

**SUSTAINING STRATEGIES ADDRESSING THE HUMAN
RESOURCES FOR THE HEALTH CRISIS THROUGH
UNION PARTICIPATION**

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ABSTRACT

The study attempts to draw a picture of the governance debate on the human resources for health (HRH) crisis, its dynamics and main actors. Whereas the global debate on governance of HRH has involved governments, international institutions, academics, NGOs and other networks, it actually misses the direct participation of workers and their trade unions. The study argues that the absence of the workers' voice has limited the governance debate in its form, content and subsequently its legitimacy and sustainability.

Unions have a more holistic and comprehensive approach to the health crisis, as ill health results from income inequalities, poverty, exploitation and injustice. For the unions, improving health would thus require changes in economic and political priorities and the development of comprehensive social policies with full public participation. In this light, workers' and unions' involvement and participation is crucial in order to bring legitimacy to the governance process. The strategies and interventions will be sustainable, only if workers' involvement and participation is ensured.

The effective participation of trade unions in the governance of HRH calls for a more proactive union approach that involves strategic analyses and action on the global level, mobilisation of financial and human resources at all levels in order to deal with increasing challenges and a clear articulation of a grassroots-oriented and membership needs-based sectoral strategy.

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List of Abbreviations

ACOSHED	African Council for Sustainable Health Development
CSO	Civil Society Organisation
CUPE	Canadian Union of Public Employees
EPSU	European Public Services Union
ETUC	European Trade Union Confederation
EU	European Union
G8	Group of 8
GDP	Gross Domestic Product
GHWA	Global Health Workers Alliance
GP	General Practise
Health GAP	Health Global Access Project
HLFMDG	High Level Forum on Millennium Development Goals
HOPE	Hospitals of the European Union
HOSPERSA	Hospital Personnel Trade Union of South Africa
HRH	Human Resources for Health
HRM	Human Resource Management
HSAN	Health Systems Action Network
HSS	Health System Strengthening
HSTF	Health Service Task Force
IBRD	International Bank of Reconstruction and Development
IG Metall	Industriegewerkschaft Metall Industriegewerkschaft Metall
ILO	International Labour Organisation
IMF	International Monetary Fund
JLI	Joint Learning Initiative
MDG	Millennium Development Goal
MPhC	Multinational Pharmaceutical Companies
NEPAD	New Partnership for Africa's Development
NGO	Non-government organisation
NHS	National Health Service
NUPGE	National Union of Public and General Employees
OECD	Organisation for Economic Cooperation and Development
PHR	Physicians for Human Rights
PSI	Public Services International
PSIRU	Public Services International Research Unit
R&D	Research and Development
SAP	Structural Adjustment Programs
TWG	Transitory Working Group
UN	United Nations
UNISON	UK Union of Public Services
WHA	World Health Assembly
WHO	World Health Organisation
WTO	World Trade Organisation

CHAPTER I

BACKGROUND OF THE STUDY

1.1 Introduction

*“To act that you treat humanity whether in your own person
Or any other person never merely as a means
But as an end in itself” Immanuel Kant 1785*

Today more than 200 years after the death of Kant, his message sounds more important than ever. The world is actually “in the midst of a global public health crisis that plays out in all the levels of governance but it is not yet understood as a crisis because the do-ability and expansion cover the deeper malaise” (Kickbusch Payne, 2004).

This study highlights the limitations and gaps in the on-going global discourse and initiative on addressing the crisis on Human Resources for Health (HRH), attributing such limitations to the lack of participation and involvement of trade unions in the discourse. As such, sustainability issues are raised with regards to the initial global recommendations and initiatives addressing the HRH crisis. The study seeks to assess the level of the debate and the main players involved in the debate, pointing to some limitations and gaps in the proposed platform or agenda as a result of the non-participation of all stakeholders, particularly trade unions.

The HRH crisis is now a global issue necessitating coordinated, international efforts to effectively address it. This HRH crisis has contributed considerably to global health crisis and to the further aggravation of the economic and political situation. According to the World Health Organisation (WHO), 57 countries, 36 of which are in sub-Saharan Africa, have severe shortages of health workers; and more than four million additional doctors, nurses, midwives, managers and public health workers are urgently needed to fill this gap (WHO report, 2006). A report of the Joint Learning Initiative (JLI) project, the first global attempt to address the HRH crisis, shows the multidimensional aspect of the crisis, expressed in the shortage in numbers of health workers, lack of the right skills and support networks, stress and overburden “and often they are not in the right place” (JLI: 2004). Even though

some regions of the world are particularly affected by the crisis, reports from different regions and continents show that the whole world is involved, in different ways, in the HRH crisis.

There is now a clear acceptance worldwide that the UN's Millennium Development Goals (MDGs) promise will not be realized unless HRH crisis is properly addressed. Accordingly, "the only route to reaching the health MDGs is through the worker; there are no short-cuts" (JLI, 2004).

Clearly, trade unions have been absent in the global debate in an area where the world's health workers are affected. For example, the Public Sector International (PSI) has 7 million members from the health sector in 138 countries and yet they have not been involved in any way in this initiative. Even the International Labour Organisation (ILO), which is a UN organ, has not been engaged in the debate.

In light of the above, there is an urgent need to analyze the debate, identify its limitations and gaps, and draw attention to the centrality of the unions' role in effectively addressing the HRH crisis. There are good reasons to believe that the HRH crisis can be transformed in a powerful field for social movements where trade unions can take a leading role. This can be in the same time an important moment which can help to build on trade union revitalization.

To date, to the author's knowledge, no study has been done looking into the role of unions in addressing the global HRH crisis. By seeking to identify platforms and mechanisms where unions could enter and participate in the debate, the study may offer other possibilities or patterns of union involvement and influence in the overall global political debates and governance.

1.2 Brief definition of main concepts

The WHO gives these definitions on the main concepts in health:

Human resources for health (HRH) are people who make health care happen, i.e. dentists, nurses, midwives, pharmacists, physicians, auxiliary health care workers,

community health workers, and practitioners of traditional medicine, technicians and other para-professionals.

Health system strengthening (HSS) includes initiatives to strengthen the key components of health systems, which range from policy and financing to human resources, service management, supply systems, information and monitoring.

Health workers or workforce includes all workers in the health system from health professionals (as above) to a wide range of administrative, semi-skilled and unskilled workers.

Health sector includes organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; NGOs; community groups; and professional associations; as well as institutions which directly input into the health care system (e.g. the pharmaceutical industry, and teaching institutions).

1.3 Research questions:

General

4.1 How can the unions influence the overall debate and policy-making on the HRH crisis?

Specific

4.2 At which level are the unions in the political debate on HRH crisis?

4.3 Why are the unions left out of the global debate or discourse on addressing the HRH crisis?

4.3 What are the implications of the non-involvement of unions in the debate and policy-making on the HRH crisis?

4.4 How could the unions influence the debate and policy-making on the HRH issue?

1.4 Objectives of the research:

The main objective

4.1 Determine and critically assess how trade unions can effectively influence the overall debate and policy-making on the HRH crisis.

Specific objectives

4.2 Find out at which level are the unions in the political debate on HRH crisis;

4.3 Analyze why unions were left out of the global debate or discourse on addressing the HRH crisis; and

4.3 Discuss the implications of the non-involvement of unions in the debate and policy-making on the HRH crisis; and

4.4 Come up with strategic recommendations on how unions could influence the debate and policy-making on the HRH issue.

1.5 Significance of the study

This study attempts first of all to draw a general overview of the governance debate on human resources for health crisis. In doing so, the study elaborates on aspects of the HRH crisis and its relationship with the global health crisis. Though the debate on HRH has been going on for quite some years, and as the HRH crisis governance has escalated and involved more stakeholders, still the voice of the health workforce is missing. There is a clear gap in the academic literature which examines the role of the unions' participation in the HRH crisis governance. Hence the study seeks to uncover some of the reasons for the limited participation of unions and the manner in which this has impacted on the sustainability of the HRH strategies. Likewise, the study brings to the surface the different levels on which the debate is being held, pointing to potential 'access points' and 'critical areas of engagement' for unions' participation. The study highlights some relevant strategies for unions' participation, which would both address the sustainability of HRH strategies, but also serve as a platform for union and social movement revitalization.

To the extent that the HRH crisis is both a national and global concern, this study draws significance in the area of policy-making; on health and social policy at both levels, putting the sustainability issue at the core by involving a multi-stakeholder approach to the problem, particularly the involvement of health workers themselves and their trade unions. The gaps addressed in this study could serve as

valuable inputs into a more comprehensive and inclusive national and global agenda-setting on the HRH crisis in particular and the global health crisis in general.

Trade unions will likewise find this study both important and pertinent, particularly concerning the area of framing their strategies and possible courses of action in influencing the HRH debate. Platforms and areas of engagement are identified for unions to effectively enter and influence the debate. And as mentioned earlier, there are good reasons to believe that the HRH crisis can be transformed in a powerful field for social movements where trade unions can take a leading role. This can be an important moment to build on trade union revitalization.

CHAPTER II

REVIEW OF RELATED LITERATURE

The literature on the concept of sustainable development revealed over 100 definitions, but the best known is the World Commission on Environment and Development's, which describes sustainable development as a process which "*meets the needs of the present without compromising the ability of future generations to meet their own needs*".¹ The same report argues that sustainable development must "overcome not only environmental degradation, but it must do so without forgoing the needs of economic development, social equality and justice". Observers assert that "participatory democracy, un-dominated by vested interests, is a prerequisite for achieving sustainable development" (Ibid).

In the context of the foregoing concept of sustainability, it could be said that health systems, as they are today, are highly unsustainable - they do not meet the needs of the present, nor do they promise anything better in the future. The impact of this failure "disproportionately impacts the poor, as they are given less respect, less choices of providers and lower quality amenities" (Kickbusch and Payne: 2004). The JLI report argues that, "millions of people around the world are trapped in a vicious spiral of sickness and death" (JLI 2004). As privatisation has pushed through, the consequences of this failure have become much more critical. "In India, for example, families pay 80 percent of their health costs out-of-pocket, compared to those in industrialised countries with universal health care pay only 25 on average" (Kickbusch and Payne: 2004).

Problems of sustainability are highly present in rich countries as well. An OECD (2005) briefing argues that, "there is general agreement that the current systems for providing 'health' will not be sustainable in the future". The paper continues by pointing to the limited access to health care and increasing costs, which go beyond than what "societies can afford on a long-term basis" (as above). Problems of health delivery in terms of timeline and quality compromise heavily the sustainability of health systems.

¹ For more information see: <http://www.gdrc.org/sustdev/definitions.html>

Extensive literature has been developed on health systems and their problems, highlighting their un-sustainability. The first global work to link the sustainability of health systems and of the health workforce has been the Joint Learning Initiative. It argues that the mobilization and strengthening of human resources for health is central to combating health crises in some of the world's poorest countries and for building sustainable health systems everywhere.

The JLI report highlights the scale of crisis as "life's chances and health's inequities have sharply polarized" (as above). The report argues that "the average life expectancy in many societies is less than half that of the privileged. Moreover the gaps are widening as "the wealthy continue to enjoy longevity up to and beyond 80 years, but life expectancy at birth is less than 40 in more than a dozen countries, nearly all in sub-Saharan Africa" (JLI, 2004).

The JLI report points to some of the roots of the crisis: "Conflict and failed governance devastate the human infrastructure and social trust that enable a health service to function. Beyond politics are many complex reasons for crumbling health systems" (JLI, 2004).

The HRH crisis and the health system crisis are inextricably linked with each-other. "Local or regional staffing problems are exacerbated by the tendency of health workers to migrate in search of better economic and profession opportunities. Often called brain drain, this occurs from developing to developed countries, from rural to urban areas, and from the public to the private sector leaving destabilisation in its wake" (JLI 2004). The imbalance is very serious especially in Sub-Saharan Africa, which according to the JLI report, "has a tenth the nurses and doctors for its population that Europe has. Ethiopia has a fiftieth of the professionals for its population that Italy does" (Figure 1). It is evident in the report that countries where disease burden is heavier tend to have less health workers.

The JLI report has been used extensively by different institutions, NGOs and international organisations. Much of the work of these agencies has built on the JLI report. The European Commission report on Health Crisis (2005) asserts that "the

focus on Africa is set within the context of the global crisis of human resources for health, recognizes the problem in other regions". The report continues by highlighting problems in other parts of the world: Asia, as a major producer and exporter of health workers, is facing significant internal health worker distribution problems, which are limiting access to services by poor populations; and in the Caribbean, the quality of service delivery is threatened by the migration of health workers to the USA.

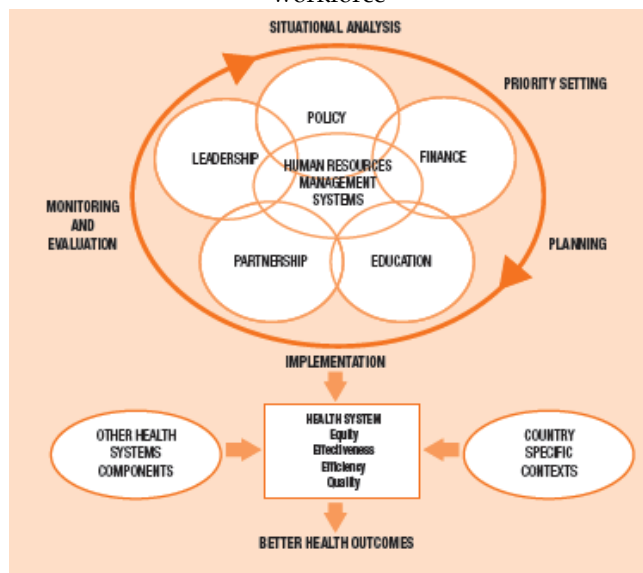
Figure 1. Distribution of health workers



Problems with sustainability of initiatives undertaken in these countries are clear. The JLI report highlights an important problem of international donors and categorical funds such as those for HIV/AIDS, which have failed to be invested and adequately implemented in country plans, contributing to the fragmentation and weakening of the health workforce. The report argues that, “the dangers of fragmentation are especially high in low-income countries dependent on external resources, which are increasingly segmented into disease-specific efforts”. The report also argues that, “these vertical efforts, for the longer term sustainability of their objectives, must build coherence into the development of human resources for stronger health systems”. At the same time the report asserts, that the process of strengthening the health workforce “can be a focal point for coordinating diverse donor activities” (JLI, 2004). The importance of the health workforce for all health activities can transform its development into “a crossroads for donor

synchronization—a common currency for the harmonization of disparate donor activities” (JLI, 2004). The WHO report (2006) likewise adopts the same position on the issue of alliance and partnership sustainability. It proposes a framework of interventions in the areas of policy-making, finance, education, partnership and leadership (Figure 2).

Figure 2. Human resources for health technical framework: achieving a sustainable health workforce



Source: WHO report, 2006.

The WHO report (2006) pays special attention to the issue of public financing of the workforce which relates to the ability of the governments to pay for staff throughout the entire duration of their careers. The donor back-up in the long run is needed for countries which “are reluctant to expose themselves to a potentially unsustainable public debt” (WHO, 2006). The report argues that, “the issue of funding the scaling up of the health workforce in the longer term, therefore, cannot be separated from the broader dilemma of resource mobilization for health. These must be complemented by national strategies that build towards sustainable financing of the health sector” (WHO, 2006).

The same preoccupation is voiced in the Global Health Watch (2005-2006). This report argues that “The frequent changing of international priorities and the short-term funding cycles of donors also needs to change towards adopting realistic and sustainable timeframes”.

From the perspective of the Public Services International (PSI), the global union federation largely representing health workers, the sustainability and effectiveness of public health care services have been undermined by several factors, namely globalization, privatization and outsourcing, demographic changes, health inequalities, migration, an increasing trend towards workplace violence, and the limitations of social dialogue. A Health Services Task Force (HSTF) is active on formulating PSI's health policy and discussing health specific issues.

Among the principles enunciated in PSI's Health Policy Statement (2005) are the following:

PSI believes that people have a right to HEALTH FOR ALL

Health service access is a fundamental human right. Ill health results from income inequalities, poverty, exploitation and injustice. People need access to food, safe drinking water, sanitation, shelter, employment and public healthcare services. Improved health means changes in economic and political priorities and the development of comprehensive social policies with full public participation. Public institutions must be transparent and accountable. This is covered in the PSI policy on Quality Health Services.

Public healthcare services should be:

- Accessible and available to people regardless of geographical distance, gender, disability, age, sexuality, education, social and economic position;
- Affordable and free at the point of use;
- User-focused so that they address the needs and circumstances of the user in an appropriate and timely way;
- Given priority in regions experiencing conflict and disasters.

PSI also advocates that the "funding, planning, policy-setting, regulation and provision of healthcare services should be a government responsibility" (PSI Health Policy statement, 2005) requiring transparency. PSI's call for adequate staffing and resource allocation and public monitoring addresses the issues of the sustainability of health systems.

