Health and Social Services

Briefing notes

for current debates on

public sector issues

Public Services International - 1999

Introduction

The PSI series of *Briefing Notes for current debates on public sector issues*, of which this is one, examines some of the issues, challenges, facts and trends in a number of public services or on particular public sector themes. The *Briefing Notes* address basic general questions on why the public sector has become an 'issue' in recent years, the development of the public sector and challenges thrown up by privatisation and public sector reform. Where possible and relevant, each *Briefing Note* identifies strategies trade unions are developing or could develop to deal with these issues.

The series grew from PSI material, finalised in 1995, on alternatives promoted by public sector unions. Initially conceived as a PSI economic strategy alternative to neo-liberalism, this developed into *A public sector alternative strategy* which looked at the full range of issues subject to neo-liberal policy prescriptions (including deregulation, labour markets, the social wage, taxation, trade and labour standards, the macro-economy, employment and unemployment, etc.). That publication was quite dense and compact and it was agreed that PSI needed to do other things to extend this material. Part of that was the production of an educational programme, *Democratising the global economy*, aimed at helping trade unions work through the alternative strategy material with their members so that they could be on top of the reform agenda.

The PSI Public Sector Working Group decided to merge this work with other 'fact-sheet' material on privatisation, public sector reform, contracting out, structural adjustment and other issues relevant to debates on the role of the state and the modernisation of the state at all levels. In theory, this means that the *Briefing Notes* can cover as many topics as are relevant to public sector trade unions' struggles to modernise the state, to promote and defend public services and to defend public sector workers and their unions.

This is one of a set of *Briefing Notes for current debates on public sector issues* produced by Public Services International, PSI, the international federation of public sector trade unions. The introduction to this paper explains the content of the series. The papers are meant to serve several purposes: to help trade unionists understand some of the issues; to enable trade union educators to run short sessions on public sector issues with their members; to provide material for union leaders writing speeches or informational material for wider audiences; and for distribution to a range of interested people. Further copies can be obtained from

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At the stage this *Briefing Note* was finalised (January 1999), titles in the series included:

- Public services and private interests
- The roots of privatisation
- Privatisation in transition economies
- International trade agreements and trade unions
- Restructuring the public sector: the New Zealand experience
- Transnationals in public services
- Municipal services
- Health and social services

Health and Social Services

"Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."
Constitution of the World Health Organisation.

Introduction

In terms of human history "health and social services", which are central to the modern welfare state, are a very recent innovation. However in many countries few people are old enough to remember what it was like before. These services were not set up without opposition, nor are they immune from attacks today. Their continuation depends on active commitment and promotion, otherwise comprehensive health and social services could very easily be lost to the next generation.

Society makes huge demands of health and social services. We expect them to be able to act quickly to deal with individual need and suffering and also to change in line with changing social needs. They have to supply emergency care at the scene of a car accident, provide for the long-term unemployed and plan support and care for tomorrow's elderly and infirm.

These services must be seen in a long-term perspective. The capacity to react to an emergency today is the result of investment, planning and training over previous decades, designed to put properly equipped people and services in the right place to deal with the problems when they arise.

Background

Before the establishment of the modern state, the poor (which made up the majority) either limited themselves to seeking help as a last resort, or turned to religious or other charitable bodies which provided free care but did not guarantee properly trained or qualified carers. To overcome this, some trade unions - especially in hazardous occupations like mining or shipping - set up their own insurance funds or employed medical staff themselves to give members access to care. In some countries, unions and other forces for social reform demanded the introduction of universal rights to health care and social provisions, with state structures to provide them.

Today there are broadly two kinds of state structures:

- those based on compulsory social insurance and tied to occupational funds which provide benefits only to contributing individuals and their families
- those where the State takes the central role in the administration of care facilities and the provision of services on a universal basis, funded from general taxation. (The "State" should be understood to include municipal and regional governments).

There are many variations around these two main models, including the involvement of charitable bodies, direct payments to providers and private services.

For example, the USA has only minimal public protection. As a result, a high proportion of its citizens have very inadequate protection. Other countries have invested the state with the responsibility of not only regulating health care and social services, but also of being the main provider. In between lie many variations, shaped by national tradition, culture, capacity, resources and compromise.

The poverty which persists in many "third world" countries has prevented the development of adequate health and social services. It has also made medical and social problems far more

widespread, more intense and more diverse. Many poor countries lack the resources to tackle their most fundamental problems, particularly the provision of safe water supplies, let alone to provide the diverse range of health and social services which can be found elsewhere in the developed world. There is still a long way to go in meeting basic needs.

