however, might result in delays. Among the major issues which needed to be discussed were the minimum rights of patients and the drain of trained personnel from developing to industrialized countries. Depending on the relative situation between countries with different levels of development, the focus of the discussion would shift. However, the basic question was to agree on the means to secure basic health-care rights without eroding workers' rights.
9. The representative of the Government of Kenya complimented the Office on the clear, focused report that it had presented, and welcomed the opportunity for an exchange of views among ILO constituents. Health services over the past two decades had evolved into very complex systems, firstly towards decentralized structures as well as privatized services with the aim of providing more efficient delivery of health-care services, and with more responsibility falling on local government. However, the challenge for the social partners was how to deliver such health services but at the same time offer decent employment and working conditions to staff. In Kenya, social dialogue was the best mechanism for achieving the involvement of all parties concerned. It was necessary for health services workers to have a clear picture of the approach which was being implemented in setting up new systems. Therefore, it was an obligation for the social partners to recognize their own role, the challenges for social dialogue and each other as partners in such dialogue. Indicators had to be established to assess the effectiveness of such dialogue. The evidence drawn from good practices was the most convincing means to achieve the end in question. The portfolio of health services in Kenya fell under the authority of the Ministry of Health. The Government of Kenya recognized that good health was a prerequisite for rapid development and successful industrialization. It had been investing in health personnel and health infrastructure in general, particularly aiming at the creation of an enabling environment for a sustainable health-care system, affordable and accessible to all Kenyans. The Government planned to decentralize the decision-making organs, resource allocation and management of health to the district levels to allow for greater participation by the communities concerned in management of health services. The emphasis was on a preventive rather than a curative approach. Private companies and NGOs had also invested in health-care services. Social dialogue had been conducted in a cordial fashion between the social partners in accordance with the prevailing labour laws; sound labour laws were essential in the social dialogue process. The Government

vigorously enforced the industrial relations section of the law, first as regards resorting to dispute settlement mechanisms before resorting to strikes and lockouts. The Government was also committed to maintaining sound labour relations through application of the measures laid down in a policy document negotiated and signed by employers, workers and the Government, providing thereby for the registration of trade unions along industrial lines. The day-to-day role of the Government in promoting sound labour relations was governed by the Trade Dispute Act of 1965, revised in 1980. Under the Act, parties to a dispute could either reach an agreement through their own machinery or report a trade dispute to the Minister of Labour. Final arbitration was pronounced by the Industrial Court of Kenya.

- 10.** The spokesperson for the Workers' group thanked the ILO for holding such a meeting which afforded workers the opportunity to meet with their government and private sector counterparts. There were indeed many different interpretations of social dialogue. However, emphasis must be placed on the importance of freedom of association and collective bargaining which were essential in building social partnerships. It should be remembered that in many parts of the world, workers did not enjoy even such basic rights.

- 11.** An observer representing Public Services International (PSI) congratulated the Office on a comprehensive and pertinent report which raised issues that were central to the interest of the Organization. PSI represented 617 member organizations in 147 countries with a total membership of 20 million members, one-third of whom belonged to the health sector. PSI was kept informed of developments worldwide and of the impact which restructuring in the sector had on the workforce. While there were wide variations, PSI was deeply concerned that reforms were not adequately taking into account the views of workers or the impact that the proposed reforms would have on them. Even in the vast literature circulating on the subject, references to workers' issues were few and far between. Despite the scarcity of information, a stand should be taken on the question of sustainable, quality health services delivery for all. By no means should such delivery be just a short-term fix responding to a financial problem or political constraints. As recorded in the conclusions of previous ILO meetings, if reforms were to be successful, they must, from the outset, involve and motivate those people who were to implement them. Social dialogue was an inclusive process where all the different interest groups must have a voice, and was of particular importance in the health sector where there were many specializations and hierarchical distinctions between different levels of workers. The very nature of the reform process itself had fragmented the workforce and led to confusion in the employment relationship. The World Bank and the International Monetary Fund (IMF), as well as donor governments, had also undermined the collective voice of workers by promoting models of reform that set out to ignore and actively discourage the proper incorporation of trade unions in social dialogue. In developing and transition countries, in particular, workers wished to know why they were not consulted in the reform process so that their views and experience could be taken into consideration, since they were the ones blamed if the reforms failed. Not surprisingly, in reviewing its reform programmes, the World Bank found that it had not achieved what had been expected. The issue of dialogue or lack of dialogue was a life or death issue in countries of Eastern and Central Europe where the nature of the top-down reform process had led to pain, suffering and premature deaths. Structures for conducting social dialogue might vary, but recent evidence from Zambia, recorded by the ILO InFocus Programme on Strengthening Social Dialogue, emphasized that certain conditions must be met if dialogue were to be a guarantee for a satisfactory voice for health sector employees. Among the essential conditions were genuine commitment by all partners, a national will to engage, clear agendas that met national priorities, the appropriate involvement of all relevant and interrelated levels, and strong and responsible partners, able and willing to participate. While the scope for the trade unions to participate was clear, their contribution would depend on whether they could stand up to the threats they faced and support their claim to be strong, independent and

valid social partners, and whether they enjoyed the same input of public training resources as did managers. PSI believed that, as worker representatives, its members must be treated as genuine social partners in all major socio-economic planning and decision-making; as partners in full social dialogue. If the government respected those principles, trade unions could then consider any proposition because they would be able to negotiate in an atmosphere of genuine social partnership. The Meeting should offer an opportunity to reaffirm the achievements of previous meetings in terms of the principles of reform and dialogue, namely that all social partners should be committed to work effectively together in order to take back with them meaningful outputs. The ILO should consider the following as priority areas:

- Formal commitments by international agencies and bilateral assistance programmes to fostering work within tripartite structures.
 - Government commitment or action for the following:
 - encourage national unions to review and participate in drafting situation analyses and country reports that provide the basis for developing aid and loan agreements before they were signed;
 - support research on levels of unionization and de-unionization in the private sector and in parallel health systems and to sponsor review of trade union support in the implementation of policy recommendations;
 - establish tripartite structures that include trade unions and employers, ensure the involvement of all levels and branches of government and health services management, and lobby extensively to build genuine acceptance of the social dialogue approach;
 - develop specific and appropriate priorities for the tripartite structures to address and monitor progress against the agreed agenda;
 - pass legislation enshrining the right to union membership and recognition of unions by employers, with special reference to the private sector, parallel health services and small establishments such as general or dental practices, and work with unions and professional associations to identify mechanisms which would ensure full representation of disaggregated workforces;
 - reassert the role of collective bargaining, confirming the statutory provisions in national and sub-national negotiations;
 - balance the role of purely professional associations in standard setting, training and negotiations on remuneration and bonuses with proper consultation with unions, and mandate insurance bodies to do likewise; and
 - maintain and strengthen bipartite structures at enterprise level to ensure full consultation on the details of specific issues relating to work, jobs, and employment and skill reproduction.
- 12.** An observer from the International Federation of Employees in Public Services (INFEDOP) referred to the Nursing Personnel Convention, 1977 (No. 149), as the reference which should be used to draft national policy with regard to nursing personnel. However, discussions had been developing along two lines: that of neo-liberal ideology whereby prosperity took precedence over social rules and worker protection, and the social and labour component only represented a cost item; and the other aligned on the values of the welfare state which held social protection as the supreme principle which, if respected,

afforded everyone a place in society. While it was not easy to strike a balance between the two stances, it was worthwhile that consultations took place among the social partners in such a forum. Conventions Nos. 149 (Nursing Personnel Convention, 1977), 98 (Right to Organise and Collective Bargaining Convention, 1949), and 151 (Labour Relations (Public Service) Convention, 1978), were relevant to the issues to be discussed in terms of shaping policy. Above all, the principle of universal access was the prime consideration in policy determination. Patients were now more aware of their rights, including medical liability. At the same time, ideas were emerging in terms of new health services design, but they were time consuming, and in the process cost again was a major consideration. Labour represented the major cost component of labour-intensive health services, so in cost-cutting measures, labour was usually the first target in an effort to reduce staff. Effective management could instead lead to satisfactory results. The sector also suffered from a lack of trained personnel and a poor image. In terms of career prospects, training possibilities and nature of employment contracts, the sector needed to review its personnel policies. In particular, caution was needed in defining the term “flexibility”, which in INFEDOP’s view meant taking into consideration staff aspirations and the quality of health services. At the same time, a distinction had to be made between the government, as managers of a nation, and private sector employers. It was fundamental in all texts that the term “employer” be defined; nor was it simple to break down the different issues involved in social dialogue into different themes since, taken together, they were part and parcel of a single concept. Nevertheless, one principle remained primordial: in the area of health-care services, social concerns held sway over economic considerations. Social dialogue should address the main issues in the sector: working conditions, both material and other; workplace attitudes; lifelong learning; recruitment; staff retention; attractiveness of jobs in the sector; and the workload. Objective national criteria which met national standards should determine who were the players in worker-employer social dialogue, whereas genuine democratic processes would be hindered by ad hoc or one-sided decision-making. The social dialogue agenda, its implementation and follow-up should be the outcome of a joint effort. It was also important that informal decision-making processes be made formal, for example that labour disputes be referred to dispute settlement mechanisms. Good health care certainly had a price but one that was affordable. While ILO standard setting had covered a certain amount of ground in the health services sector, much work still needed to be done. Solid dialogue and a spirit of partnership could produce sustainable and quality health services which could meet social policy challenges.

13. An observer representing the World Health Organization (WHO) declared that his organization was collaborating with the ILO in several areas, including social dialogue. Further research on the subject was required. For instance, health systems required physical and technical resource inputs; what therefore was the optimal balance of research and appropriate investment strategies? There were inconsistencies among countries in the ways in which human resource policies and strategies were developed and implemented. These matters often resulted in tensions and even conflict among professions. Similarly, investment decisions had long-term implications; six or seven years were needed for training health personnel, so it was important to think ahead. Investments were also subject to political interference, and they affected geographical distribution of resources and services as well as other systems. The WHO was developing a framework which would afford a better understanding of the different issues and linkages between the human resources needed for health and the health systems. Further research was required to see how health workers functioned as a team, how they were utilized, and the different issues involved in the labour market. Other questions needed to be scrutinized, for instance how professions were regulated, how the health-care system performed, how it achieved its goals, how it responded to the legitimate expectations of the population, how it was financed, and its different functions. Among the key issues to be addressed through social dialogue which were currently under examination in the WHO, in the forefront was the need to scale up health intervention, for example by immunization. Second, certain

imbalances needed to be addressed, for instance the geographical imbalances resulting from the influx of trained health personnel from developing to developed countries, and the public health workforce. Another question was working conditions, for example the impact of HIV/AIDS on health workers who were in the frontline of dealing with HIV/AIDS problems. Third, the linkages between education and the provision of health-care systems called for examination. The WHO and the ILO were already collaborating on certain projects, for example setting up a better data observatory of health workers in health sector reform for the purpose of developing policy options.