To PSI, health workers constitute the backbone of health systems. In this regard, the PSI Health Policy Statement (2005) emphasizes the following rights of health workers:

- A decent living wage, which is paid regularly and provides adequate income security;

- Work in a safe working environment, with adequate facilities and equipment;
- Safety from hazards such as violence, infectious diseases or inadequate waste disposal facilities;
- Work in a setting where they are treated with dignity and respect, so that their skills and contributions are recognised;
- Freedom from workplace bullying and violence from patients;
- Equal pay and equal opportunities for employment and access to services;
- Freedom from discrimination because of gender, ethnicity, disability, economic and social disadvantage, age or sexuality;
- Participate in the planning and restructuring of health services;
- Access to training which addresses the needs of local communities and are more problem-orientated and practice-based;
- Work for public healthcare services that are people-centred not profit-centred;
- The full range of trade union and worker rights, including freedom of association and collective bargaining.

Despite pointing out the limitations of social dialogue as practiced in several countries among the factors that undermine public health care systems worldwide, PSI nevertheless puts importance on social dialogue as the basis to any initiative to change public healthcare services. To render social dialogue as effective, PSI advocates for parity of representation of social partners.

PSI recognizes that there are global trends in health and social care services that require coordinated action at global, regional and national levels. At the global and regional level, cooperation with UN bodies such as the WHO, and the ILO and a number of NGOs that share a common perspective is required. At the national level, close cooperation with affiliates in order to implement the policy proposals is also needed.

Recently, the PSI launched its Quality Public Services Campaign to promote government investment in quality public services through adequate financing, improved accountability, better jobs and accessible, affordable and relevant services (PSI website).² The campaign involves local, national and international action. At the country level, unions are identifying their most important priorities and pursuing campaigns to win quality public services. This work is supported by PSI through its union development program.

² See: www.world-psi.org.

Meanwhile, international work includes building alliances with other organisations and institutions and participating in global actions. PSI also works with broad coalitions aiming to change the pro-privatisation policies of the International Financial Institutions (IFIs), the World Trade Organisation (WTO) and meetings of powerful, rich nations such as the G8.

Of recent importance is the joint initiative of PSI and Public World of developing a *General Agreement on Public Services* identifying gaps in eight critical areas, namely resources, accountability, equity, gender, labour, ethical, performance and sustainability (PSI website). In addressing the labour gap, this General Agreement espouses the following:

“The design and delivery of quality public services depends on a skilled and committed workforce. Yet many workers are denied the most basic rights; to join a union and bargain collectively; to be involved in decisions about their work; to have decent pay and working conditions. Women can be particularly disadvantaged by less access to training and promotion, and by unequal pay. By ensuring there are enough staff to do the work and by respecting workers and workers' rights, governments can bridge the gap to delivering quality public services”³.

Whilst the *General Agreement on Public Services* includes addressing the sustainability gap, only the transport, water and energy services are mentioned. Clearly these sectors have a direct impact on the environment. However, the broad understanding of sustainable development, as argued earlier, urges to “overcome not only environmental degradation, but it must do so without forgoing the needs of economic development, social equality and justice” (AEP, 2006). Considering the centrality of public services to the economic development and social justice and equality, the sustainable development concept should be extended to all other public services, health services included.

Clearly, there have been initiatives of PSI that seek to push the issue of sustainability of health services and human resources for health at the national, regional and global level. Despite these initiatives however, the voice of trade unions in global platforms addressing health sustainability issues remain faint, if not entirely silent or absent. Why have unions been left out of the global debate or

³ For more information see: http://www.world-psi.org/Content/NavigationMenu/English/Quality_Public_Services1/5_The_Labour_Gap.htm

discourse addressing the twin crisis of health and HRH? What factors contribute to this exclusion?

Studies looking into factors and variables that may explain the absence of trade unions in the health and HRH debate appear to be wanting. PSI in its proposed Policy Programme on the Health Sector for 2007-2012 mentions the development of specific strategies to ensure there is a health worker trade union voice at international meetings that have a bearing on the working lives of health care workers and their families and the overall development context. However, research critically exploring the factors or causes of the absence of a union voice may be better in contributing, thereafter, to the formulation of strategies.

In light of the above, this study is an attempt to fill the gap in the literature by positing that there are several factors that led to the exclusion of trade unions in the health and HRH debate. These factors are: (1) the predominance of neo-liberal ideology and actors; (2) union's lack of strategic analysis and action on global processes; (3) lack of resources, both human and financial, of international labour organisations; and (4) lack of clearer articulation of a proactive sectoral, grassroots union-driven and workers' need-based approach by unions. By identifying and critically analyzing the gaps and limitations of the debate on HRH governance, this study contributes to the paucity of literature on the topic. Moreover, the study argues of the centrality of union participation in sustainability discourses on health and HRH. The non-involvement of unions in the current debate has significant implications on the sustainability and effectiveness of policy-making and strategy formulation. Trade unions' voice in the debate effectively represents the social dimension of the debate.

CHAPTER THREE

RESEARCH FRAMEWORK AND METHODOLOGY

3.1 Analytical Framework

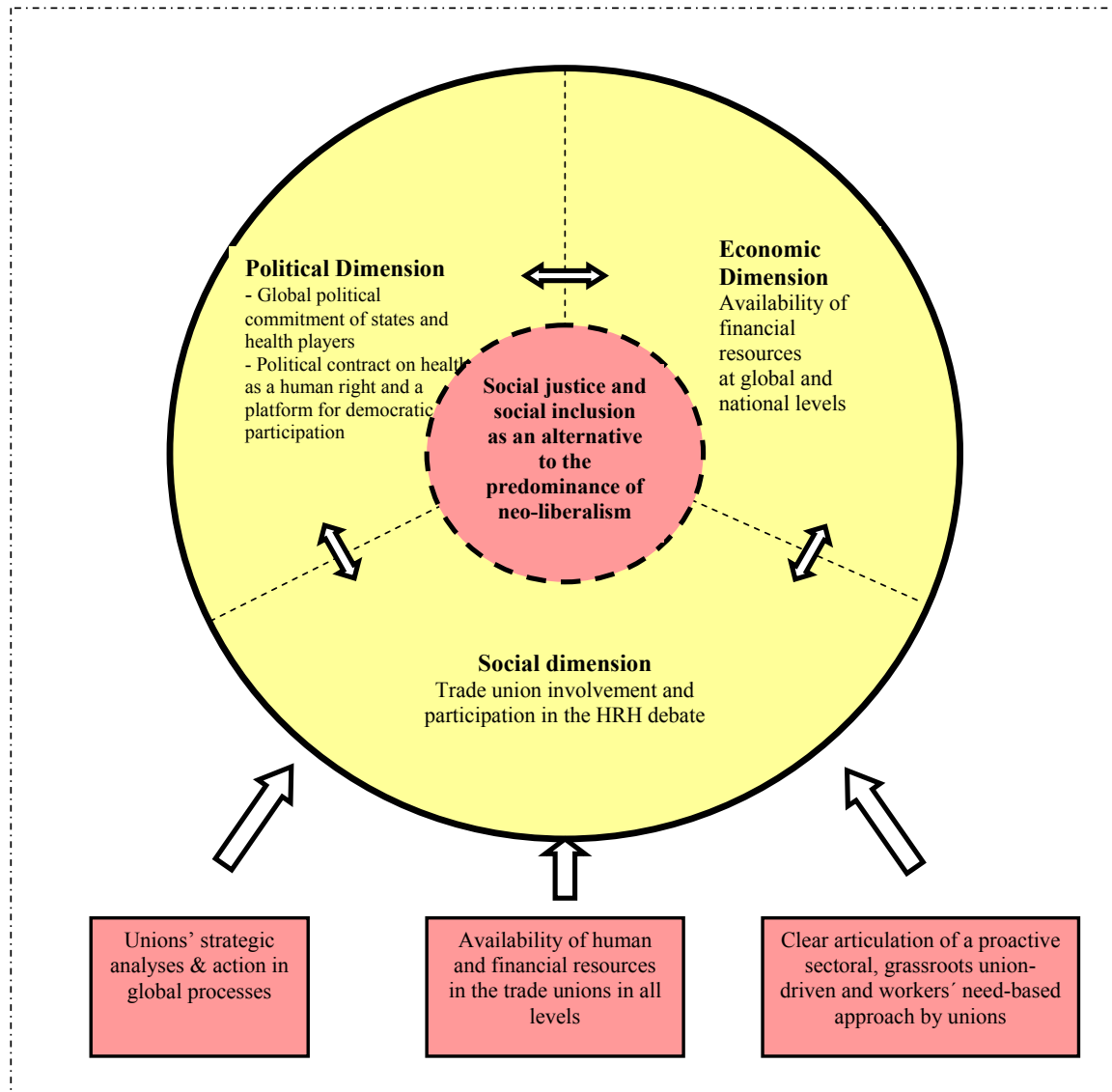
A sustainable strategy on HRH crisis needs to address three dimensions of the governance debate: political, economic and social. These dimensions influence each other and at the same time, they are affected by other important variables. The political dimension, expressed in terms of the global political commitment of states and health players and the existence of a political contract on health as a human right and as a platform for democratic participation is of key importance as it directly affects both the social and economic dimensions. The economic dimension, expressed in the availability of financial resources at the global and national levels is likewise crucial in sustaining strategies addressing the HRH crisis. Global and national institutions may be able to come up with elaborate and comprehensive HRH plans and programs but unless they are adequately financed, they will remain nothing more than weightless words.

The articulation of an alternative ideology based on social justice and social inclusion to the predominant neo-liberal one is of key importance for both the political and economic dimensions. It also influences the social dimension as the governance processes are at their core, processes of power domination. Undeniably, the inclusiveness of governance processes on HRH calls for a multi-sectoral and multi-stakeholder approach involving the meaningful participation of civil society. Civil society primarily is composed of trade unions, other peoples' organisations, NGOs, and other interest groups in society. For the purpose of this study, the social dimension variable will primarily focus on trade unions.

As said earlier, the political paradigm of the discourse on HRH is very important. However, the involvement and participation of unions depends also on other important internal factors such as: unions' strategic analyses and strategic choices, the actions unions engage in, availability of resources at the international level, and a clear articulation of a proactive sectoral, grassroots, union-driven and workers'

needs-based approach by unions. These factors define the 'entry points' for unions and the critical areas of unions' engagement in the governance debate (Figure 3).

Figure 3. Towards a more sustainable strategy addressing HRH crisis



3.2 Hypotheses

- a. The limitations and gaps in the ongoing debate and initiative addressing the HRH crisis may be attributed to the lack of a workers' voice.
- b. A host of factors contributed to the exclusion of trade unions in the political debate on the HRH crisis, namely:
 - predominance of neo-liberal ideology and actors in the debate;
 - union's lack of a strategic analysis and action on global processes;
 - lack of resources, both human and financial, of international labour organisations; and
 - lack of clearer articulation of a proactive sectoral, grassroots, union-driven and workers' need-based approach by unions.
- c. The involvement of unions in the overall debate and initiative addressing HRH crisis will result in the possibility of formulating more sustainable strategies.
- d. Factors such as unions' strategic analysis and action on global processes, availability of resources of international organisations, and a clear articulation of a sectoral approach to the HRH issue by unions will significantly contribute to greater union influence and involvement in the HRH crisis debate and overall HRH governance.

3.3 Methodology/Research Design

In addressing the research questions, the study has utilized the following methodologies:

- a. Gathering secondary data through review of literature, i.e. books, monographs, published and unpublished reports, manuscripts, annual reports, newspapers, etc. Internet research has also been exhaustively undertaken.
- b. Gathering primary data through interviews with key informants, i.e. WHO officials, PSI officials, union officials, academia, NGOs, and other networks involved in health issues.

During the course of an internship in Geneva from 22 February to 31 March 2006, the researcher started gathering secondary data and interviewing key informants. Materials as well as key informants are accessible through coordination with PSI. Nonetheless, problems were encountered in conducting thorough interviews with

key informants due to resource constraints and the informants' accessibility. Follow-up through email was also sought where possible.

c. A short structured questionnaire for trade unions was also designed by the researcher. The instrument was fielded or sent to the target respondents, with the hope that substantial retrieval will better the primary data for the study. However, due to financial and time constraints, only a limited number were retrieved. Though non-conclusive, the results of the questionnaire are cited in this study to complement the overall analysis presented.

Research Timetable

Activity	March	April	May	June	July	Aug	Sept
Review of literature							
Interviews with key informants							
Writing the first draft							
Presentation of the first draft							
Revising the first draft							
Presentation of the revised report							
Writing the final report							
Presentation/ defence of the thesis							
Submission of the thesis							

3.4 Scope and Limitations of the Study

The study envisaged to provide unions with an elaborated research on the actual debate of the HRH governance, main players and initiatives. The study attempted to highlight some of the limitations on the actual debate and the implications it has for a sustainable HRH strategy attributing these deficiencies to the lack of workers voice. At the same time, it sought to surface the levels and ways how unions can enter the HRH governance debate, pointing to some relevant strategies for unions.

The study remains limited in its literature review as the time allocated for this research has been insufficient. The elaboration on limitations and gaps of the actual debate on HRH is confined to the knowledge of the researcher, who has not a

background on health sector. Thus the study is only surfacing limitations of the governance process and does not elaborate in the technical interventions to address HRH crisis.

CHAPTER FOUR

SITUATING THE HRH CRISIS IN THE GLOBAL HEALTH CRISIS – AN OVERVIEW

4.1 The Global Health Crisis – an Overview

Health is a global public good. This concept implies the centrality of health as “a positive-sum: one person’s good health does not detract from another’s” (Chen et al, 1999: 294). A global public goods is defined as such if it meets the following criteria: when “its benefits extend to more than one group of countries and do not discriminate against any population group or any set of generations, present or future” (Kaul et al, 1999: 16). “Indeed better health usually has positive effects on entire populations-through, say, less disease transmission” (Chen et al, 1999:204). Yet, today the world faces a global health crisis.

Attempting to give a definition of what constitutes health crisis is not an easy task. “*Wei-ji*, the Chinese character for crisis, encompasses two powerful symbols: danger and opportunity” (Daulaire, 2002). The globally recognized definition of health of the Alma Ata Declaration (1978) as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity...” is being increasingly endangered.

A crisis is often associated with millions of people living with serious diseases or dying. But what should be the death toll before the world can recognize there is a health crisis? How many millions and in how many countries? Kickbusch and Payne (2004) bring another face to the crisis:

...There is also a global health crisis every time that a woman dies unnecessarily in childbirth around the world and every moment a child that could be immunized does not have access to the simplest of preventions measures. There is a global health crisis every time a sane regulatory approach to tobacco or obesity is defeated in the halls of the WHO because of economic interests. or a young man dies of AIDS because he has had no access to life saving drugs. Yet there are quiet crisis happening everyday out of sight of media cameras and news reporters.

The global health crisis has grown bigger in the last decades. “Rich health societies of the 21st century have chosen to forget, in a form of collective amnesia, what laid

the bases for the health and life expectancy gains in the first and second public health revolutions. In many cases, the development agencies and lending institutions have not been willing to support those very tenants of success in developing world: a strong state, laws and regulation, public health, public education and the understanding that health is part and parcel of a citizen's right" (Kickbusch and Payne, 2004). In the same way, poverty and political instability have contributed to health crisis and the latter has contributed to further aggravation of untenable economic and political situations. In the case of malaria, for instance, the WHO notes that malaria has significant measurable direct and indirect costs, and has recently been shown to be a major constraint to economic development (Shah, 2005). The same has been emphasized in different occasions and from different organisations as health is recognised as a corner stone "to poverty reduction and improvements in the quality of life and in human dignity" (Schirnding, 2002). The results of the health-poverty-mal-development calculus have been from severe to catastrophic, especially in Africa that "for a whole generation it is now too late" (Kickbusch and Payne, 2004)

It is challenging to describe a whole picture of the global health crisis as it is multi-faceted. It has the tangible face of the HIV/AIDS pandemic, of TBC (tuberculosis) and malaria, or of other emerging diseases caused and aggravated by limited access to clean water, inadequate sanitation and malnutrition. An article of OECD Observer of 2004 has shown shocking facts on the situation. Only in 2003, HIV/AIDS killed some 3 million people while around 40 million are presently infected, including 2.5 million children, and each year there are some 5 million new infections.

According to the same OECD study, tuberculosis is in a similar league. One third of the world's population is infected. In 2002, there were 8.8 million new cases, and around 2 million deaths from TB. There are cures, yet only around 37% of TB cases receive proper treatment, due to a lack of resources and unreliable supplies of quality drugs. As a result, Multi-Drug-Resistant TB (MDR-TB) incidence is surging, with 300,000 new cases each year. MDR-TB is a hundred times more expensive to treat than normal TB.

Another major killer is malaria – and as with TB, drug resistance is a growing problem. Each year there are 300-500 million cases, with 1-3 million deaths – mostly children. The social and economic burden of such endemic infection is catastrophic. Economists have estimated that sub-Saharan Africa's GDP in 2000 would have been US\$400 billion rather than \$300 billion if malaria had been eliminated in 1965. Instead, malaria continues to undercut sub-Saharan Africa's GDP per capita growth rates by some 1.3 percentage points per year.