This is illustrated in the table below which shows the general relationship between poverty and basic health indicators:

Health indicators - world averages

Country group	life expectancy at birth	under 5 mortality	fertility rate	health spending as % of GDP
high income	77	7	1.7	9.9
low and middle income	65	60	3.1	5.6
South Asia	61	106	3.5	4.1
Sub-Saharan Africa	51	157	5.7	5.6

(Source: World Bank).

It is important to put any debate on the future of health and social services in this long-term context. It is very easy for decision makers to take a short-term view and to ignore the thinking that lay behind the present health and social service structures. Some of these were set up to overcome problems which are now re-emerging as so-called “solutions”, such as individual responsibility for care. The impact of some of these changes might not be felt immediately, but to neglect a widening range of primary health-care activities to concentrate insufficient resources on immediate needs is a recipe for future disaster.

Examples of this include the phasing out of free eyesight examinations or the withdrawal of periodic medical examinations of young children. Though “saving” money today, the inevitable result is an increase in undetected health problems which not only will cause personal suffering but will cost more money to treat than to prevent.

Universal protection

Welfare States, by definition, sought to give universal protection. Social insurance-based schemes gradually expanded by:

- covering more occupations;
- including the dependants of the employees who were insured; and
- paying for more types of treatment.

So although they have been selective in their coverage to begin with, their expansion over the years has led to something approaching universal coverage.

The trend in the post-war period has been towards:

- increasing the general level of public health;
- increasing access to health care; and
- increasing access to social insurance.

It does not take much imagination to visualise the consequences of dismantling the underlying foundations of public health and social services. The social conditions in the centuries preceding the development of modern services **are** those consequences: appalling public health conditions, high mortality rates (especially high maternal death rates), a proliferation of contagious diseases, high levels of poverty and homelessness and no relief from suffering and hardship. Modern medical science may present a far better understanding of the nature of health and illness, but it does not of itself provide the means for putting them into practice. In

countries which have not been able to develop effective and comprehensive health services, people are exposed to enormous dangers to their health for which the remedies are often well known but not available to them.

"… rationalisation of health services, which leads to the exclusion of certain population groups from health care … because of cost-benefit analysis is immoral." (Source: ILO conclusions on terms of employment and working conditions in health sector reforms September 1998).

Measuring and improving standards in health and social services

The sorts of questions by which people judge their health and social services are basic:

- *Do I have enough to eat?*
- *Do I have somewhere to live?*
- *Am I poor or poorer than I was?*
- *Do I have a job?*
- *Is my job damaging my health and can I do anything about it?*
- *Is there any security to look forward to when I get old?*
- *Am I covered if I have an accident or fall ill?*
- *Can I take a holiday - or even a day off?*
- *Are our children happy?*
- *Will any of our children die in infancy?*
- *Will their lives be better than ours will?*

The answers to these questions are critically important to the political decisions that we take, not only at elections but also in everyday life.

It has always been possible for some individuals to amass personal wealth - even in the midst of war, famine and pestilence.

The real test is not whether those best equipped are able to succeed, but what happens to all the others. There is no value in asking, "how rich is the richest person in the country?" (or "how healthy is the healthiest?"). It is only relevant to establish the general level and how badly off the people at the bottom are. Health and social services are not just about tackling individual suffering. A system should be in place to give every possible help to all those who need it. So whilst the best reasonable care must be provided to the individual, the system which makes that care available must avoid discrimination and the creation of élites.

In order to achieve improved levels of health and well-being it is necessary to look at the causes of ill health and poverty and to take counter measures. Many health problems are caused by the working and living environment. Occupational health hazards, smoking, poor social infrastructures, road traffic accidents, poor diet, lack of exercise and environmental pollution contribute towards lowering health levels. Activities in these areas should take proper account of the impact they have on health and social well-being. But poverty remains the major cause of ill health and distress. There is a clear connection between improvements in living standards and improvements in general levels of health and social and economic independence. However, taking action on the economic front is not a substitute for effective long-term health and social service planning and provision. Both are necessary to improve levels of health and well-being.

The connection between poverty and public health in individual countries in each region is highlighted in the table below. There is a strong correlation between GDP per person, life expectancy and reduction of infant mortality. However some countries do not fit this pattern. Cuba for example has similar health indicators to the United States, despite a GDP per person less than one twelfth of its larger neighbour. A factor in this is its long-term emphasis on health

planning. Yet South Africa which has a higher GDP per head than many countries, has poor health indicators, in part due to a long tradition of lack of planning and facilities for most of its people.

Selected countries: GDP, life expectancy and infant mortality

Country	GDP per person US$	life expectancy at birth		infant deaths per 1000 live births
		Men	Women	
Malawi	142	41.4	42.4	148
Bolivia	909	57.7	61.0	75
Indonesia	1019	61.0	64.5	58
Fiji	2593	69.5	73.7	23
Mexico	2700	68.5	74.5	34
Germany	29632	72.6	79.1	6
Cuba	1983	73.5	77.3	10
South Africa	3230	60.0	66.0	53
United States	26037	72.5	79.3	9

(Source: United Nations statistics - Internet . All data is for 1995).