Health services and understanding social dialogue

- 14.** The spokesperson for the Workers' group noted that at the October 2001 Joint Meeting on the Impact of Decentralization and Privatization on Municipal Services, social dialogue was not taken to be a single event but a continuous process that did not end once reform had taken place. Several Worker members supported this view with a description of experiences at the country level; and an emphasis on all partners reaching a common understanding. Social dialogue was a time-consuming but rewarding process that would result in stakeholder ownership of decisions that were taken. Public and private sector employers had to go beyond traditional collective bargaining to consider problems before one side came forward with a solution. The notions of free association and involvement in collective bargaining were equally important. A Worker member from a German services union took the floor to explain that social dialogue was related to negotiations on working conditions, and cited examples of European Commission directives and regulations related to social dialogue. These directives talked about part-time work and occupational safety and health issues in the context of social dialogue. In Cameroon, social dialogue was not only an ongoing process but an important one to avoid social conflict. It meant that each side had to respect the other, but employers often carried a greater financial weight and influence which in turn meant that dialogue was distorted and ineffective. When the State was the employer, power and influence could be used to ensure that social dialogue did not take place. Thus, the rules of equality had to be concretely defined for everyone or social dialogue would be meaningless. From the experience of South Africa, negotiation and bargaining were seen to be important as consultation was not sufficient; in addition, once reached, agreements had to be implemented. Employers and workers could be helped to cope with processes of change through social dialogue. Through empowerment of all partners, quality care could be delivered to communities.
- 15.** Another Worker member argued that social dialogue could only be realized if health care was first recognized as a basic right. In the United States, 44 million people had no health care, and costs were rising by double digits. Private and government partners shared the view that health care should flourish in the market-place where workers would find the service niche that suited them. True social dialogue meant that the social partners grappled with major issues like improving access or debating whether health care was a right or a commodity. In the United States there were currently no debates about what ought to be done. Worldwide, health care systems were in crisis, with major shortages of qualified nurses and other health professionals. The status quo could no longer be sustained. In that respect, the Kaiser Permanente initiative in the United States that recognized unions and employers as equals at the negotiating table should be seen as an example. The results of that cooperation were a significant breakthrough that proved social dialogue was possible and did bear fruit if there was commitment to health care as a human right.
- 16.** A Worker member from France indicated that ideas expressed within his group differed but were not contradictory and could for the most part converge. Initiatives taken in the health sector had to be accompanied by social dialogue. The key elements to successful dialogue included knowing who would be around the table, what the prerogatives of the various parties were, and what power or authority they had. There had to be tolerance and

acceptance of the fact that the same interests would not always be shared. Social dialogue should cover all health-related subjects. The current Joint Meeting proved that the social partners could sit and talk about access to health for all.

- 17.** The spokesperson for the Government/Employers' group informed the Meeting that no conclusions had yet been reached on definitions. The Employers' group was carefully considering social dialogue around issues and language as the group wanted to take as broad and inclusive an approach as possible. While the task was challenging, positive results were beginning to emerge from the small working groups set up by the whole group to consider the questions. An Employer member questioned whether everyone understood social dialogue to mean the same thing. Was it confined to collective bargaining or did it go beyond that, as one Worker member seemed to imply? Social dialogue in the health sector had nothing to do with negotiations on wages or working conditions in general, and consensus would not be reached if the term was overloaded with these issues.
- 18.** The representative of the Government of Kenya stated that social dialogue included all forms of interaction between the three partners. It was a necessary tool for improving employer/employee relationships at work. It was also a continuous process for solving conflict at the workplace, providing for discussions on topics of common interest to all three social partners such as wages, terms and conditions of employment, disciplinary procedures, occupational safety and health, and training policies.
- 19.** The representative of the Government of Switzerland cautioned the Meeting not to immediately become engaged in a discussion that would expand the notion of social dialogue. While the quality of service and care were important issues, within the framework of the ILO's competence, the focus had to be on working conditions in the health sector. A step-by-step approach was the best way, as it allowed for a foundation to be laid and built upon. In a discussion on labour relations, it was important to know who the partners were so that working conditions could be improved in the widest terms. Including the aspects of financing or access to care would lead to a broader discussion.
- 20.** The representative of the Government of Cyprus agreed that it was important to view social dialogue in the context of labour relations and what it should be. With reference to the background report, it was also important to note that public sector reform was unlikely to achieve goals set due to the impact of structural adjustment; so, in this respect, one could not define social dialogue in terms of labour relations alone.
- 21.** The Secretary-General provided further clarification on the ILO's working definition of social dialogue by referring to the background report prepared for the meeting (p. 64). Intended to cover a number of phenomena in the broadest sense possible, the working definition was used in the ILO's programme and budget document three years ago at the time when the Social Dialogue Sector was established. It included, for example, negotiation, consultation or an exchange of information between and among the three social partners. Questions of working conditions, wages, working time arrangements and leave were covered, it involved tripartite or bipartite negotiations at central level, and covered negotiations on labour relations at the sector or enterprise level. The idea of collective representation, as expressed in the ILO's Workers' Representatives Convention, 1971 (No. 135), was important.
- 22.** The spokesperson for the Government/Employers' group informed the Meeting that once consensus on the first discussion point had been reached, the group would move on to address the second point concerning issues for social dialogue; points 2 and 3 could actually be taken together. An Employer member stressed a firm commitment to social dialogue and cited its importance in the strengthening of social partnerships in Germany for decades. Reiterating that it was difficult to respond to the second point, without

consensus on the first point being reached, the member expressed the view that the third point should go further by including reference to all employers and all workers as they had to finance the health sector and they needed, therefore, to decide on the appropriate health system.

- 23.** The spokesperson for the Workers' group indicated that issues related to social dialogue were defined according to what boundaries had been set, and what legitimate interests were being pursued. Understanding what issues and circumstances were being protected was necessary because dialogue often broke down at the early stage of setting the agenda for discussion. Governments tended to involve workers only after policy decisions had been made or to give credit to the impression of a shared reality. In other cases, workers were used to ensure the process of introducing social policy reform would be a smooth one. To arrive at win-win situations, workers needed to identify which were the most important issues to advance their interests such as lowering costs and promoting quality of employment. Financial support from other parties could also be sought. Ultimately, all social partners had to be involved at the most relevant level. A Worker member pointed out that in situations of economic difficulty and extreme poverty, social dialogue also covered the notion of social exclusion. In Panama, those who did not have access to health care needed to at least be assured of access through social dialogue. Another Worker member questioned how access could be ensured if there were no means provided. Resources should not just be allocated to health care but to those working in health care as well. If workers were not consulted, it was not possible to achieve social dialogue because emphasis needed to be on health workers, their wages and working conditions as well. In addition, problems such as the migration of skilled workers to other countries would not be addressed without social dialogue.
- 24.** The Worker member from Barbados argued that in a globalized world with global challenges, some countries were faced with distorted health services. Social dialogue was seen to have the potential to contribute to the development of health services in five important ways. Firstly, it could contribute to the development and reorganization of health service delivery and health-care standards, which would include financing, quality assurance, information systems, maintenance and assessment of technology, drug management and disaster management. Secondly, it could contribute to human resource development, looking at issues like job mobility, training and competent management of health services. Thirdly, social dialogue could contribute to the promotion of good nutrition, environmental care and food security. Fourthly, social dialogue could promote a high-quality institutional focus on the patient through better service delivery at the acute secondary and tertiary level, and bipartite alliances could be strengthened. Finally, through social dialogue, donors could be brought on board to support health sector reform by providing finance for research and equipment, as well as technical services, among other things. Governments and employers should understand the vital role of trade unions in social dialogue if there were to be benefits for society as a whole. In closing, the spokesperson for the Workers' group reiterated that relevant actors should be involved for appropriate discussions at appropriate levels. Access to health care was, for instance, a wider discussion involving central level partners. Employment issues would involve a closer partnership at another level.
- 25.** The spokesperson for the Government/Employers' group, returning to discussion point 1, stated that her group did not have a definitive answer, but rather put forward the suggestion that all matters concerning the health sector should be included in social dialogue, with each actor having the right to submit issues and all stakeholders setting the agenda together.
- 26.** The representative of the Government of Switzerland characterized the Government/Employers' group's debate as having encompassed a broad range of views

and emphasized that the goal of social dialogue was not to deal with the health system in its entirety or with the reform of that system. Adhering to the definition proposed by the Officers of the Government/Employers' group, which focused on labour relations, was the best proposal. Although there were interactions between the health-care system and labour relations, expanding the scope of the definition to include all aspects of the health system was simply too vast to be useful.

27. The spokesperson for the Workers' group welcomed the definition of social dialogue put forth by the Government/Employers' group. Referring to the discussion of the previous day, he reiterated the Workers' opinion that social dialogue should include a wide range of issues. The most important factor, however, was the actors involved, whether this was a wide range of groups, such as in the case of health provision, or a more limited number of actors.
28. Addressing again discussion point 2, the spokesperson for the Government/Employers' group suggested a role for governments as facilitators for continued dialogue, with a legal framework providing the structure to that dialogue. Suggestions as to who should set the agenda included allowing all the parties to have input towards the agenda, as well as having a general authority set the agenda.
29. The representative of the Government of Tunisia added that points 2 and 3 were very closely linked and rested on the need for the creation of a legal framework that would establish administrative and eventually medical bodies, specifying which bodies would deal with issues at the national, the regional and even the microeconomic level. The goal of this institutionalization of social dialogue would be the creation of a system of communication for all the actors in the health services. He used the example of Tunisia, describing that country's 1991 health reform, whereby specific bodies were created to allow for debate by all the stakeholders on various health issues. The feedback from these various institutions permitted a fluid exchange of ideas among all the social partners. The reform of the Tunisian health insurance system currently under way, aimed at improving the quality of care and providing access to it for all citizens, while keeping health costs in check, has defined the direction of social dialogue between all the social partners concerned. A national health insurance commission was established by the Government in 1996, incorporating all the parties involved in the health-care system, namely ministerial departments, social security funds, occupational organizations, workers' and employers' organizations, representatives of the health professions, the consumers' organization, etc. The aim of that body for social dialogue was to participate actively in the establishment of a new health system that would better respond to the aspirations of the citizens and the expectations of the various social partners, while taking into account the capacities of the country.
30. A Worker member, speaking on behalf of her group, addressed issues raised by discussion point 3. First, concerning recognition of the representatives of the social partners, this question was tied to the idea of legitimacy; if there was clear legitimacy, then the sustainability of the social dialogue was assured. What workers wanted was a voice in who their representatives would be and in the methods adopted in choosing those representatives so as to assure the most legitimate representation possible. Also important in this process was the formulation of clear criteria on who should represent workers, especially given the number of organizations representing workers and the need for a united voice. If there was to be accreditation, then governments should consider the national organizations or workers' centres with the most expanded coverage, including coverage of the informal sector. She presented the example of the Philippines where alliances were formed among labour organizations and the Trade Union Congress of the Philippines in order to attain a more unified representation. This alliance also worked in concert with the national professional health organizations so as to expand representation

even further. Since the situations in other countries varied, governments and employers should not undermine the right of large professional organizations to be representatives in social dialogue, inasmuch as these organizations dealt with livelihood issues and had representatives that were elected by the workers. As to the question of which government levels should be involved, this depended on the circumstances. For example, terms and conditions of employment could be discussed at the local level, whereas budgetary questions should be addressed only at the national level. Employers, whether profit or non-profit, should be treated as one.

31. Another Worker member described the situation in the Russian Federation, where the Health Workers' Union was able to use social dialogue as an effective mechanism for resolving labour disputes. His country's social dialogue system was comprised of three levels: state, regional and institutional, with social partners clearly defined for each level. This system was the result of long negotiations that ended with the adoption of a Bill on social partnership, which legally bound together trade unions, employers and the Government. This legislation included a definition of trade unions as the workers' representative in social dialogue. It further specified the role of trade unions in protecting workers' interests, determined the procedures for signing agreements, and established liabilities for employers should they fail to participate in the social dialogue process or fail to implement outcomes of the process. This system was successful in resolving several major issues, such as the significant wage arrears owed to health workers. The system was also instrumental in ending plans to privatize Russian health care, and in the adoption of an employment programme to deal with the disturbances brought about by restructuring.