The HIV/AIDS and the Severe Acute Respiratory Syndrome (SARS) epidemics showed that the rich countries are not immunized either from infectious diseases. HIV/AIDS is increasingly recognized to be one of the most serious threats to global stability and progress as a report of the Education For All (EFA) Working Group states. The Swiss Centre for International Health (SCIH) reports (2005) referring to the UN 2005 AIDS epidemic update, in 2005 there were an additional five million new infections and more than 3 million people died of AIDS-related illnesses. SCIH reports that with an estimated 40.3 million people living with HIV in 2005, the global epidemic has reached its highest level. While the epidemic is progressing fastest in Eastern Europe, Central and East Asia, Sub-Saharan Africa still remains the hardest hit region (SCHL, 2005). Whereas a UN Secretariat described the frightening speed of SARS, stating that it affected 8,422 people in 29 countries and killed approximately 11 percent of those infected. China, Canada, Singapore and Vietnam were the hardest hit. It is estimated that the economic toll of SARS has already reached \$30 billion, mostly because of cancelled flights and decreased investment in Asia (UN Secretariat Report, 2004).

The threat of non-communicable diseases is also continuously increasing. WHO (2005) showed in a press release that the number of people dying from diabetes in 2003 was 3.2 million deaths, surpassing the number of people dying from HIV/AIDS. Obesity is increasingly becoming a disease of low and middle income countries, "especially among the more affluent populations that have the financial resources to adopt Western diets and lifestyle" (Kickbusch and Payne, 2004). Approximately 177 million people live with diabetes and the number is projected to double by 2030, especially among the developing countries. Unhealthy diets and

obesity are among the main factors contributing to the non-communicable diseases (WHO, 2004).

The global health crisis is intensifying and the world picture is increasingly becoming more critical.

“Poverty is on the increase, so that hundreds of millions of people are bound by their living conditions to the daily hazard of infectious disease. More than one-fifth of the world's population lives in extreme poverty. Almost a third of all children are undernourished. Half the people in the world lack regular access to the most needed essential drugs. Continuing global population growth, combined with rapid urbanisation, means that many millions of city dwellers are forced to live in overcrowded and unhygienic conditions, where lack of clean water and adequate sanitation provides breeding grounds for infectious disease. High-density populations raise the risk of respiratory disease and those transmitted through contact with pathogens in food and water. Migration and the mass movement of millions of refugees or displaced persons from one country to another - as the result of wars, civil turmoil or natural disasters - also provide fertile breeding grounds for infectious diseases and keep them on the move” (Third World Network, 1996).

Two departments of UN have pointed to another dimension of health crisis catalysed by globalisation, as basic health and safety standards are under the pressure of deregulation. The ILO estimates that there are approximately 250 million workplace accidents each year, leading to 335,000 fatalities (WHO and ILO, 1999). Moreover, one million people die each year from the 160 million illnesses caused by pollution and toxic materials and processes. Illnesses mentioned in the ILO report include respiratory and cardiovascular disease, cancer and reproductive and neurological problems, contracted by workers involved in the production of raw materials in agriculture and mining in the least developed countries. This means heavy and noisy physical work and exposure to pesticide sprays, dust and parasitic and infectious diseases. The report adds that in industrialising countries, less advanced and more hazardous technologies are used and the extent of illnesses and injuries is unknown. Meanwhile, in industrialized countries and increasingly elsewhere, more than half the workers suffer from psychological stress.

Health crisis affect women and children disproportionately across the world. Women and children are particularly vulnerable to ill health through limited access to health care. A fact sheet from Health Global Access Project - Health GAP (2005), a US-based organisation of AIDS and human rights activists, highlights the

precarious situation for women in sub-Saharan Africa, where “a woman’s lifetime risk of maternal death is 1 in 16, compared to 1 in 2,800 in rich countries” (page?).

Yet this is only the tip of the iceberg; only the very visible and tangible part of a dire situation is revealed. The picture changes quite radically if we only change the focus of looking at the crisis. As Kickbusch and Payne (2004) put it “if we speak of a global public health crisis much depends on where we locate the crisis”. The authors argue further that “the tendency of the global health community has been to locate the crisis in the disease ‘global bads’ and to build the response from there” (Ibid). As such, Africa and some other poor regions of the world have been pointed as the ones facing the health crisis and the ones from where to challenge the crisis. But looking at the crisis from another angle and considering the political development in health in the last few decades might lead us in the assumption that in fact the health crisis is global. Kaul et al (in Kickbusch 2004) point out that “the pervasiveness of today’s crisis suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than from issue specific problems” so that “issue specific responses, typical to date, would be insufficient – allowing global crisis to persist and even multiply”. This is also the main reason why according to Kickbusch (2004) the international forums of health community are focusing on health systems and their primary role on achieving MDGs. The main concerns that Kickbusch and Payne (2004) highlight are:

- Insufficient investment and national capacities for public health, primary health care, water and sanitation
- The lack of sustainable and equitable health systems
- Lack of coverage/insurance of the poor
- The dramatic fall of investment in and commitment to universal health systems – the move to privatize and commercialize health and health care
- Lack of human resources- export and brain drain

It is quite clear now that a cautious assessment of the developments in health through these lenses might give another picture of the crisis and its roots.

4.2 Some of the consequences of the neo-liberal Reforms on the Health crisis

Developments of recent decades have been influential factors for public health. The dominance of neo-liberal ideology has been pushed forward through IMF and WB agenda, prescribing Structural Adjustment Programmes (SAP) for poor countries

and reforms/privatization throughout the continents as a panacea for the efficiency of health sector. This section tries to shed some light on some of the ways on which these reforms have contributed to the health crisis facing the world.

The health sector is quite a particular sector. Lister (2005) notes that health care is one of the world's biggest industries, accounting for global spending just short of 3 trillion US dollars in 1997, or almost 8% of the world gross domestic product. The author further notes that the health industry is a major employer, with about 35 million health workers worldwide, making the industry the (world's?) biggest. In this light, policy decisions affecting health care systems not only affect users, but potentially the jobs, pay, and conditions of all health workers worldwide.

The World Bank's approach on healthcare is explicitly expressed in its World Development Report of 1993, which urges governments to "foster an enabling environment for households to improve health; improve government spending in health; and promote diversity and competition in health services" (Khor, undated). Translated into reforms, it meant changes in the organisation and management of the health system (introduction of market mechanisms among others); reforming the health care financing, health care delivery and the civil service structure and administration. This report "effectively proposed the consolidation of a two-tier global health care system, in which the wealthy countries would remain free to spend as much as they wish but publicly-funded hospital care in the developing countries would be reduced to a rudimentary minimum, or privatised" (Lister, 2005).

Quite interestingly the very term 'health sector reform' is a much earlier one dating back to 1987 when the WB issued the report *Financing health services in developing countries: an agenda for reforms*. It might have had to wait for important political developments before it was articulated into policy and imposed as a condition to transition countries or to heavily-indebted countries (HIC) as part of the Bank's Structural Adjustment Programmes (SAPS).

Except in a few cases, SAPS did more harm than good in many developing and least developed countries. Years under SAPS practically wiped out the progress

made by the African countries in the post colonial era. Nayzema, co-ordinator for Consumers International Regional Office for Africa, makes the comment that “today and everyday, the lives of the African people, to a large extent, lie in the hands of health systems inherited from their colonial masters” (Machipisa, 2005). The ‘pills’ prescribed under SAPS have deeply affected all the public sectors, but the health sector is the hardest hit. Machipisa, a Zimbabwean journalist explains the evidence of “clear indications of growing inequities in health and health care in Africa, yet these indicators often seem to be ignored and are persistently downplayed as African governments implement policy changes that affect public health” (as above). Machipisa refers to Professor Nayzema declaring “public sector cutbacks and privatisation of health services are leaving many poor people without access to quality health services, while the wealthy get costly private care; today 1 billion lack access to health care” (Machipisa, 2005).

In other parts of the world which have been heavily influenced by such Bretton Woods sponsored reforms, a deterioration of health service has also taken place. While trying to assess the impact of the SAPS in India, Dr Mira Shiva, a leading health expert and organizer in India, highlights direct and indirect factors. An article from Martin Khor (undated), the Director of the Third World Network, quotes Dr. Shiva who, explaining the dynamics of the increase of the food prices and of unemployment, points to the ways in which this has indirectly affected peoples’ health. She also points out to the cuts in the health budgets imposed by the Bank, which have directly and negatively impacted the country’s health sector. And not surprisingly, Dr. Mira asserts: “The problem is that with one hand the Bank’s policies are taking away the health services the government used to provide to the needy and with another hand the Bank is giving money for health on a loan basis to be repaid” (Khor, undated)

The picture might seem to fall quite well in the reality of the developing countries and far from the ones of developed countries, even though it is well understandable, that as globalisation processes deepen, the transmittable diseases intensify across borders. Extensive literature has been developed in this area, pointing to the fact that health systems, both in developed and developing countries, are under attack. Evans (2001:10) notes the pervasiveness of health

inequalities within countries; even in healthy places such as the Netherlands, Finland, and the United Kingdom, the poor die five to 10 years before the rich. Moreover, researchers have found large life expectancy differences according to residence in the United States.

Neither the developing nor the developed countries have remained untouched by the reforms. Kickbusch and Payne (2004), stress that “privatization of health care in many countries has turned health into a commodity that can be bought or sold on the market”. Accordingly, in the developed world, “citizens become health consumers, while in the developing world, the poorest have to use their meagre income to access health in the marketplace rather than be supported by a public health system” (Kickbusch and Payne, 2004).

The last three decades have gradually surfaced layers of society within the developed countries with unequal access to health services. The U.S. health-care system, according to Gladwell (2005) has created a group of people who increasingly look different from others and suffer in ways that others do not.

Health reforms even in the countries with a long tradition of market relations have not proved to be a success. With 43 million people uninsured and with a health care budget of 14% of GDP (double as much as other developed countries in Western Europe and Japan), the U.S. is a clear example of the failure of adopting a market driven system in health care (Khoon, 2000). The UK is also showing worrying signs. The reforms undertaken by the British Government are clearly driving towards privatization with no attention to the consequences. As Pollock and Price, in a recent edition of British Journal of General Practice (August 2006), put it, “the threat to services arises because the government is giving commercial companies a free hand to run many GP (General Practice) and hospital services while at the same time reducing doctors’ freedom to act in patients’ interests. The new GP contract provides a way of breaking up NHS primary care so that it can be taken over by commercial companies, including large US corporations that specialise in cutting costs by denying patients care”.

The purpose of health reforms was set to “to improve the functioning and performance of the health sector and, ultimately, the health status of the

population" (WHO 1997). Reforms should aim at ensuring this purpose through equity, efficiency and the quality of health systems. Yet, WHO Director General, Dr. Harlem Brundtland, had to accept that "not only do market oriented approaches lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate markets in health care to be inefficient as well" (Khoon, 2000).

4.3 Political Underpinning of Health Crisis

Professor Arnold Relman (2002) of Harvard Medical School points to the same failure of market-driven reforms in health as "the facts are that no one has ever shown, in fair, accurate comparisons, that for-profit makes greater efficiency or better quality, and certainly have never shown that it serves the public interest any better". The spontaneous question is why did countries accept to subscribe to Bretton Woods Institutions' reforms, even in the face of continuous and clear evidence of the failure of a market-driven health care system? Were the reforms the result of a political decision or of economic constraints? The answer might well fall in both economic constraints and political decision. Heavily-indebted countries were strongly pressured to accept the reforms as "the Bank, with its enormous money-lending capacity, can force poor countries to accept its blueprint by tying it to loans" (Khor, undated). While talking about who is in "the driving seat" for reforms, Lister (2005) asserts the prominent role of "global agencies of capitalism" - the World Bank, the International Monetary Fund (IMF) and the World Trade Organisation (WTO), the OECD and the European Central Bank. He highlights the particular role of WB, which through its economic power pushed for health reforms, prescribing a "one size fits all" recipe.

Yet the argument of poverty that is often pushed forward as a drive for budget cuts in health seems not to be very convincing especially in the light of the outstanding experiences of countries that have implemented highly regulated (non-market-based reforms) of the health system, such as Cuba, for instance. In less than half a century, Cuba has attained high levels of public health comparable with those of many developed countries. It has successfully achieved the elimination of diseases that are caused by malnutrition, poor public sanitation, and unhealthy water sources; all of which are major causes of death in other underdeveloped countries.

In fact, “despite a relatively low GDP, and a trade embargo which includes medicines, it has the lowest infant and maternal mortality rates, the highest doctor-to-population ratio and the highest rate of public health service coverage in Latin America. Its performance on key health indicators, including life expectancy and infant mortality, matches those of much richer developed countries” (PSI, 2003: 9).

The case of Cuba strongly supports Amartya Sen (PSI, 2003) when he asserts that “a poor country may have less money to spend on health care and education, but it also needs less money to spend to provide the same services which would cost much more in richer countries”.

There are good reasons to believe that, especially after the fall of communism, there has also been a shift in the global political paradigm. The collapse of communism gave to neo-liberal supporters a free hand to pressure for strategies which focused on the free market as being the only viable domain on which to design policy prescriptions. This is particularly important for former communist countries, where the combination of loan conditionalities and the leftovers of a system in degradation, pushed them towards a general *laissez-faire* approach which extended into the health sector.

Looking at health as a platform for democratic participation and the involvement of society, the fact that the state has been giving up its responsibility for an equal and just health system has political implications first and foremost. According to Khor (undated), the recent years have seen “drastic shifts in global health strategy moving away from the principle of state responsibility for providing health care for all people”. The economic constraints “helped” to justify the reforms, while the paradigm shift in fact drove the process (Khor, undated).

The answer becomes a bit more complicated if we have to understand why the developed countries are also pursuing or finding it hard to resist health reforms. Whereas it is easier to realise that developing countries have limited democratic mechanisms which would make sure people have a say in the process of reforms, leaving the rulers with full power to decide, it becomes quite puzzling to guess the reasons for such transitions in the developed world. Is it the case to start talking about a deficit in democracy or neo-liberalism from the bottom or both? What is

driving policy-making in the developed world? Bianchi (2005), claims that “corporate lobby groups, which include industrial associations, political consultants and cross-industry groups, are gaining ‘far too much political influence’ in the EU decision-making process, and warn that such lobbying is often detrimental to the democratic process and undermines the legitimacy of the EU among citizens”. But this might well be another research topic which this study cannot cover.

What Navarro (2004) asserts seems to be quite relevant for this discussion. According to him, “the root of world’s health and social problems is that the dominant classes in the developed world have allied with dominant classes in the developing world who are against a redistribution of resources that would adversely affect their interests”. The author continues by asserting that the powerful nations’ policies have been shaping the agenda of WHO. Clearly, health is a highly political issue and questions of wealth and power are at the heart of the discussion on the health crisis.

A discussion on wealth and power is obviously as relevant in the pharmaceutical industry which has been an important factor exacerbating the health crisis. The diseases that have plagued developing countries seem to be a paradox in the face of rapid technological development. The market dictates the areas of research and development in the science of medicine. This is why “multinational pharmaceutical companies (MPhC) neglect the diseases of the tropics, not because the science is impossible but because there is, in the cold economics of the drugs companies, no market” (Shah, 2005). Clearly market for MPhC implies people who have not only the need, but also the money to buy, hence out of thousands of new medicaments invented last years, the ones for tropical diseases hardly reach 1%. One amusing example given by Shah is the fact that unlike Viagra which has received extensive attention in R&D, medicines for leishmaniasis, (which is a tropical disease mostly found in the Amazonian regions of South America and which causes profound skin sores and abscesses and strikes internal organs of the body such as the spleen, liver and bone marrow and can be fatal), needed by poor people in poor countries are lacking. “Pharmaceutical companies judge that they would not get sufficient return on research investment, so why, they ask, should they bother?” (Shah, 2005) At the

end, “lacking market power, the disease of the poor are ‘orphaned’ by benign neglect” (Chen et al, 1999:294).

HIV/AIDS has been the tragic evidence of the crisis of the health system in many dimensions, drug access included. According to a WHO report of 2003, in Africa only 2 percent of the 44 million people who need treatment have access to the necessary drugs. But even when poor countries dare to produce their own generic drugs, they get penalized and threatened through the World Trade Organisation (WTO) rules regarding patents and intellectual property, known as the TRIPS Agreement (Trade-Related Aspects of Intellectual Property). Among many cases, the case of CIPLA seems to better illustrate the situation.