A global view…

To many people, health and social services represent something which is unique to their own country. Yet all health and social services operate within an increasingly international environment. They are increasingly subject to international influence, including the intrusion of multinational companies, the introduction of new forms of management and control, the impact of international organisations such as WHO and the IMF and the rapid spread of epidemics arising from ease of international travel. To understand what is going on in health and social services today, it is necessary to have a broader appreciation of what is happening to services globally.

Industrialised countries have benefited from relatively positive economic and trade conditions over recent decades (and before), but the majority of the world's population do not live in these countries. Even if their economies develop, there is no guarantee that the current political conditions and influences will result in the setting up of good health and social services in such countries. Indeed, the so-called 'Asian crisis' in the financial markets in 1997-98 led to massive World Bank and IMF interventions which resulted in much higher unemployment in economies with no social safety nets.

Neo-liberal economic policies and the heightening of global competition have put all social spending under a critical spotlight and employers have become increasingly opposed to occupation-based social insurance.

Transnational companies (TNCs) are becoming more prominent in health services, as the trend to privatisation increases. Privatisation allows TNCs to compete for business in the health sector and thus take over from government and local companies. TNCs raise issues and problems which private companies working only in one country do not raise. It can be much harder for the workers and unions to establish where the decisions on the company's strategy are really made. Even the national management of the company may not be fully aware of the company's intentions.

TNCs also have a greater capacity to obscure their operating costs, for example, by putting in bids for contracts which are low because they are being subsidised in the initial stages by operations in other countries. There is also the possibility that a TNC may decide to transfer all or part of its operations to another country. At first sight this may seem difficult in operations such as cleaning and catering, but it is easy to transfer billing, accounting and computerised administration to low cost areas, possibly in another part of the world altogether. Unions need to

watch for 'shape-changers'. These are TNCs which enter a country via one municipal cleaning contract or computer operations management and a short while later are buying hospitals and running the health insurance systems of major cities or the whole country.

All these factors seriously undermine employment security and the capacity of the workforce and its union to participate on a proper footing. One very important thing for unions to bear in mind is that an employer with whom they have reasonable relations at home may well operate quite differently in other countries. Such employers may well be looking not just for new markets, but also for new centres of operation where labour is less regulated. They will cross-subsidise between sectors or countries to win entry into new markets at low prices.

Public service unions must be prepared to look at new options and learn from the experiences of unions that have been working with TNCs for a long time. This must include working with unions from other countries. Dealing with specific companies might well include co-operation with all the other unions dealing with that company, especially the union of the company's home country. For many unions, that is a new experience.

The gathering, analysis and sharing of information is a key union activity in the process of dealing with transnationals and it is important that more joint international activity is carried out by unions in this area. Affiliates of PSI should look towards PSI as a forum when planning new strategic approaches. The data-bases on TNCs to which PSI has access started in the water sector but have extended across into waste, energy and health and related services both as a conscious strategy but also as a result of the TNCs shape-changing referred to above. Much of this data and many TNCs have a direct bearing on health workers' interests.

This internationalisation of the services sector and public utilities is also becoming a feature of regional trade agreements and international trade and investment agreements at, for example, the WTO and the OECD. The proposed OECD Multilateral Agreement on Investment, coupled with the tendencies of many central and local governments to contract out many health and social services, is making it easier for TNCs to enter these 'markets', with consequent attacks on job levels, wages and conditions for the workers in these services.

Public versus Private

The argument over whether public or private health services are best has been run and re-run many times in many countries over the course of this century; it looks as though it will continue to occupy time - and resources - in the next century as well. Yet the main issues are essentially ones of principle, rather than of detail:

- *Do people want health and social care arrangements which are available to all?*
- *Is it right that some people should be denied the help that they need because they are too old, too poor, unemployed, or too ill?*
- *And if some people are excluded, what should happen to them?*
- *Do people want health and social services to be available whenever they need them and regardless of whether they can pay at the point of delivery?*

It seems obvious that taking away public health and social services will take away good health and social independence from many people. But there is every sign that some people have been convinced into believing that they would be better off if health and social services were provided on a user-pays basis (that is, privately). In this way, it is maintained, services would be more economically responsible as they would have to perform to the rigours of competition. Recipients of care would become paying clients and would therefore have greater influence over their care and there would be less room for waste, fraud and abuse.