32. A Worker member, speaking on behalf of her group, addressed the issue of representation. Although this concept could be interpreted differently in different countries, it was important to keep in mind Conventions Nos. 135, 87 and 151, but particularly the Workers' Representatives Convention, 1971 (No. 135), Article 3, which stated:

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

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

This definition clearly showed the role of partners in social dialogue. It could be very dangerous, however, to provide only a partial definition that might result in the exclusion of certain workers' voices. This emphasized the importance of creating rules at the national level, that could also be carried across to the international level, which would allow for the clear identification of those participating in social dialogue.

33. The spokesperson for the Government/Employers' group in turn addressed the questions of representation and levels of government involvement, indicating that his group had enjoyed a lively debate marked by the expression of various points of view. The opinion that emerged was that in different instances there would be involvement from the local, regional and federal levels and that this depended on specific cultures and past practices.

34. Government representatives (Panama, Egypt) responded to earlier comments from members of their group. Although situations would vary from country to country, in Panama the Ministry of Health played the central role in guiding the process of consultation and dialogue. In Egypt, the process of health reform in the Egyptian Ministry of Health and Population was described, including some of the goals of this reform. In

order to achieve these goals, committees were established with representatives from other government ministries, not just from the Ministry of Health and Population.

- 35.** A Worker member, speaking on behalf of her group, stated that trade unions were the formal and legitimate representatives of workers and that, within trade unions, leaders were freely elected by the workers they represented. She asserted that recognition of the right to collective bargaining as put forth in the Right to Organise and Collective Bargaining Convention, 1949 (No. 98), was a prerequisite to meaningful social dialogue. In the United Republic of Tanzania, all health workers, both public and private, were represented by one union, which facilitated the creation of an effective mechanism for social dialogue. An example of this mechanism was a joint staff council with permanent representation from government and workers. Although in the United Republic of Tanzania workers were represented only by their trade union, it would also be possible to have representation of workers by a professional organization. This would be particularly pertinent in cases where trade unions were not permitted, although in these cases the professional organizations should be viewed as unions. It should be noted however, that Convention No. 87 protects the right to form trade unions. Concerning the involvement of different levels of government, this would depend on circumstances. While it was sometimes possible to discuss certain issues at the local level, other questions, notably those related to budgetary matters, needed to be discussed at the national level.
- 36.** Concerning discussion point 4, the spokesperson for the Government/Employers' group noted that "early warning systems" could take different forms: monthly social dialogue forums; effective and repetitive communications; and sensitization of the media on health-care provision to help the public understand, another linkage to effective communication. Various Government members (Kenya, Syrian Arab Republic, Tunisia, Malaysia) contributed additional measures which could be taken: follow-up on action plans; review of decisions already made in order to keep the dialogue process on track; standard setting and monitoring of minimum standards; establishment of indicators on decision-making which took into account all factors and interests, including the macroeconomic situation, different administrative levels and the concerns of patients; and more transparency by overcoming the cloak of secrecy during deliberations and planning stages.
- 37.** The spokesperson for the Workers' group noted the conclusions of the 1998 Meeting on Health Services, specifically the third one which called for reforms not to be imposed from above or from outside, and to be implemented in effective and efficient concertation with the workers' representatives. For an early warning system to be effective, workers needed to be involved at an early stage, not late, as had occurred too often in the past. This enabled workers who knew systems and their defects to be fully involved in devising solutions to problems in time. Did the lack of reference to trade unions by the representative of the Government of the Syrian Arab Republic for example, mean that such organizations did not exist; was social dialogue carried out in that country?
- 38.** A Worker member, noting that social dialogue had prevailed for a long time in Germany, provided recent examples of early warning systems use, including: regulation of training at the federal level and discussions over reform of the legislation in which representatives of the Ministry of Health, professional associations and his trade union representing workers were involved; the creation of joint government/union working groups at the level of the Länder to review and develop strategies to combat nursing shortages based on indicators; and the establishment of round tables a year ago with government, private employer and trade union participation to review health-care reforms and a possible new law. His union, VER.DI, had also undertaken a national campaign and reviewed the health-care programmes of political parties prior to discussing further reforms with the Government, though this was not the strongest form of social dialogue. That form was collective

bargaining, which itself could be an effective early warning system. The Employers were quite right to emphasize early communication as a basis for social dialogue.

- 39.** Other Worker members (Spain, United States, Barbados) offered their viewpoints on discussion point 5. One Worker member representing nursing staff opened the debate by suggesting that measuring quality in services was not easy. Negotiations in Europe focused on aspects linked to the quality of service and user satisfaction, but this was a very relative measurement, sometimes subject to user dissatisfaction with care providers and not reflecting a holistic view of the health-care system. Measurements of the quality of service should be realistic and the subject of negotiations to permit adaptation to change. Another Worker member felt that the dignity of workers had to be considered in this debate. Quality could be measured, including through user satisfaction, but the heart of the matter was the creation through social dialogue of adequate conditions for workers as the major players in the system so that they clearly felt the importance of their role in delivery of services. A third Worker member insisted that quality standards, employment and service went hand in hand. The ILO should assist governments in understanding the relationship between social dialogue, decent work and quality services. Trade unions in Barbados had been part of social dialogue for ten years and recognized the importance of involving all partners in ongoing public sector and health sector reforms. All partners were involved in dialogue over quality standards, particularly in matters pertaining to private enterprises: safety, standards, leadership, human resources, information management, care environment, education and training. Governments should establish national standards institutes and productivity councils with full participation of workers to monitor these issues.
- 40.** Other Worker members (United Republic of Tanzania, Russian Federation) agreed on the difficulties of establishing quality parameters. Ultimately, quality depended on assessments by users, civil society and health-care workers, and therefore on the quality of the human resources ensuring delivery. In addition to adequate financing, the salaries, working conditions, training and opportunities for social dialogue of health-care providers affected not only their retention in the service, but their motivation and thus the quality of their services. Agreements between the social partners conditioned quality standards which must also be enforced. Examples were cited of the involvement of trade unions in the Russian Federation in planning health-care budgets, managing medical insurance funds, participating in national training councils, including proposing new mandatory training standards for health-care workers paid for by employers, and participating in licensing commissions to certify health institutions.
- 41.** The spokesperson for the Government/Employers' group linked quality standards to medical ethics. Adding to this aspect, another Employer member admitted that it was difficult to set quality standards in services because quality was a process of development, changing as time went by. One could identify bad quality in the form of unsuccessful health care or worsening diseases. However, ultimately governments should establish mandatory quality standards, based on advice from employers' and workers' representatives. One also had to consider costs with quality and standards; were new procedures economically effective? Quality was also linked to health system competition, which should yield the best health-care products. Finally, health-care providers who did not meet certain standards should be excluded from the market.
- 42.** The representative of the Government of Switzerland echoed the sentiments that final decisions on standards should remain with governments, based on expert advice from professional associations and other health-care providers. Implementation of standards could be the responsibility of local levels, based on social dialogue. In monitoring standards, governments had the responsibility to carefully examine situations when social

dialogue was appropriate, and when the key decisions should be made by governments alone.

43. The representative of the Government of the Syrian Arab Republic reassured the Workers' group that in his country, a workers' federation with branches in various sectors and ministries sought, among many other things, to improve working conditions, provide incentives and help develop criteria for quality standards.
44. An Employer member agreed that quality was subjective but objective criteria existed to assure quality in clinical care and professional practice. With regard to staff, accreditation and credentialing, curriculum and training standards were important in Malaysia. With regard to clinical care, quality is assured by adopting/following/formulating CPG (clinical practice guidelines), consensus statements and practising EBM (evidence-based medicine). Indicators to monitor clinical care standards include, among others, infection rates, missed diagnosis (appendicitis), unscheduled return to the operation theatre and mismatched transfusion. With regard to non-clinical aspect of quality, operational indicators (for patient satisfaction) such as, among others, waiting time to see doctors, queuing for (e.g. hip replacement) operation, are used.
45. A Worker member agreed with some of the statements from the Employers, notably with regard to the State's responsibility to establish and monitor standards, involvement of the maximum number of stakeholders in defining quality and effective means to enforce them, including sanctions where necessary. These criteria were the basis for the establishment of the independent National Institute for Quality Assurance in the Netherlands, which operated satisfactorily, and for a similar system in Germany where the hospital association and doctors' association and insurance associations had developed a quality management based on transparency. Quality also had to be measured in relation to economic criteria, but the latter should not be the major determinant, particularly where no uniform conditions existed for competitive health services. His union, VER.DI, opposed profit-making in health services; health was a right, not a product.
46. An observer from the WHO indicated that in structural change decisions, her organization sought to fully engage health-care professionals and workers in policy dialogue. Often nurses and midwives, representing up to 80 per cent of health-care workers, were not involved in major decisions, and studies in Latin America had demonstrated that in such situations, the quality of health care suffered. WHO and the ILO should incorporate capacity-building aspects in their programmes to ensure involvement of a multidisciplinary health-care profession in decisions.

Health services and participating in social dialogue

47. The spokesperson for the Government/Employers' group initiated discussion on training programmes to develop social dialogue in the health-care sector. One Employer member thought that this should be designed to achieve specific goals such as how to resolve disputes. Communication and consultation skills, language, theoretical and practical skills, and information and communication technology were also of primary importance. Discussion point 6 would determine the outcome of the subsequent discussions. It was important to set some benchmarks which would facilitate reaching agreements on the kinds of training required.
48. On behalf of her group, a Worker member stressed the important role of the ILO in establishing benchmarks and best practices. Capacity building, too, was important for trade unions. In developing most training programmes for health-care workers in South Africa for example, both the Government and the trade unions had been involved. All levels of

training were equally important, as was flexibility. The Confederation of South African Trade Unions (COSATU), for instance, debated political, economic and social issues with the Government, but each party maintained its own peculiar status. As a result of good labour policies, the incidence of strikes had dropped. In cases where trade unions used their own resources for training, they were compensated by the Government, which in turn helped to avoid duplication. It was the responsibility of the Government to involve all stakeholders in the design of training programmes to ensure that they were effectively managed. It was a question of building trust and a long-term relationship, which in turn maximized the social dialogue potential.

- 49.** Another Worker member signalled the dangers of claiming that economic forces could dispense with the State and trade unions. In Yugoslavia, not enough experience had yet been accumulated in building democratic institutions. The ILO's standard-setting process and technical assistance were vital in promoting social dialogue in her country, both in Serbia and Montenegro. The trade unions were far from satisfied with the prevailing situation. The ILO's role in promoting social dialogue was important for all those who were confident that social dialogue would achieve the noble objectives of Yugoslavia, Serbia and Montenegro.
- 50.** A Worker member recalled that social dialogue in Venezuela had held pride of place in previous years but that it had recently broken down. Public sector workers had received sufficient training and information in Latin American and the Caribbean as they had been trained by the University of Workers of Latin America (UTAL) in matters relating to social dialogue in defence of workers' interests. The strategies of the Government of Venezuela had recently led to changes in labour legislation that, far from benefiting workers, had damaged their collective interests. They had consequently been denounced by trade union confederations such as the World Confederation of Labour and other international organizations at the 2002 session of the International Labour Conference. Sanctions had been sought against Venezuela for the violations suffered by the trade union organizations and their workers, and support had been received from other countries. In the health services monthly wages totalled less than \$130, which was resulting in ongoing poverty. Discussions with private sector employers concerning improvements in working conditions were proving favourable.
- 51.** Another Worker member considered that it was important to strengthen social dialogue institutions. Most health workers in the Philippines were not allowed to join trade unions or professional associations, yet a unified voice was needed for effective social dialogue. Each party needed to invest in proper training in such a way that social dialogue became an integral part of day-to-day activity. It was therefore important that the ILO assisted trade unions in capacity building so that health workers could have greater representation. In Asian countries, where social dialogue had achieved a certain level of success, auxiliary providers of health services should be included in the process. In the Philippines, the failure of the Government to properly consult health services workers in redeploying them had led to protest, eventually their reinstatement, and an outcome which was a waste of resources. Care should therefore be taken to avoid similar experiences in sectoral reforms.
- 52.** The representative of the Government of South Africa declared that the Government could assist in the delivery of training by adopting measures such as time off and on-the-job training. Quality workers meant quality work. It was also important to set in place an enabling environment where social dialogue could thrive and so enhance human resource development. Education and training authorities could also assist by filling any sector-specific gaps in training.
- 53.** The representative of the Government of Kenya considered human resource development to be crucial in strengthening social dialogue institutions if an organization's goals were to

be achieved. Workers needed to be properly trained, remunerated, and equipped with the tools and equipment needed to perform their jobs. Any effective training programme should aim to clarify different roles and responsibilities, undertake a review of human resources at district and provincial levels, develop guidelines on performance management, monitoring and evaluation and develop a district programme to train health personnel.