When CIPLA, one of India’s leading generics companies, offered a cocktail of anti-retroviral drugs for AIDS at \$350 a year, compared to \$10,000 from the multinational companies, this sent a shockwave in two ways. Poor countries realized they might have more affordable means to deal with a massive health crisis that afflicts them the most; and the large multinationals saw their monopoly prices severely threatened, and, exposed. India’s patent laws have allowed the production of cheap generics. CIPLA, for example, offered this low-cost price for their AIDS drugs at a loss of itself, because it said it made profits from other drugs, and this was something that was more than about profit and loss. However, India’s patent law has been under pressure from the rich countries for a long time now. Their patent laws were tightened up in early 2005, to come into line with WTO laws, thus making cheaper alternatives less easy to produce” (Shah, 2005)⁴.

It should not be very difficult to find out what lies beneath the power and influence of MPhC. An Oxfam Briefing paper of November 2003 points that “the U.S. government is pursuing this pro-patent agenda on behalf of its powerful pharmaceutical lobby, PhRMA”. The same paper alludes that the industry has an interest in strong patent protections, which limit generic competition and therefore protect its market share and profits.

“In 2000, the industry contributed approximately \$20,142,583 in campaign contributions, 76 per cent of which went to the Republican Party, and in 2003, the industry gave \$29,371,406, with \$21,719,527 of that money going to Republicans. In addition, it spends approximately \$120 million each year on lobbying. This is a drop in the ocean compared with its yearly sales: an estimated \$400 billion in 2002. The ten largest U.S. drug companies made \$35.9 billion in profit in 2002, with a rate of return for shareholders of 27.6

⁴ Read further on:
<http://www.globalissues.org/health/overview/#WTOpatentsIntellectualPropertyEmergencyDrugsandDevelopingCountries>

per cent, more than two and a half times the Fortune 500 average of 10.2 per cent" (Oxfam, 2003)

There are many indicators pointing to the fact that "American agenda seems to be increasingly driving the global agenda" (Kickbusch and Payne, 2004). And this holds particularly true for health as some of the examples above tried to highlight.

Meanwhile, the Doha Declaration, WTO negotiations of 2001, which acknowledged the importance of health care and accepted the need to interpret the rules of property rights in a way that would not prevent poor people from accessing drugs, seem to have been forgotten and is presently gathering dust in the archives of the WTO.

The real health crisis today lays in the fact that in spite of the technological revolution and fantastic achievements in the health industry, the reality is saturated with outrageous contrasts. Kickbusch and Payne (2004) see the global health crisis as best "expressed in the distance between the do-ability of health and the inequity of the global health situation". Some questions arise unsurprisingly: Why did many countries 'forget' that the foundation on which developed countries progressed started as a revolution under the flag of health care for all, free at the point of delivery? Why is it that the life of a poor person today is regarded as being less valuable than the life of a rich one? Why is the life of a citizen in the developed world more important than the life of a developing world citizen? For how long can we accept life differences which are, in some cases, as wide as 40 years? Or, more pointedly put by Kickbusch and Payne (2004), would, in some cases the limits set by the market on the do-ability of health in this age qualify as crimes against humanity?

The dynamics of the global health crisis today indicate serious problems on the key health determinants: water and sanitation, air, housing, education, safe work, better food, shorter working days, maternal care and access to family planning. "Over a billion people still do not have access to clean water and 2.4 billion have inadequate sanitation" (Parris, 2004). At this point, it becomes clear that at whatever point you look at it, the debate on human dignity, equity and social justice is of prominent relevance and should be at the core of a more sustainable strategy addressing the crisis. A long term solution to the crisis should build on this debate and focus

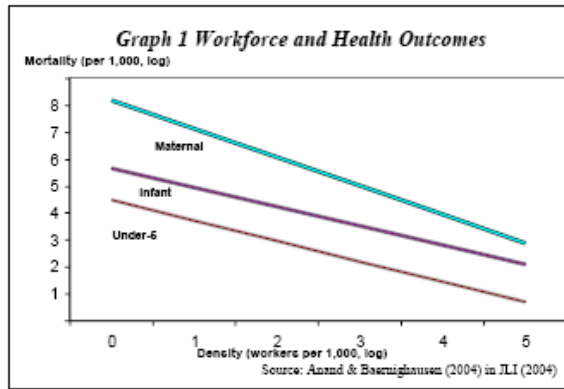
should be elevated from mere disease-combating approaches to a multi-dimensional and multi-sectoral approach.

Undoubtedly, regarding health care, there is clear evidence of the obvious tension between the “philosophy of neo-liberalism, emphasizing self-interest of market based economies, and the philosophy of social justice that sees collective responsibility and benefits as the prime social goal” (Kickbusch and Payne, 2004). Unless we win the battle of this tension, many questions will remain unanswered.

4.4 Human Resources for Health Crisis - its Dimensions, Causes and Effects

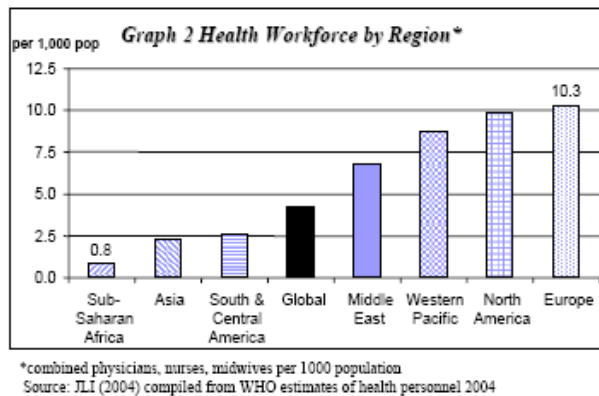
The crisis of Human Resources for Health (HRH) contributes directly to the global health crisis. As a WHO report (2006) puts it, people deliver health. A crisis in human resources in health is proliferated in a crisis of the whole sector, as “health services are labour intensive” (PSI, 2003). The HRH crisis affects both the service providers and receivers. As the High Level Forum on Health MDGs (HLFMDG, 2005) emphasizes, “whether viewed from the perspective of a person who is ill, in need of urgent care but denied access to essential services due to the absence of a health worker, or viewed from the perspective of an over-stretched health worker who is inadequately equipped and supported bringing barely poverty-level wages back to her family, the crisis in HRH is an old problem exacerbated by fresh forces taking on new forms”. Extensive research has pointed out the direct relationship of the number of health care workers per population and the quality of health delivered to people. There is now abundant evidence that “a motivated and skilled workforce is critical for reducing maternal and child mortality, to manage HIV/AIDS, TB and malaria, as well as for the provision of essential preventive, diagnostic and curative services” (HLFMDG, 2005). The graph below gives a clear picture of health workforce and health outcome, pointing to the adverse relationship between mortality reduction and the number of health workers.

Figure 4: Workforce and health outcomes



Whereas JLI (2004) estimates talk about a density of 2.5 health workers per 1000 as a necessary proportion to hit key milestones such as 80% coverage of immunizations and skilled birth attendance, the global situation appears to be extremely different from a negative standpoint. This is notwithstanding the fact that the world’s regions show great differences in terms of numbers of health workers per population, as JLI reports “all countries confront a common set of challenges – severe shortages, mal-distribution of workers, inappropriate skill-mixes, negative working conditions, and huge knowledge gaps”.

Figure 5: Health workforce by region



While trying to explore the extent of the HRH crisis, it turns out that the analyses of health crisis are quite relevant in enabling a better understanding of this crisis. The JLI report (2004) draws an extensive picture of the crisis pointing to the fact that the crisis is multidimensional: the number of global health workers is not enough, they lack the necessary skills and support networks, they are overstretched and overstressed, and often they are not in the right place. Three main factors have

strongly contributed to the crisis. The following discussions from JLI elaborate on these factors.

Investment was replaced by neglect: Almost three decades of health sector ‘miss-reforms’ under the neo-liberal agenda, treated health workers as a cost burden, not as an asset. “Amazingly, buildings are considered capital assets, while human capital is considered a recurring burden” (Chen 2004: page?).

The JLI report (2004) highlights the particularity of health workers as it takes more than a decade to prepare a qualified health worker, but it takes much less time to destroy the will, dedication and qualification of the worker to commit him/herself to health service. The domination of the neo-liberal agenda and the pressure for reforms from International Financial Institutions (IFIs) shaped most countries’ policies on health. The effects have been catastrophic as Khor (undated:) points out “in many countries, the public health budget has been cut, health-related fees have shot up, and the health situation, especially of the poor, has deteriorated. Problems such as malnutrition and child deaths and the resurgence of cholera, tuberculosis, malaria, and plague will worsen if present trends in health policy continue”. In his paper on the case of Malaysia, Chan Chee Khoo (2000:), asserts that: “rather than over-spending, there is in fact under-spending, which leads to the real problem in the health sector: the massive and sustained haemorrhage of senior, experienced staff from the government service to the private sector, due in part to large differentials in remuneration”.

Technical support for the health sector has been the main feature of donors’ intervention, undermining the need and importance of investing in human resources. Underinvestment in health worker training is particularly critical in Africa. A report of the EU Commission (2005) considers underinvestment as an important factor which has led to “limited training capacity in many countries. Some of the under capacity is a consequence of insufficient public investment in the health sector aimed at limiting unsustainable growth in salary (recurrent) costs”. The report further states that the level of the service now “has fallen below the levels needed to maintain even basic service provision and a significant proportion

of those who are trained leave public service or their country of training without making any significant contribution to health care delivery” (Ibid).

The tendency has been clearly looking at health as a technical problem and avoiding its very political core, embedded in health as a human right.

The triple threat of HIV/AIDS. HIV/AIDS, according to an LJI report (2004), poses a triple threat to the workers, in terms of workload and skill demands of health workers, health workers dying and psychological stress offering help to people dying and taking care of their families. HIV/AIDS has affected health workers in a particular way, especially in Africa where the facts are alarming. “Caring for the sick is not only demanding but risky, because of the work-related hazards of contamination. In a few years the HIV prevalence rate among nurses in Lusaka rose from 34 to 44 percent” (JLI, 2004). The situation raises serious concerns about the quality and productivity of the existing workforce. In the face of the HIV/AIDS pandemic, the shortage of health workers becomes a determining factor for the future of the countries. An NGO’s press release of 2005 expresses the emergency of the situation where in Malawi, for instance, “only 10% of the physician slots are filled, while 10 people die every hour of AIDS” (Health GAP 2005). The press release highlights the fact that “across Africa AIDS has killed thousands of health care workers, and large numbers of doctors and nurses are migrating to the West, driven out by impoverished health care systems and lured by elaborate recruiting packages by hospitals in G8 countries” (Ibid).

Migration: The main problems above constitute some of the main pushing factors for the migration of health workers. HIV/AIDS ‘helped’ to surface the serious impact of migration in reaching objectives of fighting AIDS, and this holds particularly true for sub-Saharan countries. It was when global initiatives to provide retroviral drugs in Africa were swamped by an insufficient number of health workers to deliver the drugs, that the international community fully realized the depth of the crisis. The crisis is particularly serious in Africa, where as HLFMDG (2005) estimates “over 600 million sub-Saharan African people are served by fewer than one skilled worker per 1000 population, less than 100,000

doctors in total". Worldwide the numbers are as well dramatic as JLI (2004) shows below. Asia, home to about 50 percent of the world's people, has 30 percent of the global stock of doctors, nurses, and midwives. Together, Europe and North America have 20 percent of the world's people, but almost half of the physicians and 60 percent of the nurses. For doctors and nurses the regional differences are enormous. Average density is 1 worker per 1,000 people in sub-Saharan Africa, but more than 10 per 1,000 in Europe and North America. Country densities vary even more. Doctors range from a high of 6 per 1,000 in Italy to a low of 0.02 per 1,000 in Rwanda. Nurse and midwife density ranges from 22 per 1,000 population in Finland to a representative low of only 0.09 nurses and midwives per 1,000 in Uganda—a more than 200-fold difference.

The 'brain drain' of health workers, amidst the consequences of miss-reforms and the AIDS pandemic, has contributed further to the "weakening of already fragile health systems" (Kickbusch and Payne, 2004).

The JLI report (2004) states further that "often magnifying the geographic imbalances are within-country workforce inequalities in gender, ethnicity, skill mix, and private and public sector employment".

The crisis of health workforce persists worldwide. With less alarming figures (partly because of the cushioning effect of migration) it is more present, everyday, in the developed countries as well. The facts are alarming. "By 2008, the UK will need 25,000 more doctors and at least 35,000 more nurses", whereas "by 2010, the USA will need to recruit an extra one million nurses" (Save the Children, 2006). The shortage is a consequence of many reasons which have build on each-other for more than two decades. The growing of the elderly population is often presented as a main reason, without considering that in fact demographic data have warned for a long time the coming challenge. In spite of clear demographic trends, the policy-makers did not respond with sustainable health workforce policies which could live up to the challenge. Ironically, they did the contrary. WHO (2006) asserts that "wealthy countries are not producing enough health workers locally", by restricting access to training programs due to inadequate teaching staff and

facilities (ICN/FNIF, 2006). At the same time, decades of health care reforms have transformed nursing in a job which is less and less attractive as expressed by the high turnover of the nurses in the hospitals and in the high proportion of nurses choosing a job outside nursing⁵.

Migration itself is a central component contributing to the HRH crisis and as such, it gives a better understanding of the real dimensions of the crisis. The report of the EU Commission (2005) points in this direction as well: "High health worker mobility, lack of decent work opportunities, lack of social protection coverage, limited incentives, particularly to work in under-served areas and with poor people, combined with high global demand for health workers, has created a severe crisis in health care provision for the poor". The report continues further and accepts that in fact the actual market for health workers is a "distorted market, shaped by global inequity in health care provision and the capacity to pay workers, rather than by health needs and the burden of disease" (Ibid).

The JLI report (2004) indicates that the demand for health workers will increase in the future. The report states that the U.S. alone will need an additional one million health workers from the global market and that poor countries are most probably the ones which will fuel this gap. Another report from HOPE (2004), an employers' organisation in Europe, also recognizes the seriousness of the crisis in Europe. This report stresses that "over recent years there have been increasing concerns about shortages of staff to provide care for patients at a time when demands for care are increasing as population age and the range of treatments which can be provided increases" (HOPE 2004). The same report states that one of the ways of mitigating the staff shortage has been to recruit health workers from other countries, both inside and outside the EU.

With regard to regional health workforce patterns, the WHO report (2006) points to enormous variability where the "OECD countries may be characterized as calm before impending storm of shortages and imbalances; Africa is experiencing a

⁵ In the US, one in 20 licensed nurses (5%) has chosen a job outside nursing (Lovell, 2006).
"The NHS is struggling to recruit and retain nursing and midwifery staff in a time of high turnover rates and low morale" (Finlayson et al, 2002).

severe HRH crisis in midst of severe health crisis; European labour flows are likely to accelerate with EU expansion, including massive restructuring in Eastern countries undergoing transitions in economy and policy, and the bulk of low and middle income countries in Asia and Latin America suffer common problems of skill imbalances and geographical mal-distribution”.

Migration has dramatically increased the burden of training the health workforce in developing countries. The cases are often outrageous. The EU Commission (2005) reports the following:

It has been argued that resource-poor countries are providing a perverse subsidy to health services in resource-rich countries. Calculations based on migration of health workers from Ghana to the UK, estimate the saving in training to the UK from recruitment of the 293 Ghanaian doctors and 1021 Ghanaian nurses registered as practicing in the UK in 2003/2004 at £65 million for doctor training and £35 million for nurse training. Ghana’s loss includes both the training cost and the opportunity cost of understaffed health facilities”.

Sometimes, governments even decide to train the health workforce for migration purposes despite the fact that they face shortages of health workers. The same report from the EU Commission (2005) notes that “India, the Philippines, Cuba and, increasingly, Indonesia and China, are responding to the global demand from the international market for health workers by increasing health worker production and supporting outward migration”. And this happens despite the fact that these countries are likewise facing a crisis of HRH. The Philippines, for example, “operates a managed migration policy and is the largest source of registered nurses working overseas although its own health service suffers from entire nursing units migrating, leaving hospitals understaffed, and is now facing the problem of doctors retraining as nurses in order to migrate to higher paying jobs, particularly in the USA” (Ibid).

In light of the above, HRH-related problems overlap, intersect and produce a very complex combination, which aggravates the crisis and poses serious challenges for the future of the health sector. The JLI report (2004) emphasizes the main concerns challenging the health workforce today. These are:

- *A massive global shortage of workers.* An estimation of the shortage speaks of 4 million workers, yet the estimation is very approximate. Sub-Saharan African countries remain the region hardest hit by the crisis and it is in this context that often reference will be made to that region. The research considers the importance of making sure an urgent increase of one million workers in this region, just to approach the MDGs achievement.
- *Skill imbalances, which create huge inefficiencies.* There is a skill mix which depends mainly on doctors and specialists; and the public health workers based on the needs of population are often left aside. There is obviously a need for a workforce which reflects the needs of the population and which uses better auxiliary staff and community workers.
- *Mal-distribution which is worsened by unplanned migration.* Nearly all the countries have problems with a high concentration of the population in urban areas, leaving the rural ones in very poor conditions of health service. The mal-distribution has another aspect which is the movement from public to private sector, which from the other side is again more concentrated in the urban areas. Migration, especially unplanned migration, has caused severe crises, especially in countries which are already facing a desperate health service situation.
- *Negative work environment.* Nearly all the countries have problems with professions and work incentives, career opportunities, financial and non financial incentives, drugs, equipments and supplies.
- *Weak knowledge on workers impacts negating possibilities for greater effectiveness.* There is lack of information on workers, the data are fragmentary and there is limited research and these deficiencies heavily impact on planning, programs and policies.