Less fraud? Fraud in privatised health care is of real concern. "Sun Healthcare Group Inc., which has been acquiring nursing homes and rehabilitation concerns at a white-hot pace, has come under the shadow of a federal investigation of a possible billing fraud" reports the Wall

St Journal. “According to a search warrant application filed …… and an FBI affidavit that accompanied it” (there was evidence that) “Sun had a “verbal” policy of misrepresenting group therapy sessions as individual sessions for billing...” (Source: Wall Street Journal 29 August 1995 reported in Dow Jones News Database).

In other words, health and social services would be bought and sold like any other goods and services in the market place. Private individuals and companies would sell care if they wanted to, but there would be no obligation for them to do so. Conversely, individuals could choose whether to buy care and how much is needed, although without any guarantee that what they want or need at any particular time would be available where they want it and at a price they can afford. Likewise, there would be no guarantee that *other people* would be able to avail themselves of care and therefore avoid becoming a health risk to the community.

One factor which has been decisive in building today’s services - and which is particularly relevant to the present situation - is that health and social services have been recognised as being of collective importance to society as whole and not just a matter for the individual. Promoters of private health care treat medicine as a commodity that people can buy according to how much they want and what they can afford to pay. They imply that their product is of higher quality than that which is publicly available and that direct payment provides superior access to care and an incentive for people to use health services more “responsibly” (often meaning delaying access to care or even not using it). This type of “dealing” in medicine should not be confused with universal health care, for it is very different.

Two cases in point are New Zealand and the UK where the neo-liberals established internal private markets in health services. The systems have focused on quantitative, contracted services and productivity. In both cases, the following applies: one patient is treated successfully via a five day hospitalisation; another patient has a rushed two-day hospitalisation which does not fix the problem and has to be re-admitted for another three days to fix it. The latter is judged better since two procedures were done with an average stay of 2.5 days versus one procedure with a five day treatment! This approach is weighted against those who genuinely have a need for long-term or permanent care, which is seen as a drain on resources.

The question of patient choice often enters into the privatisation debate. The Ljubljana Charter on health care reform adopted by the World Health Organisation (WHO) Europe favours increasing choice in health care. But it also points out that the exercise of choice “requires extensive, accurate and timely information and education.” This includes access to information on the performance of health services. In the rush to privatise, often justified by reference to patient choice, these factors are often entirely overlooked.

Collective concern

There is a fundamental difference in aims between public and private sectors in this area. Public health and social services are collectively funded, collectively provided and accessible to all individuals, whilst private health and social services are simply products sold to individuals.

As long as collective provision of health and social care is seen as a financial burden, rather than as a central pillar of a civilised society, then there will continue to be attempts to undermine it. The State will be encouraged to cut resources and abrogate its obligations by making its citizens responsible for their own problems, as they were before health and social services were set up.

“Health care is not a commodity and thus not a tradable good.” (Source: ILO - conclusions on terms of employment and working conditions in health sector reforms, September 1998).

Private health services promise to sell service products to an individual to maintain and improve his/her health. It does not aim to provide health care nor could it ever aspire to do so, because *real* health care and social services aim to be comprehensive - not just selling profitable surgical procedures to the rich. Such private providers will not supply inherently unprofitable care to those who are in no position to pay.

A similar case exists for employment services. Public employment services exist to help all people without work or those seeking employment. Private employment agencies will often demand a fee from those on their books or even a commission on their wages. For the long-term unemployed poor who can't afford such services, these private agencies may as well not exist.

In order to provide "freedom of choice" in a private health and social services market, whilst at the same time safeguarding overall levels of public health and well-being, a strong element of compulsion would be necessary, obliging citizens (now consumers) to take out all the necessary insurances - although their choice of company would be free, as would be the company's choice of client. It would probably end up looking very similar to a car insurance market: unionists who believe in access to choice need to think about that.

Such a system would never have public support. Not many governments bother to ask, but the neo-liberal New Zealand government *did* ask voters to support the move to a compulsory private sector-based pension scheme in a 1997 referendum: it was rejected by over 91% of voters.

So it is a fallacy to suggest that a market-based system of provision is the answer to problems in the health and social services sector. It points to a critical misconception of what health and social services have to do and a failure to accept that they demand a permanently high priority in a nation's ambitions for development and therefore in its expenditure.

Turning public into private

Health services, and to a lesser extent social services, have been a principal target for privatisation or commercialisation by a wide range of means, the most obvious one by selling off particular services which looked profitable to private buyers. There are also more surreptitious methods, like introducing management from the private sector into the public sector so as to infuse the system with market-oriented methods and principals. In some instances, the legal character of the supervisory bodies has been changed so that those who control the service are no longer publicly accountable for their decisions.