- 54.** An Employer member pointed out that all workers and employers could not be trained to participate in social dialogue, so individuals must be selected for such training. There should be no obstacles to such training in the sense that each partner should assume responsibility for training its own representatives, finding the resources and time off for such training. Another Employer member held the view that, in addition to the social partners, all users of health services, NGOs, and representatives of academia could contribute to the development of training programmes in social dialogue skills which were necessary to ensure professionalism at every level of the health-care system.
- 55.** The spokesperson for the Workers' group welcomed the proposal of the Employer member to ensure that time off was provided for training. A Worker member added that it was the responsibility of all partners to invest in the funding, time, facilities and diverse training costs required, but that it was particularly important for the employers and the governments to assist the social partners so that they could operate from a position of strength and independence. In some situations, frontline workers might be needed, but plenary representation might be required in others, so legitimacy and the level of representation were important considerations. The speaker provided an example of a Danish Technical Cooperation Agency (DANIDA) technical adviser based in the United Republic of Tanzania for the purpose of developing trade union bargaining skills among workers and trade union representatives. Social dialogue funding agencies would also be effective, with the added advantage that no party was solely reliant on the resources provided by another. Policy-makers, in collaboration with other agencies, including the ILO, should consider the possibility of introducing a module on workers' rights in the training curricula of health sector workers to sensitize them on industrial relations issues so that they could better appreciate their rights; thus empowered, the trade unions could play an even greater part.
- 56.** An observer representing INFEDOP noted that the quality of training in the health services sector had always ranked high in Europe, but was now taking on an even more important role. Workers were more and more left to acquire their training in their own free time and at their own cost. Yet properly trained workers were an asset, therefore at least a part of training costs should be covered during working time. Such measures would only have positive repercussions on the health services sector.
- 57.** In summary, the spokesperson for the Government/Employers' group expressed the view that there seemed to be agreement that all three partners should be involved in the planning process. However, other speakers wished to have other stakeholders included, such as users, NGOs and academia. An Employer member insisted on dispelling a basic misunderstanding: the debate was about training experts in social dialogue, and it was up to each partner to secure such training for its representatives. So it was by no means a question of granting or refusing training proposals.
- 58.** The representative of the Government of Panama recognized the importance of access to vocational training as well as to training in social dialogue skills. This was possible when the political will was in place, but attention should also be paid to the need to train civil servants to manage social dialogue.
- 59.** The spokesperson for the Workers' group summed up his group's opinion that social dialogue meant people working together, so training should be designed and delivered

jointly. If training became a question of opposing the employers, however, then social dialogue ceased to have any meaning. Social dialogue afforded the social partners a means to reach a solution, including on this issue.

- 60.** With regard to discussion point 7, the spokesperson for the Government/Employers' group stated that all three partners should be involved in the planning process and the setting of goals. One of the subgroups established by the Government/Employers' group indicated that the partnership should be extended to users and stakeholders, NGOs and academic facilitators. The type of social dialogue selected depended on the issues, the time frame and the process used. Consensus should be reached by all the partners based on national law and related to costs.
- 61.** On behalf of the French-speaking group of Governments, the representative of the Government of Tunisia stressed that a pre-defined environment naturally determined the rules of the game. Programmes could be developed on the basis of defined priorities, involving all the social partners.
- 62.** The representative of the Government of Kenya reiterated that planning and goal-setting should take place at the national, regional and local levels. The Ministry of Health had a role in preparing plans at each of the three levels, with formulated objectives and identified processes. At all levels, the social partners should be involved, reaching agreement on the time frame to achieve the objectives set.
- 63.** A Worker member, speaking from the experience of the Nurses Federation in Ecuador, stated that it was important to be well prepared for social dialogue. Training was therefore crucial. Governments as employers needed to invest in training those representatives who would be engaged in dialogue on their behalf, so that they would be able to respond to demands of unions and occupational organizations. The process should not be too long so that one did not lose sight of goals set; and partners should be clear about the process of, and their role in, planning, implementation and follow-up. It was vital that everyone, including professional associations involved in the process, should be united in purpose, but with the constant change of government in Ecuador that was difficult to achieve. The unions had made efforts to unify the different elements of the health sector but 60 per cent of the population were living below the poverty line and it was difficult to expect the poor to shoulder more economic burden for health sector reform. That was the problem faced by many Latin American countries.
- 64.** The Worker member from Barbados noted that governments had learnt the lesson that it was important to involve all the social partners, and so responses from all sides were on a par with each other. The nature and urgency of the issue, as well as the cost involved would determine how the process of social dialogue was planned. The importance of training was stressed by several Worker members, who reiterated that this was crucial to achieving a common understanding among the social partners. Since social dialogue in the health sector had to be seen as a continuous process that took place in an environment of constant change, planning had to be done on a daily basis. Good practice needed to be collected and disseminated, and partners, especially government, had to engage in dialogue without any prerequisite conditions. In France, for example, negotiations for the 35-hour week went smoothly but flaws were revealed in the follow-up process due to prerequisite requirements.
- 65.** A Worker member cited the example of a Danish social dialogue project that looked at other ways of organizing work in public hospitals that were mostly run by county councils. The project successfully built on joint decisions and binding agreements reached between the two sides, and was taken to the European level for replication. Two conferences had so far been held and a third was being organized at which the specific issues of recruitment

and retention, skills recognition, migration and general service could be items for discussion.

- 66.** The spokesperson for the Government/Employers' group began the discussion on discussion point 8 by reiterating that, depending on the issue, any one of the partners could take the initiative. For example, an issue of national significance could be initiated by the government but this depended on circumstances. A subgroup of the Government/Employers' group thought that it was important to set terms of reference which made it clear why a meeting was being held and what would be discussed. Another view within the Government/Employers' group was that open dialogue, involving other partners, should be promoted.
- 67.** The representative of the Government of Kenya insisted that social dialogue was mutually beneficial for all the social partners, so any one of them could take the initiative. The process was vital to realize the objectives of the organization and could begin at the level closest to where action was needed. A third party should be consulted in any dispute and initiatives started at the informal level could draw assistance from formal channels in accordance with national labour law.
- 68.** The spokesperson for the Workers' group emphasized that the issue for many workers around the world was actually being able to enter into dialogue in the first place. Freedom of association and efforts to engage in collective bargaining were sometimes met with harassment and potential arrest. The Republic of Korea was cited as an example where trade unionists had been arrested and denied their basic worker and human rights. The Workers' group deemed such actions unacceptable for a member country of the ILO.
- 69.** On the issue raised under discussion point 9, how to carry out dialogue, the spokesperson for the Government/Employers' group indicated that the government should facilitate and promote the process, through regular meetings of committees, subcommittees and task forces. Established institutions could also be secured. An Employer member stressed that all partners should be involved so that the process was an ongoing one that was shared.
- 70.** The representative of the Government of South Africa emphasized that social dialogue had to be carried out in good faith to ensure a meaningful interaction for all and to avoid unintended consequences. Citing the example of an employer who violated national labour law that stipulated consultation had to take place prior to the retrenchment of workers, the representative stressed that a rubber-stamping of decisions should not be disguised as consultation. Reiterating this view, the representative of the Government of Kenya repeated that social dialogue was a continuous process to be maintained at all levels. As a tool for dispute settlement, an open-door policy should be adopted and mutual consultation promoted.
- 71.** The spokesperson for the Workers' group complimented members of the Government/Employers' group and international organizations such as WHO on their willingness to work with workers' organizations and reiterated the importance of having strong independent social partners who recognized the role of the other partners as a prerequisite for meaningful dialogue. The right of health workers to organize freely and bargain collectively should be honoured, and resources – in terms of money, time, training and facilities – should be provided by governments ideally, so that all partners could operate from a position of strength and independence. Cautioning that European experiences could not necessarily be transferred to other parts of the world, the speaker did, however, cite the example of the United Kingdom whose Government provided funding to local partner initiatives that strengthened the capacity of representatives through training.

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- 72.** A Worker member from Estonia gave a general overview of the national context, highlighting the existence of good laws and strong unions representing doctors, nurses and other workers in the health sector. The ILO's Conventions had been particularly useful in raising Government/Employers' awareness of the rights of all workers in the sector. An agreement had subsequently been reached on minimum wages in the health sector following dialogue between the unions and the employers' organizations.
- 73.** An Employer member gave support to the suggestions made by the Workers' group but stressed that there should be no new funding agencies or bureaucratic institutions put in place. Social dialogue should be allowed to continue to exist without being forced to, or tied down by, new institutional frameworks.
- 74.** An observer from the WHO, based in Latin America, agreed that social dialogue was an important strategy for progress in the health sector. In the region, a serious problem had to do with continuity of governments, but in general, other bodies such as the training institutions and professional federations had also been involved in looking at qualifications, training and certification and legal migration. Work was also being done across 17 countries in the region to establish social dialogue on human resource issues. In the Latin American context, it was important to clearly define the issues requiring solutions; the State had to also invest in knowledge development so that the discussion and analysis of issues could be based on reliable information and statistics.
- 75.** At the Meeting's fifth plenary sitting, the Chairperson of the Meeting reported that the Working Party on Resolutions had met to consider the receivability of two draft resolutions submitted by the Workers' group. The draft resolution concerning access to health services as a human right (WPR/D.2) was declared receivable, but the Working Party decided that the draft resolution concerning the migration of health service workers (WPR/D.1) related to the agenda item of the Meeting and referred it back for consideration.
- 76.** The text of the operative part of the draft resolution read as follows:
- ... calls on the Governing Body and the Director-General of the ILO to:
- (1) promote the principles and full implementation of relevant ILO labour standards as part of the reform of the health-care sector;
 - (2) work closely with the WHO and encourage it to promote respect for the rights of migrant workers, especially those in the health services;
 - (3) cooperate with the World Trade Organization and relevant governments in promoting and securing the rights of migrant health workers through positive approaches to the GATS, Mode 4, negotiations;
 - (4) promote a study of specific activities relating to the migration of health workers from the special perspectives of the ILO;
 - (5) promote the universal coverage of health care for vulnerable populations such as migrant workers, especially women and children;
 - (6) call on governments and all employers in developed countries especially to pay workers a living wage and ensure good conditions so that the flight of health workers in those countries from poor pay and conditions does not create the vacuum which causes the brain drain of nurses, doctors, etc.;
 - (7) call on governments in developing and transition countries to pay health workers a living wage which is at least sufficient to become a disincentive to economic migration of health workers;
 - (8) call on all governments, using the services of the ILO where necessary, to develop national employment and health sector development policies so that they both plan for

the training of their health workforce and the managed immigration of workers needed for such workforce and sectoral development;

- (9) call on the governments of all countries which host people on the move between countries to ensure that these people, especially where they are health workers, are enabled to exercise all of the human rights, including trade union and workers' rights as well as access to education and health care, to which they are entitled under UN, ILO and other international treaties and conventions, and no less rights than those of people of the host country;
- (10) call on all governments and recruitment agencies which recruit workers from other countries, especially essential workers such as nurses, doctors and other health professionals, to commit themselves to ethical recruitment codes and principles, preferably bound in regulation or legislation, so that they do not exploit developing countries and their workers. Such instruments should be negotiated with trade unions representing health workers;
- (11) urge governments to establish education and information programmes for intending emigrant health workers, with input from trade unions;
- (12) bring to governments' attention the fact that health workers moving to another country on a temporary or permanent basis, as with other workers, have the right of freedom to emigrate and the right to return to their home country.