To the extent that shortages of properly trained, motivated and proud health workers may spell the collapse of whatever health system in the world, the implications the aforementioned issues have on the global health crisis are very serious. It is in this regard that the HRH crisis has ranked quite high in the global agenda and is now widely recognized as a precondition to realize the promises made in the MDGs. In the same spirit, the WHO report and the Day of Health for

2006 were dedicated to human resources for health. The recognition that health workers could be “a main constraint or a contributor” (JLI, 2004) to the progress implies the significant role they play in the global health agenda. The main challenge now is to accord the health workers the place they deserve and appreciate their real value in society.

CHAPTER FIVE

THE GOVERNANCE OF HRH – STRUCTURE, TRENDS AND SHIFTING PARADIGMS

5.1 Human Resources for Health at the top of the Global Health Agenda - Main Players and Initiatives

The crisis of global health has provoked political action. Greater public awareness and concern has obviously created conditions for faster responses through stronger political commitment, more financial resources, and new mechanisms. New actors have entered the global health arena, challenging existing paradigms of dealing with health issues. These new actors, such as academic institutions, researchers, NGOs, and health leaders, have been at the forefront of campaigning for health as a human right and HRH action.

The HRH crisis has, in the same manner, elicited varied reactions from the global health community and other players from political circles, international institutions, transnational companies (TNCs), powerful foundations, and international support organisations for civil society organisations and trade unions.

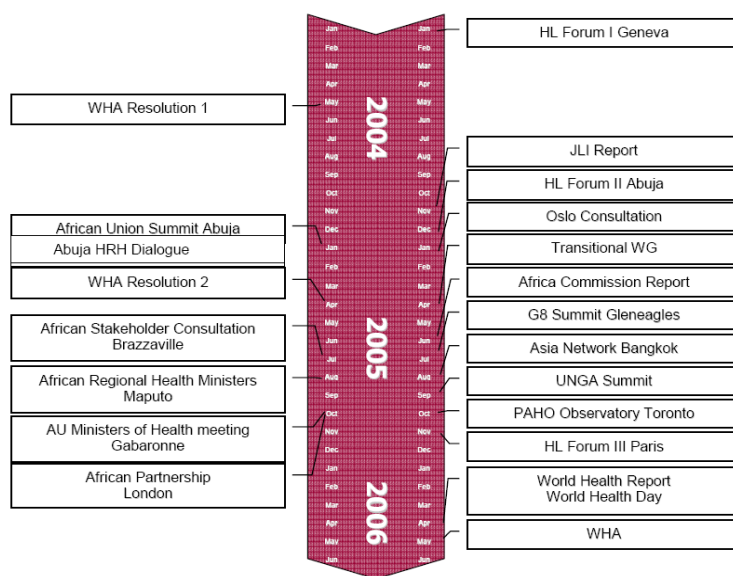
Between 2004 and 2005, the three high level forums convened (Geneva in January 2004; Abuja, December 2004; Paris, November 2005) to evaluate progress on the MDGs for health increasingly focused on the issue of human resources for health, in particular, the crisis in Africa (WHO, 2006). HRH was identified as a key priority by the African Heads of State in Abuja, Nigeria in January 2005 and this was further echoed in a later meeting in October of health ministers of the African Union in Gaborone. The UK Africa Commission devoted a major share of its health recommendations to the strengthening of the workforce in health systems. Political commitment to HRH was expressed in the G8 meeting of June 2005 in the Gleneagles Summit and was reaffirmed at the UN Summit for the MDGs in September (HLFHMDG, 2005). The European Commission, too, has focused attention on the HRH crisis, recognizing the scale of the crisis in Africa and showing strong commitment for a long-term solution. Some regional conferences

and workshops dealing with HRH issues have also resulted to the formation of regional networks such as the NEPAD/WHO/ACOSHED Conference on Human Resources held in Brazzaville in June 2005 in Africa, and a network in Asia sponsored by the Thai Ministry of Public Health workshop held in August 2005.

The foregoing initiatives along with others are chronologically listed in Figure 6.

Figure 6: Global and regional initiatives tackling health workforce

Figure 1: Health Workforce Activity



Source: Global Health Workforce Alliance Strategic Plan, 2006.

The Joint Learning Initiative (JLI) is the first overarching network of 100 health leaders and experts that produced, with the support of important foundations, the first report of this scale of participation on human resources for health. It was launched in November 2002 in recognition of the centrality of the workforce for global health. The JLI report has been an important catalyst in inciting political action on the HRH crisis. In the Oslo Consultations in February 2005, the JLI Working Group was transformed into a Transitional HRH Working Group aimed at strengthening HRH to achieve national and global Health goals.

Building on ongoing collaboration among stakeholders catalyzed by the High-Level Forums, the Oslo Consultation, the Joint Learning Initiative (JLI), the WHO

and the World Bank, bilateral and nongovernmental bodies, and regional networks; a global alliance has emerged from the Transitional Working Group (TWG), not as a separate new organisation but built on collaborative linkages across existing and new actors. The importance of the issue was clearly reflected in the World Health Report (2006), which in the same year was dedicated to HRH.

To date, the latest overarching initiative is the Global Health Workforce Alliance⁶ (GHWA), a global platform for human resources for health which was launched on May 24th, 2006. GHWA is claimed to be part of a global plan of action embedded in a global social movement on HRH. In the Paris Conference in November 2005, the High Level Forum of the MDGs on Health, highlights in its report that the “alliance should be a mission-driven, 10 year time-limited partnership of key stakeholders aimed at strengthening health systems and priority programmes.... (It) would be open and inclusive to Governments, academia, educational institutions, NGOs and professional bodies” (HLFMDG, 2005).

Meanwhile, different initiatives and networks have emerged lobbying and pushing policy-makers to adopt sustainable and more-inclusive strategies. The High Level Forum on MDGs (2005) highlighted some of the main initiatives.

Public attention in Northern countries has been further fuelled by the press, media, and NGO advocacy. The BBC, the New York Times, and the Guardian all have extensively featured the HRH crisis in Africa. Nongovernmental organisations have been successful in bringing the workforce crisis into public focus and into policy formulation in the US congress, UK parliament, and other legislative bodies. Professional groups have also been active, with major coverage of HRH by leading medical journals like the Lancet and the British Medical Journal. Indeed, among the most active advocates for correcting the unfairness of migration depletion from the poorest countries has been the British Medical Association.

Clearly, developments indicate a unique moment in history for the HRH issue as for the first time there is general awareness and recognition of the crisis and there are resources available. But will this historical opportunity be seized?

5.2 The Global Health Workforce Alliance - Leading HRH Platform

⁶ <http://www.ghwa.org/>

The Global Health Workforce Alliance (GHWA) is an open and inclusive global platform conceived as “a global focal point to maintain political visibility for the health workforce and, through targeted catalytic activities, to strengthen the workforce plans and activities of its stakeholders in countries around the world”(GHWA, Strategic Plan, 2006). It was founded to build on the work of the two previous global initiatives, the JLI and TWG and on the World Health Report of 2006, recognizing the twin problem of shortage and the lack of training and knowledge of health workers which pose major obstacles for health systems to effectively respond to chronic diseases, avian influenza and other health challenges (GHWA, Strategic Plan, 2006)

As discussed above, there is already strong evidence expressing the importance of HRH as “progress in health in the poorest countries will not be possible without strong national health system for which the workforce provides the backbone” (GHWA, Business Plan, 2006). Indeed, health workers are at the heart of health systems as they “determine health outputs and outcomes drive health system performance and command the largest share of health budget” (Ibid).

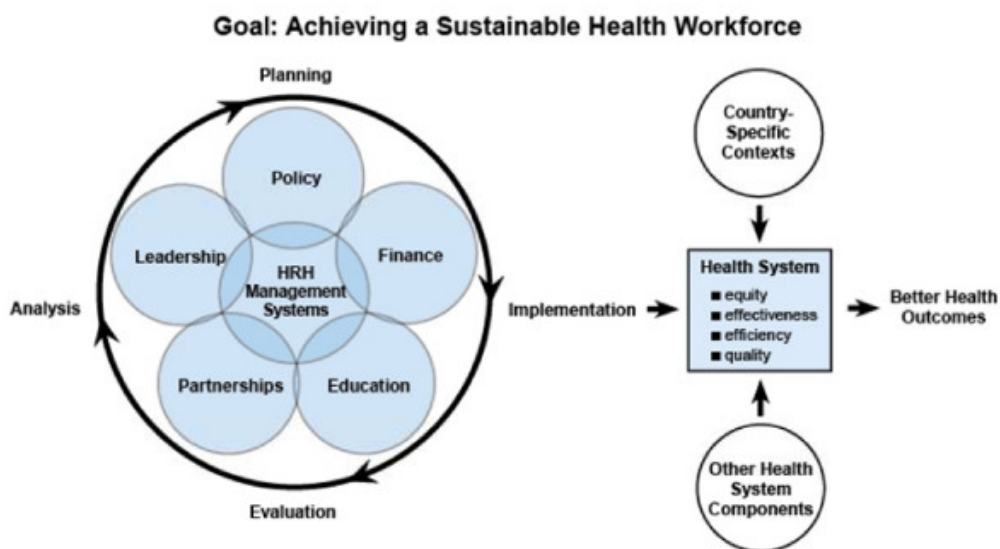
It is on this crucial role of HRH in strengthening the health systems that much of the literature would point out to the exceptional possibility to transform HRH into a platform of cooperation and coordination. As the report of HLFMDG (2005) puts it,

“In the same way that human resources represent the cement of the health system, essential for holding the various components together, coordinated action addressing the HRH crisis can effectively link and strengthen joint work between existing global initiatives. HRH provides a common unifying theme. Addressing the crisis in HRH requires a modality to accelerate more effective action – for without greater cohesion there are real risks of fragmentation, competition, duplication, and insufficiency. There are already signs among the many new starts of independent initiatives, often donor driven, that are neither well aligned with country priorities nor the investment policies of others”.

It is in this spirit that the Global Health Workforce Alliance tends to be an all-inclusive and coordinating platform, attempting to ensure the highest participation and the maximum number of contributions from different initiatives. It builds up and follows on the work done by representatives of multilateral and bilateral

agencies, donors, partner countries, nongovernmental organisations and the academic community who came together at an informal consultation sponsored by the World Health Organisation and the United States Agency for International Development in Washington, DC, in December 2005. The main purpose was to prepare a technical framework which would enable countries to develop a concrete national health workforce strategy "that could be supported and implemented in a planned and systematic manner" (Dal Poz et al, 2006). This framework presents 6 components of planning and managing the health workforce: health workforce management, policy, finance, education, partnerships and leadership, with health workforce management systems at the centre as the glue of health systems, integrating all the other components.

Figure 7: Global Health Workforce Alliance framework on sustainable workforce



Source: Global Health Workforce Alliance Strategic Plan, 2006.

Areas of priority of GHWA

This part of the study gives a full description of the Global Health Workforce Alliance, its main areas of intervention, the governance mechanisms, surfacing possible spaces for a wider participation of trade unions and civil society and it builds mainly on the Strategic Plan of GHWA.

- 1) Accelerating country work for HRH

The main purpose of this intervention is to ensure that countries will have the domestic capacity to develop national workforce plans, policies, and management systems. Partnership arrangements with the country showing interest, readiness and leadership as well as in conjunction with regional networks will be formed by the GHWA.

A combination of initiatives will be realised by the Alliance aiming at raising political visibility of HRH through global, regional and local country advocacy; providing information, tools and guidelines for best practice country assessment, development and implementation of comprehensive evidence-based HRH plans and programmes; providing technical cooperation as needed to develop realistic country plans, foster ownership at the country level and help countries to develop capacities to raise funds; and providing catalytic funds for achieving the above.

A transitional strategic advisory group may be appointed to develop details of the first intervention. The group would propose short-term actions as well as medium-term and long-term outcomes for the Alliance regarding assessment of country HRH systems.

2) Harmonizing priority programmes

The GHWA asserts that harmonization is both an intra-national and an international process and as such actors will be approached at both levels:

At the country level, HRH issue should be fully integrated into the national development plans. This will call a special focus not only on the HRH issue, but also towards the promotion and coordination among other important players such as Ministers of Finance, Health, Education, Labour, Planning and Defence). The Alliance will help out the process of integrating and coordinating the initiatives and actions of different organisations in line with country strategies on HRH.

At the global level, the Alliance will assist the coordination of health partnerships and initiatives working on scaling up health systems and HRH issue. This will aim

both at aligning initiatives into a global framework, target and policies, but also at sharing experiences on bottlenecks and move into a common agenda.

3) Building knowledge and stimulating learning

The Alliance will operate as a global hub for information and knowledge on all HRH issues through consolidating knowledge, data and information (from WHO, WB and ILO, regional observatories, academia, HRH experts and NGOs) and developing an international research agenda and disseminating knowledge and best practices. A yearly report on HRH global status will be published. The main purpose of this intervention is that in the long run it will ease the access for countries concerning HRH knowledge and resources as well as building a common agenda for new learning in the HRH area.

4) Advocating for HRH issues

The Alliance will advocate for the central importance of HRH issues and effective strategies through political visibility and catalysing action. The yearly report on HRH will be used as a strong tool for advocacy, whereas the Alliance will act as an early warning system in cases of worsening. HRH agenda will be placed at key global, regional and national meetings.

5) Addressing specific global challenges

As stated in the Priorities of GHWA (2006), the Alliance will identify issues of a trans-national, political and economic character which are too complex and can not be tackled by a country or a region itself. Already some challenges may be identified: fiscal space policy regarding HRH, migration, HRH responses in fragile states, universal access to anti-retroviral treatment, HRH research prioritisation, donor impact on HRH markets, skill mix and community health workers, scaling-up of pre-service training, safety and health of health workers, particularly those exposed to HIV/AIDS. The first two challenges have been identified as requiring special urgency.

Structure of the GHWA

As stated in the GHWA's 'governance' chapter, the Alliance is first of all a convening forum for HRH issues and it will not serve as a funding organisation or implementer. Hence the Alliance will leverage what networks and initiatives already exist, including regional networks, health partnerships and initiatives, multilateral agencies, public-private partnerships (PPPs), NGOs, and other agencies. The Alliance will ensure that all stakeholders have equal voices in the forum, a disproportionate voice from any agency will be inappropriate.

The Alliance consists of the Forum, Board, Secretariat, Task Forces and Regional Networks. The highest level of the Alliance is the Forum, of which membership is open to all the agencies able to demonstrate that they have a mandate or relevant expertise in the field of HRH. This will include groups within and beyond the health sectors such as NGOs, health partners and initiatives, professional associations, national governments, regional networks, private sector organisations, donors, UN members, and academia – at the public and private as well as national, regional, and global levels. Among other objectives, the Forum will aim at providing a space to share information, experience and learning; serve as peer reviewers and be responsible for mutual accountability and monitor progress according to priority interventions and endorse the Board as nominated by stakeholders.

The Board is representative of the main constituencies supporting the Alliance in order to ensure that the spirit of cooperation and coherence in support of national plans and regional and global actions is maintained in all the work of GHWA. It appoints and oversees the work of the Secretariat, plays a decision-making role in the creation and dissolution of task forces, oversees the work of the Alliance, negotiates partnership arrangements, engages with the Forum to ensure the participation of all the stakeholders in GHWA, promotes the work of the Alliance, helping to define the clear role for each Alliance partner and align support at the global and regional levels behind the strategies of support to ensure country-led action.

The role of the Secretariat is the one of facilitating communication and activities of the Forum, Board, regional networks and task forces as well as other administrative work.

Task Forces will be key mechanisms for implementing priority interventions and will consist of appropriate stakeholders and experts. Some of the activities will include: gathering evidence and knowledge regarding an issue, mobilizing resources, advocating for change, monitoring and reporting on progress, and coming up with policy recommendations. They will perform any work that does not fall under the purview of the Secretariat or regional networks.

Regional networks consist of groups from all the regions and will serve as arms for the Alliance, as implementers of various priority interventions, especially at the country level. Since the platforms have the expertise, knowledge coordination functions and relations with countries on the ground level, they are better suited to implement interventions such as accelerating country work. Regional networks will serve as all important links for the Alliance to the countries, for example: African Platform, Asian Action Alliance for HRH or Pan-American Health Organisation for Latin America.

The Global Health Workforce Alliance includes as its initial partners the Bill and Melinda Gates Foundation, the Canadian International Development Agency, the European Commission, the Global Alliance for Vaccines and Immunization, the Global Equity Initiative at Harvard University, the International Council of Nurses, the New Partnership for Africa's Development, the Norwegian Agency for Development Cooperation, the Ministry of Public Health-Thailand, Physicians for Human Rights, the World Bank and WHO (GHWA, 2006).