Forms of privatisation

- privatisation of ownership - ownership of facilities and service units is shifted to the private sector through e.g. direct sale, transfer to management, sale of shares or voucher privatisation;
- privatisation of responsibility - e.g. entire responsibility for a service is formally transferred, or state-owned enterprises are liquidated or state services are abolished;
- privatisation of provision - e.g. through contracting out and leasing concessions to the private sector;
- privatisation of finance - e.g. through higher co-payments and chargers to users, using private capital for public investment, joint ventures and shifting to private health insurance fund;
- privatisation through markets - e.g. competitive tendering between public and private contractors, choice for patients, or by splitting purchasers and providers.

(Source: PSI).

Sometimes the squeezing of the public service is accompanied by the promotion of private sector competition from companies set up with government assistance. But privatisation also goes as far as making others do some of the work. Examples of this include insisting that patients, employers or insurance funds do more of the administration of claims and contributions. Transferring more of the costs of treatment to patients not only limits access to care, it also encourages the better off to buy private insurance, possibly with the attraction of tax relief as well.

In Australia in 1997 the conservative Federal Government introduced a scheme which gives income tax breaks to people who take out private health insurance. However the universal health care insurance scheme, "Medicare" has remained in place due to public and union pressure. 1998 figures show that private health membership is still falling while private contribution rates are increasing.

Although it makes little sense, one very lucrative aspect of privatised services is providing staff and services to fill the gaps left by cuts resulting from the part - privatisation of public services. In effect, staff cuts in public health and social services are filled by agency staff with worse conditions of employment (albeit sometimes with marginally higher basic pay). This is a rather convoluted way of taking money out of the wages bill and giving it to entrepreneurs.

Where there is a basic provision of health and social services provided by the state, private services can ride on the back of it, taking trained and experienced staff from the State system, selecting patients/clients whose needs have already been identified, offering only the services it wants to, taking advantage of holes in the system to set up private facilities which can be rented or contracted to the public service, from laboratory analysis to residential care. And it is **never** cheaper or more comprehensive than state care.

The USA, the most extreme in this kind of provision, has the most administratively expensive health system on the planet, covering the lowest percentage of its population.

Adapting systems to demographics

There are major health care differences within countries as well as between countries. Differences exist between the rich and the poor and, by extension, between those who are well protected (through wealth, secure employment, etc.) and those who are inadequately protected. There are often major differences between city and rural based people and sometimes between men and women. It would be impossible - and undesirable - to propose a "blueprint" for a system and structure of health and social services that would be universally applicable. Whilst there are common factors and even some common "landmarks" in terms of occupations, there are aspects to every system which make it unique. Each has developed in order to serve a population in a particular geographical area and distribution, with different demographic profiles. Problems - especially those related to the targeting of welfare benefits - are specific to that society.

The demographic trends in the newly industrialising and developing countries are different. Although there are still huge deficiencies in health and social services in the latter, health levels are generally rising, with the result that there are lower rates of infant mortality and longer life expectancy. The immediate result is similar to industrialised nations. There is a higher number of the population economically inactive and a smaller funding base for health and social services. The speed of demographic transition is also far higher in these countries than it was for industrialised nations in the 19th and 20th centuries.

Also, identifiable groups within society (such as women, the unemployed, young people, migrant workers, retired workers, the poor) have their own specific needs and demands and their needs can change extensively in line with demographic, economic, social and technological developments.

Health and social services have to serve the communities in which they are based and of course those communities are themselves changing rapidly. A significant *ageing* is taking place in post-industrial societies and in the world in general i.e. a growing proportion of the population is in the older age brackets. This has sweeping implications. To begin with it means that there will be pressure on retirement pensions as not only will there be more retired people but they will tend to live longer. It also means that the proportion of people of working age who are paying for the pension funds of others (through income tax, social insurance contributions, etc.) will be proportionally much smaller, creating a strain on funding. (Although this must be read with caution since, in the USA, where this 'fact' is most heavily trumpeted as a reason for pensions and service provision to be **cut,** the social security funds are actually in an all-time record **surplus**).

Age structure of the world population 1950-2030 (percentage)

Age group	1950	1980	1990	2000	2030
0 to 4	13.5	12.1	12.0	11.0	8.4
5 to 14	21.0	23.0	20.4	20.5	16.7
15 to 59	57.5	56.4	58.3	57.8	59.7
over 60	8.0	8.4	9.3	10.6	15.2

(Source: World Bank).

In several countries there are moves to reverse the trend of progressively lowering the age of retirement, intended to take some of the pressure off the labour market. Instead, *raising* the age of entitlement to a retirement pension (and imposing other limits to access) is proposed so as to take pressure off social service funding. In other circumstances, this might be called theft since it takes jobs and entitlements from people who had contractual rights to them. This is a complex debate for some unions since it is also important to allow people the reasonable choice to not work when they are no longer capable and for yet others to work for longer because they want to. Democracy can be difficult.