77. The representative of the Government of the United States, speaking for the Government/Employers' group, agreed that the report given by the Chairperson of the Working Party on Resolutions reflected his group's understanding of the events as they had transpired.

78. The representative of the Government of the Republic of Korea responded to comments made by the spokesperson for the Workers' group regarding the strike of hospital workers. He first stated that in the Republic of Korea the hospital sector fell into the category of the essential public services in the strict sense of ILO standards. Even though the strike started on 23 May 2002 and was still continuing, the Government had in vain, made every effort to resolve differences through dialogue. Not able to reach an agreement, the Korean Labour Relation Commission, which was an independent body, subsequently conducted arbitrations in accordance with the law. However, the hospital workers refused its decision, continued the illegal strike and asked the withdrawal of the decision. While the Government had attempted to protect the rights of the workers, there were other rights that also needed to be taken into consideration. In this sense, the Government decided to solve the situation in accordance with the law.

79. The spokesperson for the Government/Employers' group began the discussion on point 10 by presenting the varied views of her group. It was suggested that deviations from the planned process of social dialogue could be identified either by a subcommittee created for that purpose with members from all three groups, or by a third party selected by the social partners. Evaluation of the impact on the health services could be carried out by all three parties, with expert guidance as necessary, and with the involvement of international specialized agencies and civil society as needed. Another view was that such evaluation could be carried out by the Ministry of Health, with the help of independent experts. The indicators for evaluating this impact should be established by the social partners. Any required action should be initiated by all three partners, with any given partner taking the lead role, depending on the measures required. Such action could also be initiated by the Ministry of Health, with assistance as required from the social partners.

80. An Employer member stressed that although previous comments from the Workers' group had indicated the possibility of sharing work with organizations such as the World Bank or the World Health Organization, this should not be taken as a general appeal to include these organizations, since the latter pursued their own policies and it was not always

desirable to have organizational policies conflicting with the policies of individual countries.

- 81.** A Worker member described assessment and evaluation as continuing processes which should be initiated during the planning phases. It was important to ensure tripartite representation in any assessment body and to provide training in methods for all members of the assessment body. In that way, an activity was not evaluated solely by the same group that was carrying it out. Through continuous evaluation, the quality of assessments would improve, which in turn would lead to more effective actions. Another Worker member echoed these points, stressing that all social partners had a responsibility to monitor social dialogue.
- 82.** Another Worker member emphasized the importance of investing in health services and described public investment as a prerequisite to providing health services. Social dialogue could be used as a tool to ensure public support for how those investments were made, allocated and administered. It was also necessary to look at the yield resulting from each investment, for which social dialogue could prove particularly useful. If the social partners made a contribution to planning and administration, then governments and employers could benefit from their shared involvement and thus enhance the level and the quality of the overall service.
- 83.** A third Worker member stated that by identifying needs, social dialogue could play an essential role in dealing with staff shortages and training issues. She cautioned, however, that social dialogue alone could not solve all the problems. Governments had the final responsibility for organizing financial resources in such a way that the decisions reached through social dialogue could be implemented and managed. To ensure that workers fully benefited from social dialogue, it was necessary to have a regulatory system overseeing cross-border recruitment. The right for cross-border recruitment needed to be equal to the right of workers to migrate across borders. It was essential to protect the rights and interests of migrant workers and to prevent social dumping.
- 84.** Proceeding to point 11, the spokesperson for the Government/Employers' group indicated that her group was of the opinion that the first question of point 11 should have been rephrased to read "What resources are needed for social dialogue?", to which the answer would have been "financial and human resources". To answer the question as it stood, however, she stated that necessary resources could include experts, infrastructure, information technology, capacity building and financial resources. All three parties should contribute, to different degrees, to the mobilization of these resources through agreements, legislation and community participation, but governments should have the main responsibility for resource mobilization.
- 85.** An Employer member declared that with reference to point 11, it was not to be understood as a general appeal for complementary financial resources, nor for the creation of new bureaucratic institutions. Whether or not such measures needed to be taken or not would depend on the specific circumstances of any given country. He agreed that anyone participating in social dialogue should also participate in its funding, but added that allowance should be made for the participation of other groups such as non-governmental organizations.
- 86.** The spokesperson for the Workers' group expressed his general agreement with the comments of the spokesperson for the Government/Employers' group. He pointed out, however, that while the Workers would not object to the inclusion of the wider consumer community in social dialogue, they did not believe those groups should be involved in collective bargaining matters better suited to employers and trade unions.

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- 87.** A Worker member, speaking on behalf of his group, drew the Meeting's attention to the fact that although women comprised the majority of the health-care workforce, in most countries they continued to suffer discrimination, including unequal pay. With the commitment of the social partners, social dialogue could contribute to the elimination of that problem.
 - 88.** Another Worker member, reverting to the question of financing that had been raised the previous day, provided an alternative to the view expressed by the German Employer member. He cited the example of German legislation, whereby any training needed by workers was financed by the employers. Therefore if social dialogue were to take place at the local level, workers would need the tools to organize it and those tools would have to be paid for by employers.
 - 89.** An Employer member recognized that the social partners had enjoyed many years of fruitful social dialogue in Germany.
 - 90.** The spokesperson of the Workers' group urged care in choosing words since concepts were different around the world and translation had to be taken into account.
 - 91.** A Worker member called on the ILO to continue building on the existing body of work by focusing on policy development via consultancy and advocacy services, and by developing a programme of work to articulate linkages with other international institutions and governments for the purpose of applying social dialogue to decent work principles and quality services. The ILO should also consider providing technical support for setting up central funding agencies to provide training in principles and methods. Attention should be given to developing a code of practice on cross-border recruitment of health professionals.
 - 92.** Another Worker member expressed the view that both partners needed to mobilize their resources, but that if the trade unions obtained funding from donors, that would provide a further means of empowering workers in addition to the financial compensation already allocated to the trade unions for training purposes, as was the practice in South Africa. Resources needed to be invested in accordance with the capacity of each partner in a spirit of balanced engagement which in turn would optimize output.
 - 93.** A Worker member provided an example in the United States where management and workers, through the collective bargaining process, agreed to fund training by allocating 1.5 per cent of the growth payroll, and then developing programmes and policies around the needs and projections of shortages: which workers needed to be trained, what kinds of education were required. The funds were then negotiated and the training programmes implemented. Funds were also used as leverage which allowed the different foundations to share the obligation. Social dialogue afforded a non-adversarial and constructive approach, both in the public and private sectors.
 - 94.** The representative of the Government of the United States had been struck by the diversity of interests and needs expressed by all three partners, but at the same time found it encouraging that there were more similarities than differences among the small work groups in the Government/Employers' group.
 - 95.** The spokesperson for the Workers' group recognized the wide range of approaches and experiences brought to the fore in the Government/Employers' group, whose dedicated efforts had proved positive and helpful. The Workers on the contrary had adopted a more common position and a more cohesive approach and the group looked forward to the conclusions being drafted by the secretariat.

Consideration and adoption of the draft report and the draft conclusions by the Meeting

- 96.** The Working Party on Conclusions submitted its draft conclusions to the Meeting at the latter's sixth sitting.
- 97.** At the same sitting, the Meeting adopted the present report and the draft conclusions.

Geneva, 25 October 2002.

(Signed) Mr. V. Klotz,
Chairperson.

Conclusions on strengthening social dialogue in the health services: A framework for practical guidance¹

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness,

Having met in Geneva from 21 to 25 October 2002,

Adopts this twenty-fifth day of October 2002 the following conclusions:

General considerations

1. There is widespread recognition that social dialogue has great potential to contribute positively to the development and reforms of health services, even though it cannot be a panacea for all issues. Health services also require appropriate policies to be adopted by governments and international institutions. They need to be affordable and sustainably funded to provide for growing, changing and diverse needs of the whole population. Social dialogue can contribute positively to health service reform by enabling governments, employers' and workers' organizations and other policy leaders to draw upon their knowledge and experience. Dialogue with user organizations and other stakeholders should also be encouraged where it is appropriate.
2. The social partners each bring their own interests and concerns to social dialogue. While they have many interests and concerns in common, they also have competing concerns and interests. Social dialogue can improve their ability to go forward together where they have interests in common and can also contribute positively to reaching compromises about matters on which they have different views. Social dialogue in the health services is, however, based on certain values and principles to which all social partners subscribe. Patients' needs, professional ethics and affordable and universal access to health services are also fundamental components.

Health services and understanding social dialogue

3. Social dialogue in the health services may include all types of negotiation and consultation, starting with the exchange of information, between and among representatives of governments, employers and workers on issues of common interest relating to economic and social policy. These elements of social dialogue are crucial to the outcome sought by the social partners and their choice depends on this targeted outcome. A common understanding has to be reached on the purpose of social dialogue. Therefore, at the outset of a process of social dialogue, the social partners should have clear ideas on the elements of social dialogue to be included and who will decide on the inclusion of these elements.

Agenda of social dialogue in the health services

4. Social dialogue in the health services does not take place in a vacuum. It requires concrete economic, social and labour issues to be on the agenda. In principle all matters concerning

¹ Adopted unanimously.

the health sector should be included in the social dialogue. These issues should be identified and each social partner should have the right to examine such issues. In the health sector these issues are often related to institutional reforms, financing of health services, the quality of health services, working conditions, skills and lifelong learning, recruitment and retention of personnel, career development, pay systems and gender issues. All social partners should set the agenda together and hence agree on a number of questions in relation to the agenda of the social dialogue such as the issues to be covered and how the agenda for the social dialogue in the health services will be set. Women, who make up the majority of the health care workforce, continue in many countries to face discrimination, including inequitable pay. Social dialogue can contribute positively to addressing the issue and to enabling women to be proportionately represented in social dialogue institutions.

Representation of the social partners

5. A prerequisite for effective social dialogue is strong, independent and responsible social partners who recognize the legitimate roles and interests of each other, commit themselves to constructive engagement in agreed processes of dialogue and deliver their side of negotiated outcomes. Freedom of association and clear and transparent rules in each country in accordance with ILO Conventions Nos. 87, 98, 135 and 151 are essential.
6. The social partners in health services are in principle public authorities as regulators or as employers, private employers' and workers' organizations in the health sector. However, in view of the financial implications of the health sector for other government structures, employers and workers, other stakeholders beyond the health sector may also be involved in policy developments, except on matters properly the concern of negotiating and collective bargaining parties. The organizations or institutions which represent the groups in the health sector have changed over the past two decades. A greater variety of government levels are also involved. New private employers have entered the health sector and related services.
7. Social dialogue can take many forms and can operate at various levels, from highly structured national institutions to relationships in the workplace. The legitimacy and level of representation should be suited to the context and issues concerned, bearing in mind the stakeholders involved. The representatives of the social partners should be recognized as equal partners by each other.