5.3 A Shifting Paradigm in the HRH Governance Debate – Some Implications

The HRH governance debate brings to the surface very important developments in the discourse on the role of nation-states, globalisation and its governance. The JLI report argues that “the strength of a health system is deeply embedded in a nation’s

political economy" (2004). Historically, "the development of public services and social programmes is an important element in the creation of communities and political entities at all levels" (PSI, 2003). This is hinged on the premise that public services "are organised to meet political, social and economic needs" (Ibid). Many cases around the world from sub-Saharan Africa to Canada have clearly demonstrated that the expansion of public services has been crucial to creating a sense of a shared identity and solidarity. The welfare state was the solid foundation for the development of rich countries. The policy shift of the states in the last three decades included "closer integration with flows of trade, investment and finance, rendering macroeconomic policy weaker and contributing to the process of 'shrinking the state' via declining social expenditures" (McMichael, 2000). It widely affected the welfare, public sector-based system and it did "jeopardise the sense of national solidarity" (PSI, 2003). Health was particularly badly hit. Expectedly, health would have been the most tangible effect of such 'reforms' and the most 'reactive' to the market rules imposed by international financial institutions and easily accepted by the governments.

Without doubt, the neo-liberal policy has hit the core of health politics - that "governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures" (Alma Ata Declaration, 1978). The power of a government is expressed, among other things, on its capacity and ability to provide social security to its own citizens. Restructuring, privatization and other market-led reforms gradually took away this power from the governments. Castells (in McMichael, 2000) argues that "it is the disembedding of power from place that generates a legitimacy crisis undermining the meaning and function of institutions in the industrial era (e.g., the nation state, class politics, citizenship...)" . He points to this contradiction as the basis for social movements "emerging to restore local systems of power and identity or to refashion power and identity in transnational level" (Ibid). The health debate has unearthed signs of these possible developments. Kickbusch and Payne (2004) also point to the dynamics of participation of Civil Society Organisations.

Health has benefited from the many CSOs that are visibly active in the global arena and have put health at the top of the anti-globalization agenda. These organisations participate forcefully in setting global agendas, most prominently in recent years regarding access to

antiretroviral drugs for AIDS patients in poor countries. In effect, CSOs have become health policymakers by establishing codes of conduct, developing social labelling and reporting, and playing the role of watchdogs. Horton asserts, for instance, that Medecins Sans Frontières has replaced WHO at policy development, especially in relation to access to essential medicines.

Indeed, these groups have played a crucial role in pushing the HRH crisis up in the national and global agenda, as the study showed earlier.

There are good reasons to believe that the developments in the governance of HRH can be transformed into important political developments worldwide. Polanyi (in McMichael, 2000) characterises “the dialectic of market rule and social countermovement as the source of ‘the great transformation’, whereby society was discovered in the form of the welfare state”. The wave of protests in Europe during the 90’s was largely a response in defence of jobs and welfare against the austerity programmes associated with the newly unleashed EMU (European Monetary Union) convergence criteria. Taylor and Mathers (2002) provide examples of IG Metall (German Metal Workers’ Union) which “successfully mobilised a national strike on defence of sick pay agreements that were jeopardised by social security reforms, the strikes in Italy, Belgium and Greece against pay restraint, pension reform and privatisation. This is a historical moment which unions should fully seize. “Peoples’ discontent with current developments has to be taken seriously; their anxiety and dissatisfaction should be politicised and channelled into trade union and political class-based struggles for their working and living conditions” (Wahl, 2005).

The health debate is increasingly mobilising society in different levels. As “the tension in between neo-liberal and social justice philosophy expressed in health as commodity and health as human right” increases, it “has generated global debates and has spurred national and global social movements” (Kickbusch and Payne, 2004). The ‘forgotten’ debate of wealth and power distribution is resuscitated again as a debate at the heart of the discourse on health.

Some important implications are derived from this discourse. The GHWA initiative implies a historical shift on health and HRH issues. It highlights the importance of

strengthening health systems and investment and the crucial role of national leadership. In this light, the HRH crisis can be transformed into an excellent opportunity for countries to 'take back' their power and to recover from the crisis of legitimacy. Strengthening national health systems and "the development of health policies provides a unique opportunity for building consensus around health issues and for allowing citizens to voice their opinion, thus giving a greater degree of legitimacy to actions that will be proposed later" (Dussault and Dubois, 2003). Clearly, the enhancement of health which "requires the action of many other social and economic sectors in addition to the health sector" (Alma Ata Declaration, 1978) may lead to the most important battle of getting public services back in the hands of public. Kickbusch and Payne (2004) talking about health as a human right to global citizens, recognize that, "this means underlining the importance of the state and the public sector".

Public Sector Unions have long fought to keep public services public. Despite the fact that there is already strong evidence of what Professor Relman (2002) asserts that "markets are simply not designed to deal effectively with the delivery of medical care, which is a social function that needs to be addressed in the public sector", forms of privatisation have pushed through nearly all around the world.

Privatization needs to be fought at national and international level. The role of the unions and their interaction with other movements becomes crucial. For the first time global players on health issues will be under the same umbrella of the GHWA which makes it quite a challenge. The Alliance will have to "strive to broker enhanced coordination amongst key players active in HRH and social sector investment and development - and work to convene and gain consensus among 'liked minded' and 'non like minded' donors to this end"(GHWA, Strategic Plan, 2006). Trade unions and other progressive health organisations will need to articulate a clear position and use this opportunity to reshape power balances in global health.

The HRH governance may be transformed into an historical opportunity to influence these developments. This would require the articulation of a clear

platform which would challenge the developments of the last decades as well as the establishment, empowerment and closer interaction with civil society and other progressive institutions.

The very contentious issue of an all-inclusive labour ideology is crucial for an all-inclusive platform from the local, to national, regional and international levels. The ideological vacuum among labour has impacted in what Lillie and Lucio (2004) observe as “differences of the role of the unions both within and between national union cultures”. As such “international collaboration at various levels reflects the struggle between different ways of regulating capital and labour” (Lillie and Lucio, 2004), which also reflects ideas of different types of unionism. It is understandable that the ideological discourse of labour may be the most difficult challenge for unions as a whole. Yet, since human resources for health crisis is also an ideological discourse, it opens spaces for a vibrant debate on labour ideology worldwide.

The importance of expanding the public services and ensuring that all people have equal access to health care, education and their determinants is not disputable. Other very important considerations relate to the impact that this expansion has on employment at the national level, as well as on mitigating the disturbing effects of outsourcing for national economies which rely on industrial production. Elaborating on this issue goes beyond the scope of this study, which attempts to highlight the fact that public services are essential for a life with dignity and the development of society.

5.4 Limitations and Gaps on the Ongoing HRH Governance Debate

The WHO report (2006) on HRH calls to “all people engaged in action whose primary intent is to enhance health”. Indeed, HRH crisis offers a unique opportunity to rethink and reshape the future of global health in the spirit of the Alma Ata Declaration (1978) as “a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal”. The HRH crisis is at the heart of health crisis. This part of the study

attempts to highlight some of the present dynamics and gaps in the governance discourse of HRH crisis with the objective of designing a sustainable strategy.

For quite a number of years now, increasing attention has been devoted to the development of health policies by governments, public and private health institutions, international bodies, academics, and NGOs. However one of the main problems in the earlier debate on health policies as Dussault and Dubois (2003) emphasizes, has been “their failure to make room for issues of human resources”. This drawback has influenced the initial debate on HRH which, according to the same authors, has been characterised as “reactive, ad hoc attitude towards problems of human resources; dispersal of accountability within human resources management (HRM); a limited notion of *personnel administration* that fails to encompass all aspects of HRM; and finally the short-term perspective of HRM” (Ibid).

Advocacy of progressive health community and civil society organisations were materialised on the JLI report which drove the debate to another scale by taking a broader perspective on HRH crisis, its roots and the prominence on addressing the health systems’ crisis. The recognition of HRH crisis has been reflected in the debates of important agencies influencing policy-making. Yet, important limitations have characterized the HRH debate.

The G8 meeting of July 2005 recognized, for the first time, the responsibility of the rich countries to invest in strengthening African health systems. The realization that MDGs will not be achieved unless health systems are strengthened has been at the heart of this recognition.

The core aims for education and health are stated in the UN Millennium Declaration. We will work to achieve these aims by investing in improved health systems in partnership with African governments, by helping Africa train and retain doctors, nurses and community health workers. We will ensure our actions strengthen health systems at the national and local level and across all sectors since this is vital for long-term improvements in overall health, and we will encourage donors to help build health capacity (Health GAP, 2005).

Even though the focus on HRH has increasingly attained more political involvement, with the UK Prime Minister, Tony Blair's Commission for Africa

report calling for a tripling of the health workers in Africa and ex-Secretary General of the UN, Kofi Annan's petition of 2005 for one million new health workers for the continent, "the G8 statement, however, failed to devise a plan to alleviate the crisis or specify a sum of money which must be committed to the problem" (Health GAP, 2005).

The reaction of the health community has been immediate with the British Medical Journal "urging the United Kingdom, the United States, and other rich countries to become self-sufficient in their health worker requirements to remove their need for health workers from the Global South" (Health GAP, 2005). The NGOs reacted in the same spirit. Eric A. Friedman (cited in Health GAP, 2005), PHR's HIV/AIDS policy analyst pointed to "the legal and ethical responsibility to invest money to rebuild the health workforce in Africa", and for a clear definition of plans, budgets and time line. "The G8 Communiqué, while a useful statement of principle, falls far short of this" (Health GAP, 2005) and resulted in more meaningless political rhetoric, devoid of concrete plans.

The HRH crisis is also an issue of high interest for the World Bank. The 2005 World Bank Global HIV/AIDS Programme of Action expresses clear involvement of the Bank in the strengthening of health systems and on HRH. It follows that the Bank's engagement will be in areas which include, particularly, "human resources for health, health planning, key public health functions (including surveillance and governance), procurement, management and other logistics of drugs and other essential supplies, and enhancing laboratory and diagnostic capacity" (Baker, 2006: page?). Brook Baker, a professor of the North-eastern University School of Law and a member of Health GAP, commenting on the Bank's Programme of Action, points to some limitations (Baker, 2006). He asserts that "there is little to quibble about the content of this list of activities, but there is little discussion of actually providing significantly increased resources from identified sources for educating, training, hiring, and retaining a skilled and diverse health care workforce". He continues further by pointing to the Bank's strong approach of relying "on concessional lending - a form of financing that is unlikely to lead to sustainability given developing countries' current debt burdens" (Ibid). In the same paper, Baker points also to the fact that the Bank is silent about fiscal space "or about the IMF's

macroeconomic policies that currently depress spending in health and education sectors" (Ibid). Yet the Bank is "convinced that it has a unique capacity to provide funding in Central and West Africa, in middle-income IBRD countries, and in post-conflict countries" (Ibid). It commits itself to work on strengthening health systems "within a sustainable fiscal framework" (Ibid). As in other documents, produced on HRH from international agencies, Baker also points to the fact that the Bank does not mention "the negative impact of the IMF macroeconomic conditionalities (low inflation targets, low fiscal deficits, and low public sector wage expenditures) on countries' ability to invest domestic and donor resources in HRH/HSS" (Ibid). Baker continues by alerting on the risk that this approach might imply, "This sounds ominously like policing macroeconomic restraint policies that have undermined health systems in the past" (Ibid).

The WHO report on HRH (April 2006) elaborates thoroughly on the scope of the health workforce shortage and many policy interventions which are important in tackling the crisis in HRH and strengthening health systems. Earlier, the High Level Forum on MDGs (2005) while elaborating on HRH crisis recognised the fact that "The platform (to tackle HRH crisis) would be the political articulation of global commitment to address an issue which is, in part, the product of global labour market failures". Again, Baker (2006) asserts that despite these analyzes and recognitions, "paradoxically one proposed solution is outsourcing!". He continues further by pointing to other limitations in the discussion on community health care workers, which are sometimes referred to as a 'volunteer' force.

The World Health Assembly (May 2006) unearths, once more, the tensions on the issue of human resources for health crisis and migration. Khor (2006) describes a tension emerging among the Assembly members. The rich countries' intention to help to fund medical education of developing countries to train more doctors and nurses to provide health care at home country and for other countries was received with disappointment from many in the Assembly. The proposal was considered "an inadequate solution" and instead the developing countries proposed more direct interventions as "disallowing out-migration of health personnel, or asking for compensation to the 'source countries' that have trained the personnel at high

cost” (Khor 2006). Khor mentions that these interventions proposed by developing countries are too “sensitive” for the developed world. As a result, the World Health Assembly adopted a mild resolution on ‘scaling up of health workforce production’. It urged governments “to consider having mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel, through migration” (Ibid).

This cleavage of approaches among rich and poor countries may lead to the fragmentation of initiatives. Even though the GHWA initiative has been launched as an overarching platform to tackle the HRH crisis and strengthen sustainable health systems, other initiatives have been emerging recently. The last conference on HIV/AIDS in Canada noted the materialization of another network with health leaders from developing countries – the Health Systems Action Network (HSAN). It is a network of the health leaders of 31 health systems from all over the world attempting to address urgent health priorities through health system strengthening.

It is said that HSAN initiative is a response to “the lack of a current platform for developing countries’ health system stakeholders to influence and provide input into priorities and practices of global health initiatives” (Abt Associates, 2006). HSAN aims at being a global network “facilitating the development of equitable, accountable, and sustainable health systems for improved health outcomes”. Surprisingly, in their press release, there was even no reference to a relationship with GHWA.

So far, initiatives addressing the HRH crisis, undertaken by various actors, focus merely on the symptoms rather than the roots of the crisis. Box 1 illustrates, for example, how the HRH crisis is constructed in the context of the inability to respond to world pandemics such as HIV/AIDS, TB and malaria.

Box 1:

“The question of human resources for health has different aspects, but they relate essentially to shortages. In parts of sub-Saharan Africa shortages are so acute that they limit the potential to scale up programmes aimed at achieving health-related Millennium Goals including the roll-out of treatment for AIDS. Action is needed in relation to salaries and incentives, investment in pre- and in-service training, adjustment of staffing and skill mix, filling of immediate gaps in service delivery, harmonization of donor-led initiatives, provision of care and treatment for health personnel affected by HIV/AIDS, and the migration of health professionals”

World Health Assembly 2005

Mark Heywood of the AIDS Law Project commented on this issue during the International AIDS Conference in Canada in August 2006: "Human resource crisis is not a just global crisis, but globalised crisis and will require a global strategy" (www.aids2006.org). Heywood stresses that it is a mistake to work on health human resource crisis only to address the HIV problem; the HRH crisis should be put on the developmental agenda.

5.5 Implications of the Gaps and Limitations on the HRH Governance Debate

Some important limitations originate from the dynamics of the HRH governance debate. The HRH crisis is a crisis of the low numbers of people offering health amidst the global health crisis. The HRH crisis lies at the heart of the health crisis, thus any debate on HRH is indivisible from the overall debate on health. Moreover, the reasons for the crisis in health and HRH can be traced to the same roots.

As the global debate on HRH has been growing quite rapidly, involving increasingly more partners, it has overlooked the formulation of a genuine political debate on health as a human right. This is clearly reflected in the examples above, which may uncover both a limited discussion on health as human right, but also a distorted balance of power at the international level; these two limitations reinforce each other well. Clearly, limited articulation on health as a human right would lead to further deficits in policy making and sustainable strategy building. Marshall Marinker (2006), a professor of King's college in London, highlights the same limitations as "much political debate focuses on managerial issues such as the levels of health funding and the setting and missing of targets. Meanwhile our moral imperatives, our values and principles, go relatively unexamined". The implications are clear, and if not properly tackled might seriously compromise the sustainability of the HRH strategies.

First, the roots of the HRH crisis, as are the roots of the health crisis, are primarily political, caused by failures of past policies and programs shaped by the very same international agencies that today claim to have exclusivity in the drawing-up of sustainable HRH strategies. There is clear evidence that the policies of the last three

decades were a direct outcome of the paradigm shift from health as a human right to health as a commodity, and from health workers as assets to health workers as burdens. For example, it could be recalled from the previous section how the 2006 World Health Assembly (WHA) came up with its mild resolution of “scaling up health workforce production” (Khor, 2006). It is not surprising, therefore, that the overall political articulation of global commitment addressing the HRH crisis includes outsourcing and the promotion of community health workers as a ‘voluntary’ workforce, both cost-cutting strategies. In this light, denial or avoidance of the recognition that health is a human right would lead to patchy and incoherent strategies on the HRH.

The overall response to the HRH crisis has been reduced to technical solutions. It is as if the crisis in Africa is a technical malfunction merely requiring proper management, coordination and more money. The importance of recognising what Kickbusch and Payne (2004) observe as a limitation on the health crisis is also essential for HRH discussion, “The solution to the crisis in global health goes beyond the expert-based answers, many of which are known”. Both authors claim that what is really needed, “in addition to forceful public health action at the nation state level, is new global social contract on health” (Ibid).