At the heart of the matter lies the whole issue of solidarity between generations. The economically active generations support the financially inactive or less active - principally children and the old. In earlier times (and in poor countries) this was left up to each family. This not only increases inequality but it leaves many people without any protection. The dispersion of families, as well as greater personal mobility and a change in general attitudes towards independence make it essential to have properly functioning structures for income transfers. If the structures which facilitate this social contract are deliberately eroded, then the whole basis of society will be put in serious jeopardy.

An ageing population not only narrows the funding base but imposes new requirements. In general, people require more care the older they get, although not just hospital care. There will be an increasing need for elderly people to have access to care and services which will allow them to avoid serious illness or injury whilst retaining their independence and remaining in the community. Each person's needs are different and must be carefully identified; measures must be agreed with the individual which are appropriate and acceptable to them and these needs should be regularly reviewed. Hospitalisation or removal to residential care should not be used as a way to avoid the complicated process of needs assessment.

Protecting health and social service staff

Health and social services are highly labour intensive: they depend on, and consist largely of, *people*. This can be looked at in very different ways:

- staff are crucial to help those in a vulnerable position, so it is important that services maximise contact between service staff and users; and

- staff are crucial to the effective provision of health and social services, so employment and working conditions (as well as training, morale, recruitment etc) must be given a very high priority if users are to be served by quality staff with high morale and commitment.

People's needs for care and support do not go away at the end of a normal working day, nor disappear at weekends or public holidays; health services are by their very nature activities which have to run round the clock, every day of the year and social services likewise have to respond to people's needs. Work in health and social services involves a lot of unsociable hours, including night work, public holidays and shift work.

In fact, for many social services and some emergency health services, it is the 'out-of-office-hours' times which often produce the most urgent needs for crisis intervention. This adds to the stress inherent in the job by putting pressure on home and social life, especially for those with family responsibilities. Another factor which health and social service staff have in common is, not surprisingly, a deep commitment:

- to the work that they carry out as individuals;
- to the team they are a part of;
- and to the service as a whole.

Yet pay and conditions for health and social services are, by and large, low, as can be gleaned from PSI and affiliate publications on health services and social services[1].

Low pay and falling?
Even in parts of the North, medical professionals are not doing so well:

- In Austria, there was a rise in average real pay in the medical occupations of 1.4% between 1990 and 1996;
- In Finland, average real salaries of male physicians fell by 2% between 1990 and 1995, real salaries of professional nurses fell by 10%;
- In the United Kingdom, average earnings increased between 13 and 30 percent between 1990 and 1996 for physicians and nurses;
- All medical occupations in the US except male physicians experienced falls in real earnings 1990-96.

(Source: ILO - report on terms of employment and working conditions in health sector reforms, 1998).

Health and social service employees are a vulnerable group of workers. They are generally reluctant to take industrial action in defence of their interests. However, trends in health and social services in recent years have led to growing frustration at the failure of decision makers and managers to acknowledge the commitment of staff to the service and those it cares for. There is a growing awareness that higher workloads and cuts in services not only lead to deteriorating working conditions, higher stress and low morale, but also put patients and clients at risk. Continuing to refrain from protest action to cover this may, in reality, be putting the long term interests of patients and communities at greater risk and so health and social service employees are being forced into a corner. They see that their work is not only undervalued, but also undermined and under-resourced, whilst their commitment is abused.

Much service restructuring is not aimed at improving services but at cutting costs. "Targeting services at those whose need is greatest" has become a euphemism for rationing - rather than meeting - basic needs. Even if the time and effort is taken to identify needs and match them to services, the services themselves must be available and accessible and this is far from the case at present. Staff may be understandably cautious about raising clients' expectations when they know that the right to a particular service is not matched by its availability. And of-

[1] See PSI resource list at the end of this publication.

ten, wages and other staff-related costs are the first to suffer in cost-cutting exercises, viewed as being a quick way to make a big difference to the budget.

Those working in services which have been privatised may very well find themselves in an even less enviable position, as the profit margin for the new service owners is likely to come largely from cuts in pay and conditions of employment, e.g. through lower holiday entitlements, less training, inadequate sick leave arrangements, poorer pensions and higher workloads. Less job security can also be added to the list, as privatised services maximise "flexibility" by the use of fixed-term contracts, seasonal employment and casual labour.

"Health sector reform efforts should foster primary care and preventative medicine for all, improve quality of care and create better working conditions in this area". (Source: ILO conclusions on health sector reforms September 1998).

The role of unions

Unions need to be in the forefront in making proposals for change, improvement and innovation in social services and health services. No one who works in these services or who is helped by them would maintain that they could not be improved. There will always be scope for improvement, to make sure that all people get what they need, when and how they need it. The instinct of health and social service workers is to do things better, find new treatments, develop new ways of dealing with pain and hardship, and above all, avoiding suffering and exclusion. If unions do not actively campaign to modernise, improve and defend these services, governments and neo-liberals will cut or restructure them such that:

- more illnesses will go untreated and more personal, family or community problems will be left to fester;
- some people will suffer avoidable pain, hardship and exclusion which could be avoided by a realignment of resources;
- there is a limit to the provision of care and that limit is quickly reached.