Social dialogue in situations of structural change

8. Social dialogue has proved particularly important in situations of structural change and reform in the health sector. Such situations are particularly complex, however, and take a long time to evolve. They involve a wide variety of social partners who have to deal with a long agenda of issues. The task often appears to be so overwhelming that some of the social partners may not have the capacity and possibilities to participate to the full extent. Capacity-building should be promoted to equip social partners to participate in social dialogue. Difficult situations are better tackled if there is a continuous process of social dialogue to enable the partners to discuss issues long before they become urgent and thus to participate in upstream decision-making. Regular discussion forums, effective means of communication, sensitization of media and continuous professional analysis of prevailing problems will facilitate necessary change. The social partners in a given situation should therefore, *inter alia*, decide the following: the mechanisms that will provide for an "early-warning system" when reforms of health services are needed; who will be involved in

continuous consultations on reform processes; and who will provide professional analysis of prevailing problems.

Identifying and enforcing quality standards

9. All structural changes and reforms in the health sector should be geared to the overall goal of improving efficiency and effectiveness as well as the quality of health services and, to this end, raising the quality of and access to health services. To identify quality standards for health services is, however, a particularly difficult task which has to be tackled carefully and realistically and which will have varied results for different countries. In the health sector which is highly labour-intensive, the standards have to realistically include the quality and capacity of the workers in each country, a question which is closely related to decent work and social dialogue itself.
10. In social dialogue it is necessary to identify quality standards which are shared by all the social partners. Such participatory approaches to performance management will facilitate that quality standards and indicators of outcomes can benefit from the particular knowledge and experience of all stakeholders. A common understanding of quality standards has to be reached which should also be shared by groups beyond the social partners such as the users of the health services. Governments should set the framework for the development and enforcement of quality standards for health services. These standards should be developed in consultation with the social partners and scientific or other relevant expert bodies. All parties should observe and implement these standards. In order to assess the reality in a given situation, the partners will have, inter alia, to consider the following: the type of quality standards that should be identified; who will decide on the choice of quality standards and their enforcement; and what mechanisms will be used to monitor their implementation.

Establishing and strengthening institutions for social dialogue in the health services

11. Governments can facilitate and promote the process of social dialogue by laying down the framework to establish and strengthen institutions of social dialogue. Social dialogue is conditioned not only by legal and institutional provisions but also by human capabilities to initiate and maintain social dialogue. Dialogue can be promoted through education and human resource development, which in turn will strengthen the institutions for social dialogue. Training programmes should create among the social partners awareness about the values of social dialogue systems and knowledge about procedures as well as negotiation and communication skills. Training programmes should be developed by all social partners who would have to decide in a given situation on a number of elements such as: who will be involved in such training; how can the individuals involved be prepared for social dialogue; and how can they be trained while continuing to carry out their professional activities.

Planning for social dialogue

12. All stages of a process of social dialogue are interrelated and depend on each other. The stage of planning is, however, of particular importance and should be carried out through social dialogue itself. Planning for social dialogue in health services has to be based on the continuing analysis of the current situation in the health sector and has to be closely related to general processes of health sector reform. Planning has to anticipate the process of reaching a common understanding, of recognizing the social partners and of identifying

indicators for the effectiveness of social dialogue. This planning process has to be designed in advance and depends on the issues and the elements of social dialogue chosen for a given situation. Therefore, the social partners have to consider, inter alia, the following: who will be involved in the planning process; who should set the goals to be achieved through social dialogue; how should the agenda of social dialogue be set; how should the type of social dialogue be selected; and how should the time frame and different phases for social dialogue be determined.

Initiating social dialogue in the health services

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

Carrying out social dialogue

14. Social dialogue is a process to be carried out in good faith. If a process of social dialogue is well prepared and well planned in advance, it may appear as if implementation were just a matter of clear and well-informed action. However, in health services the implementation of the plan is often difficult and dependent on factors which may be beyond the complete control of the social partners. Therefore, to sustain support for these efforts, continuous attempts have to be made to adjust or reinstate social dialogue. To this end, the social partners should adopt a consensual approach to implementation. For a given situation the following should, inter alia, be considered: who will manage and facilitate the process of social dialogue; and what mechanisms should be provided to match the plan against reality.

Monitoring and evaluating the process of social dialogue in the health services

15. Planning and implementation are closely related to mechanisms of monitoring and evaluating the process of social dialogue in relation to the goals to be achieved. Already during the implementation process, action has to be taken to monitor implementation in the light of the initial plan agreed upon by the social partners. Indicators have to be set for this purpose. Substantial deviations from the plan need to be examined and evaluated in the light of the goals to be achieved. If the results are not satisfactory, corrective action has to be taken by the social partners.
16. Social partners have to be trained in methodologies for the monitoring and evaluation of the process of social dialogue. All social partners should participate in such process and appropriate institutional arrangements should be foreseen for this purpose. The initiative for the process may come from the Ministry of Health or other appropriate competent

authority; other stakeholders such as users, experts and international agencies may be included if so requested by the social partners. The following elements need to be taken into account: who should identify deviations from the planned process of social dialogue in terms of substance, timing, methodology and other aspects agreed upon; who should evaluate the impact on the health services; who should set the indicators for this impact; and who should initiate the action required.

Mobilizing the resources needed for social dialogue in health services

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

Proposed action by the ILO

Concerning practical guidance in strengthening social dialogue in the health services

18. The ILO should take action to:
- (a) create awareness among other international agencies about the close interrelation between social dialogue, decent work and quality health services;
 - (b) undertake case studies for awareness creation and training for social dialogue in the health services;
 - (c) develop social dialogue training programmes for social partners, including government representatives, and a module on health workers' rights which could be used in the curricula of education and training programmes for health workers;
 - (d) collect data and undertake studies on pay equity and the gender gap in the health services;
 - (e) consider the development of a database containing all relevant information on social dialogue in the health services to facilitate the process of social dialogue at the national level.

Concerning the migration of health services workers

19. The ILO should take action to:
- (a) promote for health service workers respect for the principles and rights contained in the ILO Declaration on Fundamental Principles and Rights at Work;

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- (b) undertake a study on social and labour issues relating to the migration of health workers with input from the WHO and with a view to its possible contribution to the report to be prepared by the ILO on migrant workers for the 92nd Session (2004) of the International Labour Conference;
 - (c) call on the governments of all countries which host migrant health workers to ensure that they are entitled to the principles and rights contained in the ILO Declaration on Fundamental Principles and Rights at Work as well as access to education and health care;
 - (d) call on all governments and recruitment agencies which recruit workers from other countries, especially essential workers such as nurses, doctors and other health professionals, to commit themselves to ethical recruitment codes and principles, preferably bound in regulation or legislation;
 - (e) urge governments and social partners to establish information programmes for intending emigrant health workers;
 - (f) bring to governments' attention the fact that health workers moving to another country on a temporary or permanent basis, as other migrant workers, have the right of freedom to emigrate and the right to return to their home country.

Part 2

Resolutions

Consideration and adoption by the Meeting of the draft resolutions

At its fourth plenary sitting, the Meeting set up a Working Party on Resolutions, in accordance with article 13, paragraph 1, of the Standing Orders.

The Working Party, presided over by the Chairperson of the Meeting, consisted of the Officers of the Meeting and three representatives from each of the groups. The members of the Working Party were:

Officers of the Meeting:

Mr. V. Klotz (Chairperson)

Mr. R. Tremblay (Government/Employer Vice-Chairperson)

Ms. D. Matebeni (Worker Vice-Chairperson)

Government/Employer members:

Dr. K.J. Lim (Employer member)

Mr. S. Mashkook (Syrian Arab Republic)

Mr. G.H. Moratorio (Employer member)

Worker members:

Ms. E. Ocampo

Mr. K. Øst-Jacobsen

Ms. R. Smith

The Working Party had before it two draft resolutions submitted by the Workers' group: the *Draft resolution concerning the migration of health services workers* (WPR/D.1), and the *Draft resolution concerning access to health services as a human right* (WPR/D.2).

The texts of these draft resolutions were discussed. In accordance with paragraph 2 of Article 14 of the Standing Orders, the Working Party decided that draft resolution WPR/D.1 concerning the migration of health service workers related to the agenda item and was to be referred to the Meeting for consideration, with a view to the possible incorporation of its substance in the record or conclusions on that section of the agenda item.

The text of the draft resolution concerning access to health services as a human right WPR/D.2 was declared receivable.

The Working Party met again to examine in detail the text of draft resolution WPR/D.2 concerning access to health services as a human right and amended it where necessary on the basis of proposals made by the two groups in a manner that would secure general acceptance.

At the Meeting's sixth plenary sitting, the Chairperson, in his capacity as Chairperson of the Working Party on Resolutions, and in accordance with paragraph 8 of article 14 of the Standing Orders, submitted a report on the deliberations of the Working Party on Resolutions and recommended that the Meeting adopt the revised draft resolution.

**Resolution concerning health care as
a basic human right**

The Meeting unanimously adopted the resolution.

Text of the resolution adopted by the Meeting

Resolution concerning health care as a basic human right¹

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness,

Having met in Geneva from 21 to 25 October 2002,

Recalling that the governments present at the UN World Summit for Social Development in Copenhagen (the “Social Summit”) committed themselves to give a high priority to health, especially for women and children and in rural areas,

Recalling also that the Social Summit recommended a reinforcement of cooperation between all competent international institutions, including the UN and its specialized agencies as well as the World Bank and the International Monetary Fund,

Recalling that the Declaration of Alma Ata of 1978 adopted by the International Conference on Primary Health Care reaffirmed that health is a fundamental human right,

Recalling the conclusions of the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reform in 1998,

Recognizing that health systems in some countries continue to remain in crisis – or even to be deteriorating from what were parlous circumstances,

Recalling that an effort must be made to improve the training, the access conditions to the profession and working conditions of people employed in the health sector, so as to guarantee the best quality of care,

Adopts this twenty-fifth day of October 2002 the following resolution:

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacities and Effectiveness calls on the Governing Body and the Director-General of the International Labour Office to:

1. promote to governments, the social partners and other key policy-making bodies the belief of the ILO, as expressed in the 1998 Meeting that: “the ILO considers health care as a basic human right and an essential requirement for improving working and living conditions”;
2. identify ways in which social dialogue can contribute to: (a) making health services more accessible to all sectors of society so that no person is denied access to essential health services;² and (b) improvements in the quality of such services;

¹ Adopted unanimously.

² “Essential health services” can be defined as “health service interventions that are considered important and that society decides should be provided to everyone. Values such as equity, cost-effectiveness, transparency and solidarity explicitly or implicitly underlie these concepts”. *Essential*

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3. assist governments and the social partners in ensuring that social dialogue in the health services incorporates the views, concerns and needs of women working in those services;
 4. work with other international organizations such as the World Health Organization, the World Bank and the International Monetary Fund in promoting discussions on the development of universal and accessible health services in developing and transition countries so that they especially involve all stakeholders, including employers' and workers' organizations³ and representatives of key user groups such as women and rural people;
 5. provide information to governments and the social partners on how effective training and lifelong learning on an agreed basis in the health services can improve the quality of such services;
 6. assist governments and the social partners, as concluded by the 1998 Meeting, in the development of a patients' charter and conscience clauses for workers;
 7. take into account the issues raised in this resolution in the future work programme of the ILO Social Dialogue Sector.

Health Service Packages: Uses, abuse and future directions. Current concerns, ARA Paper, No. 15, WHO/ARA/CC/97.7.

³ When the term "workers' organizations" is used, it refers primarily to trade unions.