On another side of the debate, the HRH crisis, in similarity to the global health crisis, “is increasingly defined in economic and managerial terms rather than as a commitment to equity, justice, democracy, and rule of law.” (Kickbusch, 2002). This tunes well with how consequences of the health crisis are described by Kickbusch in the same paper (2002):

The investment-based global-health debate uses essentially the same arguments for a marriage of economy and health: increased interdependence, threat to the rich countries if they do not act, and great economic benefits for all if they do. For this argument to hold, the global disease burden must be explained by a lack of good governance, of money, and of efficiency in implementation rather than as the result of inherently political decisions and the distribution of power.

In light of the above, the implicit ideological orientation “frames the health mainly in terms of economic productivity” (2002). Without underestimating the economic implications of the crisis, it is important to embrace “the understanding of health as

an end (the right of citizenship)” is “as important as the utilitarian principle of health as a means” (Amartya Sen; cited in Kickbusch and Payne, 2004). Here it follows that the importance of the HRH debate as a developmental issue is essential for the understanding of health as a commitment to justice and democracy in the world.

The debate on health has been short of a clear vision which recognizes the fundamental role of health as crucial for the functioning of democracy and as a platform for democratic participation. In the words of the Alma Ata Declaration (1978 “the people have the right and duty to participate individually and collectively in the planning and implementation of their health care”). The limitations of the vision are clearly mirrored in the debate on HRH, which can best be described so far as ‘designing strategies about workers without workers’. The failure to involve those people directly impacted by the crisis in solutions compromises the legitimacy of the actual governance debate. It also leads to serious implications questioning the sustainability of the strategies and interventions.

Trade union avoidance of the HRH governance debate may be well justified from within this premise. There have been at least three attempts to create an overarching platform, starting with JLI, Transitional Working Group and the more recent Global Health Workforce Alliance. GHWA is initiated and hosted by WHO, a UN organisation, but has not involved unions either as part of the ILO or as representatives of millions of health workers in their preparatory work. Even though the health workforce is at the heart of the debate, legitimate representatives of health workers have not been involved.

Paradoxically, the JLI report, a ‘predecessor’ of the Global Alliance, highlights the importance of involving health workers in the global strategy for HRH. In the words of the report, “no one could better represent the experience of being a health care worker—whether in terms of its benefits or its challenges—than health workers themselves. Yet, except among elite physicians, their opinions are rarely sought, their voices often silenced” (JLI, 2004). The report further states that health workers must be treated as partners in delivering health, not mere employees.

From here it is clear that whatever sustainable HRH strategy sought will need the participation of workers in the design, implementation and monitoring processes. The JLI report (2004) also points to this direction when it recognizes that “implementation of even the most carefully tailored and tested strategies for health improvement will depend primarily on the workforce”. Yet workers’ representatives have been out of the first three global initiatives. Clearly, the HRH debate is one example of global governance where trade unions are missing. One can even notice a tendency not to use internationally recognized labour ‘vocabulary’ such as decent work or social dialogue, even though the global platforms and strategies come up with the same concepts expressed in different ways. It would be an interesting topic for research to know whether the exclusion of trade unions in the debate is a question of limited knowledge on the part of the actors dominating the global debate or a deliberate attempt of keeping trade unions out of the debate.

The actual state of the HRH governance debate is limited both in terms of content and form. Lack of a clear articulation of health as a human right and a platform for democratic participation, as well as the absence of internationally recognised workers’ organisations in the HRH governance lays the bases for further implications on the limitations of the debate as discussed below.

If health is not perceived as a primarily goal for the whole society the ‘mistakes’ of the last three decades will probably happen again. The HRH governance is already compromised by a power asymmetry in favour of international agencies involved in ‘such mistakes’. Since these agencies have not expressed any explicit recognition of their failure and have not voiced any apology, their further involvement brings a lot of uncertainty. As discussed earlier, the World Bank Programme of Action raises serious questions on the sustainability of the policies they propose on the HRH governance. While the Bank advocates for the HRH/HSS, it has no definite policy on increasing resources and is silent about the negative impact of IMF macroeconomic conditionalities affecting the provision of health services. Moreover, the G8’s political commitment on HRH is limited in terms of adequate

funding, concrete plans, budgets and a time line. These ambiguous attitudes might well reflect the reluctance of the developed world to reach a global political contract on health which is based on justice and equality. This in turn may have contributed to the cleavage or tension between the developed and developing world on tackling the HRH crisis, leading to the fragmentation of initiatives.

As Kickbusch (2004) emphasizes “health governance is always about inclusion and exclusion and health governance debates are always also debates about values and social justice”. The power asymmetry in the HRH governance urges the immediate participation of worker representatives and other civil society organisations, if this historical opportunity of HRH crisis is to be seized. Any governance debate on health which avoids the principles of values, social justice and people’s participation is doomed from the outset.

If health is not discussed and perceived as a fundamental human right and as essential to democratic processes, the much needed financial support to overcome HRH crisis will be left to the will and compassion of rich countries. Even though GHWA has dedicated a decade of intervention in HRH, guaranteed financial resources are still missing. Here again Kickbusch and Payne’s (2004) observations on global health governance are relevant for HRH governance, “it is a scandal of global health governance that WHO member states, at present 192 of them, would allow a situation in which a private philanthropy, the Gates Foundation, has more money to spend on global health than the regular budget of their own organisation, the World Health Organisation. Global health needs to move out of the charity mode into the realm of rights, citizenship and a global contract”. The whole debate on health needs to be raised to this level because “it is justice, not charity that is wanting in the world” (Mary Wollstonecraft, in: Kickbusch, 2002).⁷

5.6 Where Are Unions in the Debate?

The above discussions point out the problematic of the absence of unions in the governance debate at the international level. Unions are also missing in the national

⁷ *Mary Wollstonecraft, 1792*

initiatives as revealed in some interviews conducted by the researcher with national unions participating in the yearly meeting of PSI Health Task Force in Geneva in May 2006. The interviews involved eight unions from both developed and developing countries.

To better understand where unions are in the governance debate on the HRH crisis, it is first important to have an approximate assessment of the level of awareness among the national unions of the existing debate, their involvement and responses. The results of the interviews carried out by the researcher during the said meeting shed some light on this issue.

Interview results indicate quite a high level of awareness on the HRH crisis among the respondent national unions. However, with regards to the respondents' perception of their governments' responses to the HRH crisis, not surprisingly, the responses between the respondents from the developed and developing countries vary significantly. More efficient labour market information systems in the health sector, incentives to attract overseas professionals, more comprehensive human resource planning and additional investment for human resources are the responses of governments in the developed countries. On the other hand, the developing countries' governments tend to respond via the privatization of public health care, and the outsourcing and promotion of health workers as a 'volunteer' workforce. Additional investment for human resource development, more comprehensive human resources planning and incentives to balance the distribution of health workers are indicated as well.

Likewise, the level of involvement of unions in their governments' initiatives in addressing HRH crisis varies between these two groups of respondents. While unions in the developed countries are involved, there is a tendency of the governments in the developing countries not to involve the unions, but professional groups, academia and research institutions, NGOs, public and private health institutions instead.

The involvement or non-involvement of unions in government efforts to address the HRH crisis affect their responses to the crisis. In developed countries, the response of trade unions comes in multiple ways: with a predominant number putting the HRH issue on the national agenda, lobbying with interest groups, networking and information sharing and communication, involvement of rank and file, advocacy for additional resources, information campaign on HRH as well as cooperation and collaboration with other unions on the regional and global level concerning the HRH crisis. However, not all unions' in the developing countries point to the same responses. Some of the reasons for this weaker reaction are attributed to the lack of adequate information on the HRH crisis, limited human and financial resources to deal with the HRH issue, perception that HRH crisis is not an urgent issue, as well as lack of platform or venue made available by the government for union involvement at the national level.

An interview with Alan Leather (2006) the Deputy General Secretary of PSI, indicate the same tendencies with regards to trade union involvement in HRH. Unions in developed countries seem to be very active in lobbying with NGOs. According to Leather, Oxfam UK and UNISON, the public sector union in UK, are already working together on HRH where information on health worker shortages was provided by Oxfam for the UNISON Congress in June. In Canada, there is a large group of NGOs and unions, including the PSI affiliates CUPE and NUPGE that have put out a manifesto on development issues and HIV/AIDS that includes reference to health worker shortages. Leather, qualifies, however, that South Africa has also been active in lobbying. The Treatment Action Campaign has been very active in calling for a complete overhaul of health systems. In this campaign, they have formed a strong alliance with public service trade unions again including PSI affiliates such as HOSPERSA.

Even though the number of interviews carried out is very limited to point to a more conclusive tendency, they indicate some trends of the unions' involvement in the HRH debate, particularly, at the national level. Moreover, this was more frequent in the unions coming from developed countries. What is evident in the unions'

responses is a lack of information on the governance debate of the global HRH crisis.

CHAPTER SIX

TRADE UNIONS IN THE HRH DEBATE AND STRATEGIES FOR ACTION

6.1 Why Should Unions Enter the HRH Debate?

Some of the limitations analyzed in this study simultaneously point to the role and relevance of trade unions in the HRH governance. It is in this light that the unions' contribution to the debate is invaluable. But why should it be unions and not just NGOs dealing with health issues? It is to be noted that global health movements, involving global civil society and global health community are already very active in this issue area.

O'Brien (2000: 554) emphasizes that trade unions are an important element in the global civil society, and that -

[i]f the goal of social movements is to construct a world that balances liberal economic priorities with egalitarian values, such an aim only stands a chance of being accomplished if workers' organisations play a large part in the struggle.

This study argues that discussion on HRH governance is a debate which has at its heart the principles of justice and equity and as such makes the relevance of the unions crucial. Moreover, health unions represent health workers at all levels. It is from these principles where unions' legitimacy is derived, to be actively involved in the governance debate. Unions have the forums and the mechanisms to voice workers' needs and inputs through democratic mechanisms from the workplace to national, regional and global levels. In contrast to NGO's, unions exist and work as organisations with permanent and expanding membership, based and run by workers. In one of the consultation rounds on HRH, an NGO representative also spoke in the same spirit (Friedman, 2005).

Workers have the potential to be powerful advocates before both the government and other stakeholders as to the urgency of the HRH crisis. Since health workers know best their own needs, what will make them remain in the (public) health sector, what incentives or other support they need to work in outlying areas, their input is invaluable in designing an HRH response. Health care workers, especially at the community and middle levels, know their patient needs, and know what they require to meet these needs. They know the truth on the ground, how well national policy is actually working, whether their colleagues are more likely to

remain in the country or serve in rural areas, whether the plan is being fully and effectively implemented. And because their own lives are so tightly intertwined with the plan, they know its strengths and weaknesses.

Clearly, the importance of unions as giving voice to workers in this very important process is crucial.

The lack of recognition of health as a human right lays at the core of sustainability limitations of the HRH governance debate. This shortcoming, along with the power asymmetries discussed earlier in this chapter, highlight the importance of unions' involvement at all levels. PSI's Health Policy Statement as well as its 2007-2012 Policy Program for the Health Sector make specific reference to health as a human right and a platform for democratic participation. PSI's advocacy and strategies on the HRH crisis reveal that unions are political organisations. Here the analysis of Wedin (cited in Hyman, 2002) is important, "an organisation that lives and operates in a society influences and is influenced by it, and it is not apolitical". Unions' history has been shaped by unions' involvement and active participation in political battles for a just society.

6.2 Why Are Trade Unions Out of the HRH Governance Debate?

The question as to where the unions are in the governance debate of HRH does not really come as a surprise. Even though it is widely recognized that the health crisis is heavily affected by human resources for health crisis, the workers' voice is being neglected or silenced. While the global players seem to have 'forgotten' to invite workers' representatives into the governance debate, there should be more to that to explain the lack of a union voice. The governance issue is quite complex and certain questions must be raised to enable a better understanding of the dynamics of the situation. How has the policy-making process changed and what does it now look like? What have been the consequences of the last decades of the neo-liberal agenda for the health trade unions? How have the trade unions responded to the increasing challenges and problems this has brought about? How can the trade unions enter the actual debate and form alliances on HRH as equal partners? And finally, what are the implications for the unions, considering the actual developments in the global debate?

6.3 The Consequences of the Neo-liberal Agenda for Trade Unions

Health care is one of the world's biggest industries and it is clear that any policy decision in this sector has a particular impact as it affects at the same time service users and in many ways the workers.

Nearly three decades of neo-liberal policy imposing reforms, restructuring, privatization and tight government expenditures in the health sector have treated the health workforce worldwide as a financial burden and not as an asset. The policy platform strongly recommended to most countries in the South, driven by international bodies, in particular WB⁸ (Chen et al, 1999: 302), has been the main push factor for migration, leaving a vast part of the world in need not only for quality health service, but even for minimal service.

The prevailing ideology of the last three decades has pushed the trade union existence to the edge and it has impacted it in many dimensions. Often times the trade unions have faced very hard situations of resistance and opposition even from the political segments near to them, which has caused a very critical tension. Trade union membership has been shrinking over the last decades as the cuts in the health workforce have pushed through, contributing to the diminishing power of the trade unions in society and in decision-making processes. For more than two decades, the neo-liberal ideology has remained 'formally' unchallenged as there has not been yet an effective articulation of another countervailing ideology. The predomination of this ideology has contributed further to a tendency of union exclusion in different levels and types of governance, pointing to a discourse questioning the relevance of unions in society.

6.4 Shifts in the Playing Field of Decision-Making on HRH

⁸ World Bank lending in health approaches \$2 billion e year. The Bank's health engagement accelerated after its seminal *World Development Report 1993: Investing in Health*, which is widely credited for bringing applied economic analyses to health policies.

The accelerated pace of globalisation has contributed to an important shift on the playing field of decision-making in the realm of health and the corollary HRH issue. Chen et al (1999:296) note that “in health as in other fields, the diversity of global actors has grown exponentially in recent years, including agencies in the United Nations System.” The authors further elaborate the following:

...WHO has begun a bold reform process with as yet uncertain outcomes. The World Bank, which began health lending in 1985, has quickly become the largest source of concessional financing for health in the developing world. Growth in the private sector, however, has probably been even greater. NGOs are increasingly active in health affairs. Academia remains an important source of knowledge production and professional training. The pharmaceutical industry has gone global in production, distribution and marketing. And health has become a significant feature in newspapers and the mass media (Chen et al, 1999: 296).

Earlier discussions in this study have shown how the HRH issue has become an issue on the global political agenda which is under the influence of many of these actors. These developments are not surprising at all considering that supra-national agencies and factors have contributed to the HRH crisis. Furthermore, “global health increasingly demonstrates cross-border externalities. As a public good health risks and responses are increasingly global. No individual or nation state can fully guarantee its own health” (Ibid: 297). Similarly, this shift has made the same impact on HRH, recognizing that the governance of HRH is quite complex, with different levels of policy-making. Whereas much of the political process, regulating the relations and the pressure of global stakeholders, to strengthen the health systems is carried out at the global level, the leadership for action and implementation falls back on the nation-state, with the regional level playing a much more important role in accelerating country work. As the Global Health Workforce Alliance (2006) puts it, the effective intervention will be “country-led action backed by global solidarity”. These dynamics have made the HRH governance architecture a different structure for unions to follow as it does not fit to the ‘normal’ pattern of national union activity.

6.5 How Have the Unions Responded to the Changing Reality and the Increasing Challenges?

As already mentioned, for a long time, unions have been on the decline in terms of membership, bargaining power and influence. As Kelly (2003) asserts, “union movements around the world have been in decline since the early 1980s and whichever indicator you examine seems to tell you much the same story: trade union membership has been falling in many countries, strike activity has declined even more dramatically and many governments both Left and Right have adopted neo-liberal economic programmes that have eroded the traditional centres of union power, in manufacturing and the public sector”.

Indeed external factors, economic, political and societal, have strongly influenced developments within the unions and the strategic choices they have made. Nevertheless, it is important to analyse carefully what have been the general response of unions to these developments and hence the consequences for the organization. This study points only to some trends on union responses that are relevant for the discussion of governance on HRH. Moreover, this analysis will serve as a departure point for exploring the ways in which unions can engage more effectively in shaping future developments.

Narrow workplace agenda

The complexity of global and national challenges confronting unions today has made trade unions lose focus on very important developments affecting workers, particularly issues and problems related to human resources for health. Many issues have been affecting unions at the same time. The rapid pace of the neo-liberal agenda has dramatically increased the challenges confronting unions. Understandably, unions have not fully dealt with analysing the complex dynamics of the HRH issue and thereafter making strategic choices on how to deal with the issue. As union membership has been shrinking, tensions have emerged between resources and priorities. Issues having immediate impact on unions are thus prioritized in terms of union time and resources and issues that have more medium term or longer-term impact have been put on hold.