Commercialisation of state/public activities, including privatisation, has been introduced in many countries, either because their own governments instigated it or because general economic pressure - including debt and the influence of financial institutions such as the International Monetary Fund and the World Bank - made it hard for them to avoid it. Privatisation is a reality and unions - particularly in the public services - have had to decide how to deal with it.

Many unions have continued to oppose privatisation in principle, but have seen that the best way to offer long-term protection to their members in services which are being privatised is to 'follow' them into the private sector, i.e. to continue to organise them as members and to provide them with full rights and services even though their employer is not a public authority. In this way existing terms and conditions of employment as well as 'understandings' about work organisation and practice can be defended in the new bargaining situation. However organising in the private sector is difficult. Higher proportions of workers in the private sector tend to be associated with lower overall levels of union membership.

Health Workers: union membership and percentage in private sector.

Country	Total employees	Members %	Private %	Mix %
Sweden	220,000	96.8	10	NA
Finland	124,000	90.0	14.3	NA
Greece	84,000	89.3	NA	NA
Norway	180,000	80.6	11.1	NA
Latvia	32,000	75.3	NA	NA
Croatia	71,500	69.9	NA	NA
Romania	300,000	55.0	4.7	2.0

Turkey	39,000	43.6	20.6	NA
Czech Republic	190,000	32.6	21.1	NA
Albania	28,500	25.3	2.3	NA
Germany	2,000,000	16.6+*	30.0	25.0
France	1,072,500	15.0	28.7	NA

(Source: PSPRU).
*refers only to the major health union

Also this can raise some questions of principle, especially if the union has traditionally been strict about organising only where the employer is a public body or where a private sector union already organises workers in the private sector and in voluntary organisations. This is a potentially divisive situation and union divisions usually work to the employer's benefit, not that of the workers. Ultimately, the decision over who represents the workforce should lie with the workers themselves and the important thing is that they remain organised and do not end up as part of the army of unorganised contract workers operating at the edges of an organised workforce. The PSI viewpoint is that what makes a public service public is its *raison d'être* - not who owns or provides the service.

For some unions, dealing with such change in health services may well be central to their strategic planning, as they may have to transform their structures and tactics to meet new organising and bargaining situations. This may well involve confrontation with employers which are not only hostile to union organisation at the workplace but are also part of TNCs.

A 1997 PSI survey of affiliates organising social service workers showed that very few affiliates had considered how to deal with private operators or voluntary organisations (churches and NGOs, for example) who take over work formerly done by their members. Too few have thought about any internal structures and organising for these workers. It is not known how well municipal unions in many countries have developed strategies on these issues.

Among the best investments that unions can win and governments can make are to ensure that the conditions of work and employment in health and social services are at least as good as those of other workers. Comprehensive training should be given to all staff, with the possibility of further training and refresher training throughout the rest of their careers. This will not only promote the development of good career prospects but also ensure that health and social service staff have the best possible foundation for sustainable service development.

Danish Nurses' Organisation - Professional Development Project

Quality nursing and quality assurance have continued to be key professional areas of development in Denmark. The main reasons are the demands for increased efficiency, productivity and cost reductions in the health care sector.

Today's users of health care services rightly expect quality treatment and care. Involvement of the patients and users, their wishes and experiences about the desired outcome and their evaluation of the efforts are important to the development of quality. The aim is to give people the ability to make informed decisions about their own care and treatment.

The DNO set up a Professional Development Project 1992-1997 to raise the quality of nursing in general and:

- to enable nurses at all levels to contribute to the development of quality of nursing in the primary health care sector;
- to develop co-ordination of nursing between the primary and secondary health care sectors to the benefit of all people;

- to demonstrate the nurse's role in primary health care, as part of the WHO strategy "Health for All in the Year 2000", including health promotion, prevention of diseases, clinical, rehabilitation and palliative nursing care.

Details are available from the Danish Nurses Organisation, Postboks 1084, DK-1161 Copenhagen K, Denmark.

The experience of many PSI affiliates is that, provided unions have service quality and improvement high on their agenda, they can win high levels of support from (and commitment to joint campaigns with) community organisations in defending and promoting good services. Such campaigns can take many forms and unions should have developed strategies which might include these elements:

- direct political lobbying to ensure they are part of reform development rather than put at the blunt end of the implementation of cuts and privatisation;
- direct discussions and lobbying with involved international agencies such as the World Bank and the World Health Organisation;
- information sharing with networked organisations such as NGOs;
- media campaigns aimed at mobilising public opinion;
- reporting and publicising breaches of ILO policies in health sector reform;
- information gathering via the Internet - see UN and World Bank sites;
- industrial campaigns directly involving the membership;
- coalitions with consumers of health and social services.