Part 3

Other proceedings

Presentation on the Sectoral Activities Department one-stop window web site

Moderator: Mr. Dirk Belau, Industrial Specialist,
Sectoral Activities Department, ILO, Geneva

Presenter: Ms. Anamaria Vere, Web Site Development Specialist,
Sectoral Activities Department, ILO, Geneva

Ms. Vere provided an outline of the new “one-stop window” conception for the Sectoral Activities Department web site, which was presented officially to the ILO’s Governing Body at its June 2002 session. In contrast to the previous site, the one-stop window allowed easier navigation, much better possibilities for hyperlinks to other relevant ILO and external sources of information of a sectoral nature, and a more user-friendly design. Ms. Vere demonstrated how the improvements gave a better overview of the whole range of sectoral activities across the ILO for each of the 22 sectors, and allowed access to much information and data that were previously difficult to locate. Links to occupational safety and health material to the ILO’s flagship databases, to sector-relevant external websites and so on were illustrated. Participants were invited to provide comments and suggestions as subsequent users of the site.

Round table on workplace violence – A threat to quality health services

Part I: What is the problem?

Moderator: Dr. Alexander Butchart, Department of Injuries and Violence
Prevention, WHO

Panellists: Dr. Naeema Al-Gasseer, World Health Organization (WHO), Geneva

Dr. Mireille Kingma, International Council of Nurses (ICN), Geneva

Mr. Alan Leather, Public Services International (PSI), Ferney Voltaire

The International Labour Office (ILO), the International Council of Nurses (ICN), the World Health Organization (WHO) and Public Services International (PSI) launched in 2000 a “Joint Programme on Workplace Violence in the Health Sector” in order to develop sound policies and practical approaches for the prevention and elimination of violence in the health sector workplaces. Information gaps and cross-cutting themes were identified, country studies were launched and guidelines were drafted to address workplace violence in the health sector and to raise awareness on the magnitude and dimensions of the problem.

In her presentation on “International partnership to address workplace violence in the health sector” Dr. Al-Gasseer pointed to the cooperation between the four organizations. The study showed evidence that the personnel of the health sector was at a higher risk of violence as compared to other sectors due to a number of factors: staffing patterns; shift work; commuting to and from work at night; solitary responsibility when exposed to clients; highly accessible work sites with poor security measures; work with people in distress; home visiting; and various effects of the health sector reform.

There was clear evidence of important occurrence of violence: bullying was reported, e.g. by 40 per cent of the United Kingdom National Health Services Trust staff. A United States study reported that health-care workers face 16 times the risk of violence from patients or clients than in other sectors.

The origins of violence was multifaceted. Among the individual factors, gender prevailed. Other factors could be divided in environmental or situational factors, and factors related to the social, economic and political conditions bearing on health work. Definitions were not consistent, however, nor were sufficient data collected and analysed. Information had been found mainly in industrialized countries, but limited only to certain urban locations and to hospitals. Studies on developing countries, southern European countries, rural and community-based health services as well as outreach services were missing.

With reference to these information gaps, the Joint Programme initiated country case studies in Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand. The research work was based on detailed sampling to ensure the results from the national studies were comparable.

For the purpose of the Joint Programme's surveys, workplace violence was defined as "incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health".¹ It included physical and psychological violence, such as verbal abuse, harassment (sexual, racial, etc.), bullying/mobbing and threats. Country reports indicated a general common understanding of the concept of workplace violence, though cultural and linguistic differences needed to be addressed.

Dr. Al-Gasseer informed that the draft guidelines had been discussed at an international technical consultation and the revised document had been published as the *Framework guidelines addressing workplace violence in the health sector*. The four organizations were to disseminate the guidelines and support their use at country and institutional levels and hold consultations to prepare a model plan of action to combat violence in the workplace in the health sector. It was agreed that more research was needed on a range of issues.

Dr. Mireille Kingma summarized the findings of the country case studies carried out for the Joint Programme, based on a synthesis report which included additional findings from an independent Australian study.

The majority of the studies showed that more than half of the health personnel surveyed had suffered at least one incident of violence in the previous 12 months: 75.8 per cent in Bulgaria; 67.2 per cent in Australia; 61 per cent in South Africa; in Portugal 60 per cent in the health centres and 37 per cent in hospitals; 54 per cent in Thailand; 46.7 per cent in Brazil. The results showed that violence significantly affected all professional groups, both genders, and all work settings in the health sector but particularly ambulance staff, nurses and doctors. All health facilities were at risk, especially large hospitals in suburban, densely populated or high crime areas, as well as those located in isolated areas.

Psychological violence was more prevalent than physical violence, especially by staff, whereas physical violence was rather meted out by clients. The surveys confirmed

¹ Wynne, R., Clarkin, N., Griffiths, A. (1997). *Guidance on the prevention of violence at work*. Luxembourg: European Commission, DG-V.

the difficulties of establishing perpetrator profiles and highlighted the risks of generalizing and stereotyping.

Among the complex factors causing violence, Dr. Kingma stressed the importance of work organization such as staffing needs and workloads, and the impact of sudden reforms. Workplace layout, such as access to toilets, food and telephones played an important role as well. There was a strong reciprocal link between violence and stress.

The consequences of violence at the workplace in the health sector were devastating and went from the deterioration of the health care provided to the abandonment of the profession by many health-care staff. Often no established policies or reporting procedures existed, and therefore the reporting rate was very low. Perpetrators were frequently not prosecuted and the victims not supported. Measures taken focused on immediate responses such as security enforcement and improvement of the physical environment, but much less on strategic and organizational improvements.

Recommendations from the country reports included: better knowledge of the phenomenon and strengthened awareness raising; policies, legislation and plans of action at the local, national and international level; a participative approach; workplace planning based on workplace assessment; rehabilitation and reintegration of victims back into workplaces; and regular monitoring and evaluation.

Mr. Alan Leather referred to two studies done for the Joint Programme. Mr. Vittorio Di Martino's study analysed the relationship between stress and violence, identifying violence as a generator of stress, and negative stress as a cause of violence. Positive stress led to a desired adaptation of workers to the situation, whereas negative stress was distinguished as a physical and emotional response to situations when requirements of work did not meet with the available capacities, especially when the stress was intense, repeated, or when support was lacking.

Extensive restructuring by means such as privatization, decentralization and rationalization exacerbated the situation, as they were often accompanied by downsizing, layoffs, freezes or cuts in salaries, heavier workloads, less comfortable shifts, and more temporary and occasional work. A climate of violence may build up as a result of uncertainty, growing exasperation and vulnerability.

For certain types of violence, such as sexual harassment, victims were predominantly women who were vulnerable due to precarious, low-status jobs.

It was estimated that stress and violence accounted for about 30 per cent of ill health and accidents. The cost estimate of 0.5 to 3.5 per cent of GDP mentioned above was based on figures from the European Union, where the cost of stress was estimated to amount to €20 billion. In the United States, the cost of stress was calculated at US\$350 billion. Ten percent of the cost was attributed to violence alone. According to the study, the spreading of informal, precarious and marginal situations at work increasingly called for action that would be cost-effective and fit into the socio-economic development of the workplaces to enhance further initiatives. The emerging approach focused on the elimination of the causes of stress and violence rather than on the treatment of its effects.

The study also highlighted the importance of social dialogue and a participatory approach with an active role for all parties concerned in designing and implementing anti-stress and anti-violence initiatives.

The second study, by Jon Richards, dealt with the management of the workplace violence victims. Government guidance recommended that all employers should have resources available for interventions. Governments also had initiatives to establish

statutory or mandatory reporting on incidents. Underreporting continued as workers believed that violence was just part of their jobs or they simply did not have time to write a report. Reporting needed to be made simple through standard forms. Victims needed to receive physical and mental health treatment as well as time off for recovery. Measures were necessary to reintegrate the victim in the workplace.

Discussion

A general debate on definitions demonstrated cultural and linguistic differences, but nevertheless the given definition had been accepted broadly in the countries where it had been tested and discussed. Psychological violence such as verbal abuse was manifest when it affected the dignity of a person and when it happened as repeated behaviour over a period of time. According to several studies, verbal abuse caused a high rate of absenteeism. Shift work, especially at night, increased the risk of violence for health workers commuting to work.

An Employer representative was surprised by the high figures (0.5-3.5 per cent GDP) given regarding the costs of stress and violence which were cited from a European study (Hoel, Sparks, Cooper). Companies realized that preventive measures and programmes addressing the problems might be more cost-effective. This was supported by a Worker representative from South Africa, giving an example from a hospital which dealt with psychotic prisoners, where short-term costs rose with preventive measures but savings accrued in the long run. Dr. Al-Gasseer highlighted the benefits of low-cost prevention measures for the retention of staff. Several studies on so-called “magnet hospitals” showed that an improvement of communication and staff relationships had a positive effect on the quality of care given to patients as well.

A Worker representative from Estonia asked how staff members other than ambulance staff, nurses and physicians were affected by workplace violence. In her country’s experience, non-medical staff were often regarded as inferior and many suffered from stress and violence. A worker representative from Germany reported that in German hospitals less-educated personnel tended more towards physical violence. Regarding hierarchy, there were examples where professors used their power to hinder professional careers, thus destroying the livelihoods of subordinates.

A Worker representative from Ecuador referred to the problem of inadequate legislation. She reported an incident whereby a nurse had been mistreated by a doctor, but only a law on the protection of women covered her case. She was detached to another section, and finally left the country. Mr. Leather confirmed that hierarchy is an issue in workplace violence and that all professional groups should be considered when addressing the problem. In many countries adequate legislation did not exist regarding stress and violence, and the expectation was that it was covered by general occupational safety and health legislation, as has been revealed by the Bulgarian case study.

Part II: Addressing the problem

Moderator: Prof. Cary Cooper, Institute for Science and Technology, University of Manchester, United Kingdom

Panellists: Ms. Christiane Wiskow, International Public Health Consultant, ILO, Geneva

Mr. Vittorio Di Martino, International Safety and Health Consultant, Ferney Voltaire

Mr. Graham Hewitt, Director of Human Resources, Wirral Hospital (NHS) Trust, United Kingdom

This session aimed at proposing ways in which violence and stress at the workplace in the health services could be addressed. Ms. Christiane Wiskow presented her study on the comparison of guidelines on workplace violence in the health sector, which also covered guideline implementation in some countries. Nine out of the 12 national or subnational regional guidelines looked at the health and social services industry in industrialized countries.

The guidelines had much in common. All were voluntary and of an advisory nature, focusing mainly on employers' responsibility. Most of the guidelines contained definitions covering physical as well as psychological violence. A distinction was made between aggressors external to the workplace, such as clients, and internal aggressors, such as co-workers, supervisors and subordinates. Specific guidelines for the health sector gave a strong priority to client-initiated violence. Internal violence was mentioned least.

The guidelines recommended a multi-component, organization-wide strategy based on a systematic risk management approach which addressed different phases such as identifying the problem, assessing the risk, controlling the risk, and reviewing the effectiveness of measures taken.

Measures were classified as preventive, protective and post-incident. Risk-control measures differentiated between attention to the physical environment, such as installing security devices, and improved work practices, such as information on and for patients, training and appropriate staffing. Description of protective measures taken at the exact times of incidents were somewhat neglected. Post-incident measures included providing support to the victim, and the reporting of the incident and the evaluation of measures taken.

A well-publicized, written policy was crucial. However, little information was available on evaluating the application of the guidelines, except for the United Kingdom and Sweden, where considerable action was taken by employers. Nothing was known on any staff response. Future guidelines needed definitions and glossaries, coverage of internal violence at the workplace and the evaluation of the impact of guideline implementation.