The active involvement of unions in campaigns often results in a highly committed union membership which understands the importance of collective action.

Promoting and reforming health and social services

The promotion of good health and social welfare must be a central aim, not just of those with direct responsibilities in those sectors, but also of those in other areas of activity which have an impact on them. Economic development should benefit health and social welfare. It should certainly not be prejudicial. Health and social services should not always be put in the position of having to repair damage when it has already been done. More emphasis must be put on protecting, defending and promoting good health and social welfare.

One of the cornerstones of providing good health and social services is communication within the services themselves. A person may need all sorts of assistance from different departments in both health and social services, to deal with not only health concerns but also income support, mobility, housing, retraining, etc. Well-designed services will work together to see that, as far as the individual is concerned, the service is seamless and they do not feel that they are being pushed from pillar to post, having to go through numerous interviews in each case. Good services co-ordinate and communicate effectively and therefore complement each other.

There has to be a new attitude towards growth. At present the emphasis is firmly on trade and finance and the concentration on profit is seen as justification in itself. This not only fails to encourage the pursuit of social objectives, but treats the pursuit of such aims as a burden on the economy.

This clearly presents an immediate challenge for health and social services. Reforms are needed to bolster services and orient themselves firmly towards the needs that will arise in the future.

One important issue that the current dilemma highlights is the need to review the way that funding is gathered, in particular to look at taxing profits, speculative activity and resource use rather than taxing labour.

There are some positive indicators that health services may come under less irrational economic pressure in the future. The World Bank and the International Monetary Fund are gradually becoming more regionalised and more open to views from the community. The World Trade Organisation has been directed to work with the ILO which it sees as having the competence to take account of labour issues in relation to “free trade”. The ILO has begun to focus more directly on this sector and to become more involved with international financial institutions. And most nations have formally committed themselves to The WHO “Health for All” strategy with its emphasis on environmental prevention and universal primary care.

The greatest weapon of those who are trying to break down collective responsibility for health and social services is public complacency. Health levels and social well-being will be eroded if the public does not realise the importance of continuous efforts to improve them. Cuts in service provisions do not mean that levels will stand still, but that they will start to fall. Private provision is **not** an effective means to promote public health and without good public health then the health of every individual is endangered. Running down collective public health and social services and promoting the extension of individual private schemes is turning the clock back to a much more callous and uncaring regime.

PSI recognises the work of Colin Humphries and Dain Bolwell who helped to draft this paper.

Resources available from PSI

- At its World Congress in Japan in November 1997, PSI staged a symposium on social services, with a particular emphasis on services for the elderly. As a base for discussions, PSI produced a booklet *Services for the Elderly: a Congress symposium,* which examined the global situation facing social services workers (as well as specific papers on Denmark, Germany, Japan and the UK), the elderly themselves and on attacks on public pension schemes. The booklet is available from PSI in English, French, German, Japanese, Spanish and Swedish.
- The Report on the PSI Social Services Survey, which was carried out amongst affiliates in 1997, is available from PSI in English, French, German, Spanish and Swedish.
- In the Policy, Practice and Programme series the following papers are available from PSI in English, French, German, Spanish and Swedish: PSI Worldwide Policy Programme for Health and Social Services (1993); and Social Services Policy (1996).
- The Report and Conclusions of the 1998 ILO Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms – available in English, French and Spanish.
- Transnational companies involved in health and social services - see the list below. PSI affiliates with access to the Internet can have access to the PSIRU database which contains information on these companies, but must first obtain a password from Alice Carl at the PSI Secretariat. Affiliates without access to the Internet can send their enquiry to her.

Transnational companies

Direct Health Care Providers
Aetna
Aguas de Barcelona
Australia Hospital Care
Bangkok Dusit Medical Services
Beng & Ooi Holdings
Bumrungrad
BUPA
Bure
CinVen
Columbia/HCA
Health Care of Australia HCoA
Health Solutions International
Hospital Pantai
Hurrle
Kumpulan Perubatan Johor KPJ
Landmarks Group
Lion Group
Medi-Projects
Paracelsus
Parkway Holdings
Prasit Patana
Raffles Medical Group RMG
Samitivej
Sime Darby
Sun Healthcare Group
Vista Healthcare Asia

Contract Service Providers - Support Services (catering, cleaning, etc.)
Asia Lab M Sdn Bhd
Compass
Faber Berhad

Gehe
ISS
P&O Australia
Rentokil/Initial
ServiceMaster
Sodexho and Gardner Merchant
Tongkah Holdings
Unilabs