Mr. Vittorio Di Martino introduced the *Framework Guidelines of the ILO/ICN/WHO/PSI Joint Programme*. These framework guidelines, developed as a basic reference tool for policy development on violence at work, were intended to support all those responsible for safety in the health services workplace. Guidelines needed to be flexible in order to meet varying situations and cultural differences and need to be easily adaptable. They needed to promote the integration of violence prevention into enterprise cultures, offer guidance on how to mitigate the impact of workplace violence, how to care for workers affected by violence, and how to sustain the initiatives undertaken. Their

application should involve employers as well as workers in all subsectors and should concern all types of employment relationships including formal and informal, remunerated and voluntary work.

The Framework Guidelines recommended that policies should contain a definition on workplace violence and specify forms and actions of physical or psychological violence. Examples of physical attacks were beating, kicking, slapping, stabbing, shooting, pushing and biting. Examples of psychological violence were harassment, in particular, sexual or racial harassment, bullying, mobbing, abuse and threats. The use of terminology, however, depended on the national context. The term “mobbing”, for example, was used for bullying in certain countries where English was not the official language. The Framework Guidelines recommended reference to the rights and responsibilities of each of several groups of stakeholders such as workers and employers, governments, professional bodies and the community.

The approach to combating workplace violence proposed by the Framework Guidelines met a number of requirements. A participative, non-discriminatory approach which integrated all relevant aspects of the phenomenon and the subsequent actions to be taken, and which took into account cultural as well as gender-sensitive issues was recommended. A systematic approach was best achieved through a standard sequence of action, including the recognition of possible violence, the assessment of risk, an appropriate intervention to prevent violence or mitigate its impact, and the monitoring and evaluation of the effect of the measures taken.

The recognition of possible violence, in particular, required the identification of organizations at risk, of potential perpetrators and potential victims, without, however, stereotyping any group of persons. Recommended interventions were subdivided into three areas in the following order of priority: organizational intervention, such as impact on staffing, management style, information and communication, work practices, job design and working time arrangements; environmental interventions regarding the physical environment and workplace design; and interventions focusing on the individual such as training, assistance and counselling and the promotion of well-being.

Interventions after an incident should be foreseen in response plans, should be reported on and should comprise medical treatment, debriefing, counselling, sustained management support as well as representation and legal aid, and finally, rehabilitation efforts. Mr. Di Martino remarked, however, that interventions after an incident were long, costly and painful. Priority should therefore be given to prevention policies.

Mr. Graham Hewitt spoke about practical experience with anti-violence strategies in the Wirral Hospital (NHS) Trust, United Kingdom. He presented some figures on the hospital, which had over 5,000 employees. Violence was on the increase and had reached 271 incidents in 2001, five times as many as five years before. Four-fifths of the incidents had affected nursing staff. Increase in these figures was partially due to better reporting procedures and increased awareness of the staff. Assaults by patients were three times as frequent as assaults by members of the public, a fact which called for an in-house strategy.

The strategy of the Trust included awareness-raising, training, security measures and in general a zero-tolerance approach, which was intensively publicized. The hospital was fully supportive of victims and prosecuted perpetrators in every case. The hospital cooperated with trade unions to ensure that violence prevention was a high priority.

Training and counselling was available to any staff member who felt exposed to violent behaviour. Roughly 10 per cent of the staff had received training on verbal and non-verbal language to avoid provoking violence and on restraining perpetrators.

Hospital management had taken over the security services from an external provider to ensure better conditions for security staff, including adequate cameras and lighting. A sophisticated electronic security supervision system was installed covering the Accident and Emergency Unit. A special key pad system protected maternity and children's wards to prevent theft of babies as well as assaults on staff.

The zero-tolerance approach included refusing or withdrawing treatment from violent or abusive patients. Yellow and red cards were given like in football games. As this approach contradicted the accepted practice of offering treatment to all patients, it raised an ethical problem. Fortunately, patients who received yellow cards had immediately changed their threatening behaviour.

As a result, the staff was feeling more protected and believed that the situation was improving.

Discussion

The question of cost-effectiveness of violence-at-work initiatives was taken up again by Prof. Cooper, who gave additional information. A Worker representative from Germany stated that employers could be reassured that preventive measures would be cost-effective in the long term. He gave several examples of initiatives in Germany:

- in the entire public services sector, supervisors were to participate in mandatory training on mobbing (or bullying), the costs for which were borne by the employers;
- social dialogue regarding mobbing was encouraged. In many organizations, collective agreements had been reached;
- in some hospitals, psycho-social counselling services for victims of mobbing had been established;
- ongoing working groups were addressing psycho-social work risks, such as violence.

The overall result was that employer-financed workplace health promotion programmes showed positive results such as decreased accident rates and increased work satisfaction.

Many questions concerned practical aspects of zero-tolerance policies were presented by Mr. Hewitt, especially concerning the denial of treatment to violent patients. He explained that this policy was only in place very recently and no treatment had been denied so far. Experience showed that the patients who had been warned were shocked and changed their behaviour.

A Worker representative from Yugoslavia asked whether bullying had also been scientifically recorded. Mr. Hewitt replied that the recording of these incidents was increasing, although there was a reluctance to report bullying due to the nature of the problem. A formal reporting procedure tended to discourage victims since superiors were often involved in the bullying. Safe reporting systems were needed to encourage the reporting of incidents; on the other hand, however, many formal complaints were investigated and deemed unjustified.

A Worker representative from Ecuador commented that violence was prevalent in his country on a daily basis. Health services had to be considered as an integral part of the community, and similarly the community had a high interest in functioning health services. Dialogue within the community to find solutions was necessary. Promising examples from

other sectors could serve as models, such as a public transport company programme in France, which employed and trained young persons in high-risk neighbourhoods to ride company busses so as to defuse aggressive behaviour. Low wages was another problem related to violence in Ecuador. A basic salary for nursing staff was about US\$120, which obliged many nurses to hold second jobs

A Government representative from Hungary commented that staff training had to be improved in dealing with criminal behaviour. Patient charters could reflect a balance of patients' rights and responsibilities, and the ILO could assist and encourage governments in drafting these. Limitations of zero-tolerance policies were discussed.

A PSI representative referred to raising patients' expectations as a result of promises made by politicians, and wanted to know how the Trust tackled this problem. Mr. Hewitt explained that the Trust was cooperating closely with the media to promote a better understanding of the services, and that while improvements in health services were under way, changes were not immediate.

Closing speeches

The Deputy Secretary-General provided information on participation in the Meeting. The Governing Body had invited representatives from all interested governments, nine representatives from the Employers' group and 27 representatives from the Workers' group. The Meeting was attended by 29 Government representatives, 15 Government advisers, eight Employer representatives, 25 Worker representatives and five Worker advisers. Women's participation in the Meeting was at 37 per cent, and although this exceeded the Office's target of 20 per cent, it fell short in comparison to the percentage of women workers in the health sector workforce. The Meeting proved to be not only an important occasion to discuss social dialogue, but also an example of best practices in social dialogue, especially given the challenges posed by the Meeting's joint structure. Further opportunities for the exchange of information and experiences were provided during the round table on "Workplace violence – A threat to quality health services", and the presentation of the new Sectoral Activities Programme web site. The round table, which was carried out in cooperation with WHO, PSI and ICN, in particular highlighted the effectiveness of cooperation and social dialogue at the international level. This spirit of social dialogue also allowed the Meeting to adopt by consensus, a set of conclusions and one resolution. The Deputy Secretary-General stressed the importance for ILO constituents, as well as for the Office, of putting the conclusions and resolution into action. She closed by identifying three noteworthy characteristics of the Meeting:

- (1) the Meeting as an example of effective social dialogue;
- (2) the Government/Employers' group's use of smaller working parties to ensure broad participation on substantive agenda items;
- (3) the World Health Organization's offer to continue its collaboration with the ILO in addressing social dialogue in the health services.

Mr. Wagner (Government/Employer Chairperson of the Meeting) thanked his group for its cooperation, and thanked the Workers' group and its representatives for their openness in finding a common ground. He also thanked the Chairperson for his leadership and the secretariat for its diligence. He reminded the Meeting that the key to understanding and teamwork lay in each party's willingness to develop good human relations with each other.

Mr. Green (Workers' Chairperson of the Meeting) expressed his pleasure at the important conclusions the Meeting had produced, and welcomed these as a framework for guidelines to be used by the social partners. He underscored the importance of remembering that while certain countries had very strong histories of trade unionism, other countries were still in the process of creating these institutions. Mr. Green also noted that the round table discussion had been extremely useful and suggested that this practice be continued. He thanked his group for its cooperation and discipline and also thanked the Chairperson of the Government/Employers' group for his mediation skills and the Chairperson of the Meeting for his leadership.

The Chairperson thanked the Meeting for its participation, its patience and its willingness to seek agreement. Although social dialogue varied according to country, culture and historical background, the principle underlying all its forms and institutions remained constant: the ability of employers and workers to come together and reach their mutual goals through discussion. He highlighted the tragic events in Moscow as a situation where dialogue should be used to reach a peaceful solution. While the negotiation processes of the Meeting were not always easy, the desire for compromise always

prevailed, as evidenced by the adoption of the resolution and conclusions. The Chairperson informed the Meeting that as a member of the Governing Body, he would, during the 286th Session of the Governing Body, raise the issue of the joint structure of the health meetings, with hope of reaching an agreement that would allow each group its independence. This was an important issue to address because private and public employers had very different resources and responsibilities. The Chairperson declared the Joint Meeting on Social Dialogue in the Health Services closed.

Evaluation questionnaire

A questionnaire seeking participants' opinions on various aspects of the Meeting was distributed before the end of the Meeting.

1. How do you rate the Meeting as regards the following?

	5 Excellent	4 Good	3 Satis- factory	2 Poor	1 Unsatis- factory	Average score
The choice of agenda item (subject of the Meeting)	9	5				4.60
The points for discussion	8	6				4.60
The quality of the discussion	6	7		1		4.30
The Meeting's benefits to the sector	7	5	2			4.35
The conclusions	8	5	1			4.50
The resolution	6	5	3			4.21
Presentation	9	4	1			4.86
Round table: Workplace violence (Part 1)	8	3	2			4.14
Round table: Workplace violence (Part 2)	8	4	1			4.54
Opportunity for networking	5	6	2			4.23

2. How do you rate the quality of the report in terms of the following?

	5 Excellent	4 Good	3 Satis- factory	2 Poor	1 Unsatis- factory	Average score
Quality of analysis	7	6				4.54
Objectivity	7	6	1			4.43
Comprehensiveness of coverage	7	7				4.50
Presentation and readability	7	7				4.50
Amount and relevance of information	10	3	1			4.64

3. How do you consider the time allotted for discussion?

	Too much	Enough	Too little
Discussion of the report		13	
Panel discussions		12	2
Groups		12	1
Working Party on Resolutions		9	
Working Party on Conclusions		9	

4. How do you rate the practical and administrative arrangements (secretariat, document services, translation, interpretation)?

5 Excellent	4 Good	3 Satis- factory	2 Poor	1 Unsatis- factory	Average score
10	3	1			4.60

5. Respondents to the questionnaire

Government	Employers	Workers	Observers	Total	Response rate (%)
4	0	8	2	14	14

6. Participants at the Meeting

Government	Employers	Workers	Technical advisers	Observers	Total
29	8	25	20	17	99

7. Delegates/technical advisers

	Government	Employers	Workers	Total
Delegates	29	8	25	62
Technical advisers	15	0	5	20

8. Female participation

	Government	Employers	Workers	Total	Per cent female delegates
Delegates	8	3	13	24	24
Technical advisers	5	0	1	6	

List of participants
Liste des participants
Lista de participantes

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Représentant du Conseil d'administration
du Bureau international du Travail
Representante del Consejo de Administración
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