The union agenda, focused by and large on workplace issues, has failed to reflect the existing organic links in the overall developments within society. As such,

social movements come into arenas where union action has either failed or is limited. As Hyman (2002) puts it, “national and international trade union apparatuses, with their deeply rooted traditions and, long established political and industrial bargaining relationships and complex internal power dynamics, are both repelled and attracted by the flexibility and spontaneity of alternative modes of intervention in an arena in which unions once claimed exclusive jurisdiction”. This tendency of unions to focus on work-place issues, shrinking their boundaries of involvement and participation in shaping the society might well be a reflection of the tension on the articulation of trade union purpose which has in fact limited the scope of unionism in today’s society.

Social dialogue and social partnership: limitations and potentials

Social dialogue has a great potential in the development of affordable and sustainable health services, health service ethics and human resources for health. The equal participation of all social partners can contribute to addressing issues of performance, eradication of unfair discrimination of women, overcoming staff and skill shortages in the health services as well as cross-border recruitment. A report on worldwide trends of PSI and EI (Education International) on *Forces and reactions in Healthcare* (2002) highlights positive examples in which social dialogue has influenced developments in health care. The report mentions examples of tripartite structures in Brazil, Canada, Chile and the UK which have aimed at monitoring and developing strategies to achieve health improvement, promoting equal opportunities and changing employment practices, consultation for new health sector reforms and partnerships at work at the hospital level. These examples demonstrate “how health workers within an institutional structure can have some influence in the overseeing of health policy and the running of the services” (PSI and EI, 2002)

“However it is not a panacea”, as a paper from the same year from PSI on Social Dialogue in the Health Services puts it (PSI, 2002). The paper continues by asserting that, “a prerequisite of effective social dialogue is strong, independent and responsible social partners, who recognise the legitimate roles and interests of the

other partners, commit themselves to constructive engagement in agreed processes of dialogue and deliver their side of negotiated outcomes” (Ibid).

The rapid progress of the neo-liberal agenda has created power asymmetries in social partnerships. Wahl (2004) highlights the paradox which unions face today, “that while the economic and political climate in which the trade unions must operate has changed enormously, most unions have continued to pursue the policy of social pact”. Most unions are thrown back to defend what they have achieved decades ago, demonstrating a rather reactive than pro-active approach, which has been dominating the trade union action. In spite of a clear tendency of business and government to part away from consensus and consultations with workers, there has been a continuous pressure on the unions to use the social dialogue and tripartite institutions.

Taylor and Mathers (2002) comment that “the dominant tendency has been for union hierarchies to seek an accommodation with neo-liberalism through various forms of ‘concession bargaining’ and ‘social partnership’”. The European example has always been offered as the best experience of an effective social dialogue as an indicator of a strong democracy and social progress. Yet, the paradigm shift of the last decades has seriously questioned the effectiveness of unions. “In the context of European integration, organised labour has been accepted as a social partner only to the extent that it has accepted the neo-liberal agenda” (Taylor and Mathers, 2002). Even in cases where the social dialogue was giving positive results, it has employed much more energy and time from the unions’ side. Thus, “over the last 5 years, as the social partners for the hospital sector at European level, EPSU (European Public Service Union) and HOSPEEM have been working, with European Commission support, to formalise sectoral social dialogue at the European level” (EPSU, 2006). Furthermore, it took 5 years for the EPSU to establish a committee which “marks the end of the ‘informal stage” (EPSU website⁹). Hence, one can have serious considerations on how the situation is likely to be in other parts of the world where social dialogue and tripartite structures have by and large become but token and indeed, often sterile formalities.

⁹ <http://www.epsu.org/a/1875>

Another important drawback is derived from what Lorwin (cited in Hyman, 2002) names as the “diplomat role” of international trade unions. Windmuller (cited in Hyman, 2002) investigates on the different dimensions of involvement of labour internationalism and concludes that the “effectiveness of international trade union organisations is conditioned by their ability to achieve recognition and legitimacy, their internal cohesion, and access to certain instruments of action and there could be a trade-off between strength on one dimension and weakness on others”. Hyman builds further on his analyses by illustrating it with the example of ETUC (European Trade Union Confederation), where “the double-edged certification of labour as a ‘social partner’ within the institutions of the European Union has had analogous effects: providing recognition and material resources, but incorporating the ETUC within an elite policy community largely detached from those it claims to represent” (Gobin, in: Hyman, 2002)”. The same may happen even at the national level, where a lack of democratic mechanisms and financial base to make sure the direct participation of members in the national negotiations may lead to increasing deficits of democracy in the unions and the perpetuation of the same leadership. This situation may sound more relevant for former-communist countries, which saw social partnership as “a means by which the trade unions are able to secure the reproduction of the political role that they had enjoyed under state socialism and so guarantee the political and legislative underpinning of their own reproduction” (Clarke, 2003: 11). The tendency to pursue a trade union agenda through negotiations of unions’ leadership in the round tables has further contributed to forms of detachment from the rank and file members.

The academic literature would point to the impact that social partnership has had on the militancy of the trade union membership, as “the ideological umbrella of social dialogue reinforces lobbying against mobilisation” (Ghigliani, 2005). Transformation of trade union actions into round table negotiations has contributed to apathy and decline of militancy among the members. As Hyman (2002) points out, “this strategic option [social partnership] appeared to engender a vicious circle: a lack of mobilising capacity, modest objectives, equally modest achievements, limited recognition by and relevance of rank and file trade unionists on the ground”. Membership apathy and membership decline in the context of market

reforms, restructuring and privatisation, a detachment from rank and file members, aggravated by narrow workplace agenda, has slowly but surely diminished the historical power of unions in society in some parts of the world.

Reactive rather than proactive approach of unions

The debate and process of governance of the HRH crisis best illustrates these dynamics. At the national level, trade unions have failed to grasp the complexity of the problem. There is a remarkable tendency to deal with the consequences of difficult situations rather than with the very roots of the problem, reflecting both limited consideration for analytical processes as well as the reactive nature of unions. It may also be true that many national trade unions lack the resources and the concrete research capacities to deal with such complex issues as the HRH crisis.

The intensity of the work, information and developments requiring international union action has increased more rapidly than what the actual global union can possibly deal with. Rapid developments and changes at the global level have grown disproportionate to the human and financial resources of the global union federation PSI and ILO. While the global health governance is increasingly dealing with more issues, transferring much of the political process to the global level, the PSI's human and financial resources have not responded at the same level.

The weakening of the unions at the national level has impacted adversely on the resources of the international trade unions and their effectiveness in dealing with different political issues, which often require intensive research, coalition building, energy and time. It should be noted that the weakening of national trade unions both in terms of membership rates and financial resources, and the diminishing of militancy among members as political lobbying has replaced members mobilisation, an increasingly hostile environment against unions and the shrinking of the health sector, trade unions' rigid agenda and attitude, as well as lack of a clear strategic vision have negatively impacted on unions' voice and participation at the national level. It is thus clear that whatever path or level unions decide to pursue, the imperatives of cautious analyses and strategic choices are indispensable.

All the issues mentioned above are considered among the most pertinent ones for unions to enter the governance debate on the HRH crisis.

CHAPTER SEVEN

STRATEGIES FOR UNION PARTICIPATION IN GLOBAL GOVERNANCE AND SUSTAINABILITY OF HRH

7.1 New Opportunities for the Trade Unions Worldwide

Indeed, just as the *“Wei-ji*, the Chinese character for crisis, encompasses two powerful symbols: danger and opportunity” (Daulaire, 2002), the HRH debate represents, in reality, a great opportunity amidst the crisis.

Despite the limitations, the governance debate on the HRH crisis can serve as an important ‘entry point’ for the unions to address the shortcomings and to ensure workers’ participation in the process. The Global Health Workforce Alliance, as a platform for HRH governance, provides different levels for participation, each of which should be carefully examined and, thereafter, utilized. As stated in the vision of the GHWA, it will be “an open and inclusive global platform, a global focal point to maintain political visibility for the health workforce and, through targeted catalytic activities, to strengthen the workforce plans and activities of its stakeholders in countries around the world” (GHWA Vision, 2006). Within a decade, a plan of action will bring together health stakeholders and global players at the international, regional and national levels.

The study argues that the unions’ involvement and participation is crucial in addressing some of the gaps and limitations of the HRH governance. Moreover, the HRH governance dynamics may have important political implications, which may re-materialize the national terrain of engagement for the unions. The manner in which the unions enter the governance process is equally important due to the fact that the unions’ participation is essential. If unions are to participate in this process, it should not just be in a ‘diplomatic role’ as social partners. This process may serve as ‘the perfect storm’ for unions to undertake a process of revitalization, regain their legitimacy and contribute building on their power as representatives of all health workers facing the crisis. Even though this study does not elaborate on the situation of health unions, the continuing decline of union membership, recognized worldwide, as well as “trade unions’ exclusion from the corridors of power”

(O'Brien, 2000) indicate manifest forms of the present trade union' crisis. Carter (2004) argues that, "this crisis pushes unions to initiate or sponsor reforms on union structures and processes". And according to Frege and Kelly (2003: 9), union revitalization involves a variety of attempts to tackle and potentially reverse the problems confronting trade unions. From the viewpoint of Fairbrother (2005), it is a process of extension of union boundaries. It is also "a socially embedded purposive action taken by labour organisations to strengthen themselves in the face of declining union membership" (Cornfield and McCammon, 2003). The HRH governance offers a unique opportunity for unions as it may spur a much needed revitalization process. Whether they will be "marginal players or strategic actors" will depend on this revitalisation process and the strategy unions will use to enter and engage in the governance debate. One thing is sure, "Playing safe is the most risky strategy" (Hyman, 2002).

A clear articulation of the unions' approach on HRH is crucial to enter the governance debate at all the levels. The HRH crisis is a direct expression of crisis in health systems. The recognition that "the most critical issue facing health care systems is the shortage of people who make them work" (WHO report, 2003) makes the role of unions in the governance process a responsibility in front of the people it represents. The approach of the unions, upon entering the HRH governance, should be anchored on the principle of health as a human right and as the basis for democratic participation. The philosophy of social justice and social inclusion is deeply rooted in the history and mission of the trade unions. As the broad concept of sustainable development builds on the philosophy of social justice, unions' participation in the HRH governance is crucial.

Consolidation of the unions' involvement and participation in different health-related initiatives and programs on the HRH platform may be an important step in reconsidering the health strategy of the unions at all the levels. Questions of labour rights, health and safety and decent work can and should be integrated into the platform pushed forward by PSI and ILO.

7.2 The Need for a Proactive Role of the Unions

These developments call for a different approach from the trade unions side and for a rapid change both in terms of their operating character and in the working levels. This implies a continuous analytical process, which should follow up on the HRH governance development and possible interactions between different levels. The GHWA plan of action will start in some of the poorest African countries which are facing the most severe HRH crisis. Most probably the national unions of these countries might not have the capacities or resources to follow up and analyse the possible developments at global, regional and national levels. Hence a small research unit at the international level may be necessary to carry out this task and propose areas of intervention for unions at different levels.

7.3 Opening up of the Union's Agenda - a HRH Platform for Unions

Clearly, a well articulated platform on the HRH issue is a precondition to enter the governance debate on the HRH. As argued above, moving beyond the box of the workplace agenda and extending the boundaries of trade unions' vision and mission is an important step in shaping this platform. The recognition that the health worker should be perceived not only as such, but also "as an individual who takes care of her/his own health, as a consumer in the health market place, as a patient in the health care system, as a voter on health care issues, and as a social actor together with others in NGOs and social movement" (Kickbusch: 2004), should find reflection in shaping unions' strategies. It is as important that the platform is anchored on the principles of health as a fundamental human right and as a precondition for the functioning of a progressive democracy. The platform should elaborate on the relationship and interaction with civil society and other social movements and should integrate all the initiatives on health around the HRH issue.

7.4 Social Partner or Social Movement: Beyond the Dichotomy

The limitations of social dialogue described above by no means imply that the social partnership concept has become obsolete. Yet it is important to see the social partnership closely linked with a specific historical context. The blossoming social dialogue of the post-war period was the result of a "combination of the Russian revolution, a strong labour and trade union movement in the west, strong liberation movements in the third world, and a long period of stable economic

growth in the capitalist economy after the Second World War" (Wahl, 2005). These conditions have radically changed and the dominance of the neo-liberal paradigm has made the traditional social partnership less effective. "To aim at a new class compromise, a new social pact, under the current much less favourable power conditions is illusory" (Ibid). The diminishing power of the unions and the persistence of social dialogue in the face of the structural power of capital - which "is increasingly pursuing a confrontational policy towards organised labour" (Ibid) - makes the social dialogue questionable. Hyman (2002) argues that, "To the extent that the powerful are no longer as willing as in the past to underwrite unions' legitimacy and representativeness - whether at national or international level - the only option is to mobilise support from the relatively weak (which was indeed how unions in the main originated)".

Indeed, the developments of the last decades lay the groundwork for serious consideration among unions on the reciprocity of the relationship between the union's ability to mobilise members and to influence the external environment. Here, the analysis of Taylor and Mathers (2002) referring to the European model reinforces the crucial role of this relationship. If the labour movement "is to be reconstituted as part of a rainbow coalition engaged in a struggle for democratic values against neo-liberal globalisation" (Waterman, in Taylor and Mathers 2002), it "is clearly problematic if it is not premised on a revitalised workplace trade unionism and a critical engagement with the state" (Moody, in Taylor and Mathers 2002).

The intensive participation of civil society organisations in the struggle for social transformation calls for a deeper reflection on the unions' attitude and agenda. Civil society organisations and the health community are lobbying powerfully around the global health issue. "Health has powered social movements, defined rights of citizenship and contributes to the construction of the modern self and its aspirations in the developed world - and is increasingly gaining a similar role in developing world" (Kickbusch and Payne 2004). Unions have the opportunity to initiate or accelerate democratisation processes and the HRH crisis can institutionalize the basis for these processes as "participation in health is often a

step towards wider societal movement" (Ibid). Identification of civil society initiatives, academic and other progressive stakeholders aiming at health as a human right is crucial in building alliances.

According to Kickbusch (2004), "governance means no more and no less than managing power relationships and increasingly these are changing dramatically in the health arena". The power asymmetries in the governance process make the alliance building and coalition crucial. This study earlier argued that the HRH governance urges for a wide involvement of progressive organisations to shape the HRH governance anchored on the principle of health as a human right and as a platform for democratic participation. Unions need to recognize the fact that "this strategy of strength through diversity is unlikely to be generalised through the wider labour movement without a process of 'social dialogue' occurring within the labour movement itself (Hyman, in Taylor and Mathers 2002), including a reinvigoration of union democracy, in order to increase the accountability of union leaders to the rank and file" (Moody, in Taylor and Mathers, 2002). The union democratization challenge needs to be confronted at global, regional and national levels. Through opening up towards civil society and interacting with other civil society initiatives, unions may learn and adopt some of the forms and actions of NGOs which would influence revitalization processes in the unions. The effectiveness of these initiatives is questionable, if as Taylor and Mathers (2002) put it, "divorced from a vibrant and autonomous workplace trade unionism, and a critical engagement with corporations and state agencies".

This transformation process of unions, before and during the involvement and participation in the global platform for HRH may be a key element for trade union revitalization. It is the right time for health worker trade unions to review their political area of intervention, the political and NGO alliances, and their forms of work. Further research considering the context of the countries the GHWA will start to work with should be carried out exploring ways on how the trade unions can use the political momentum on HRH to their best advantage.

7.5 A Strategic Choice Framework for Union Decision Making

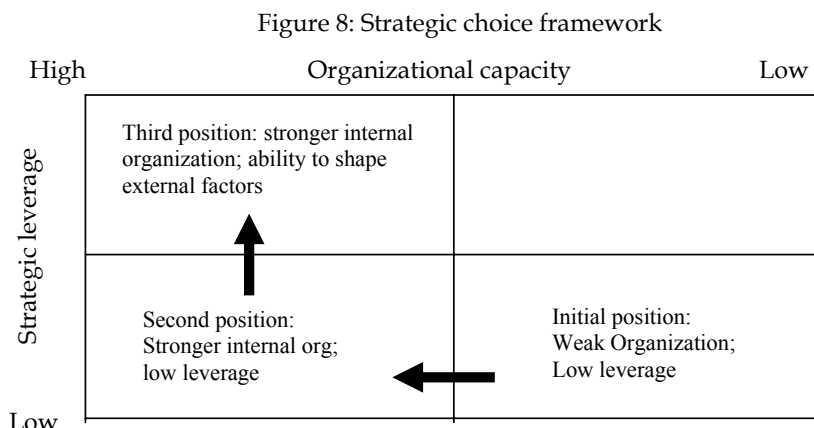
This study has highlighted some reasons why unions did not respond actively and did not get involved in the global debate on HRH, namely: financial limitations, lack of clear information on the dynamics, and increasing challenges for unions at all the levels. The study has put forward the argument that unions need to analyse carefully the challenges and make strategic choices which would consider these limitations. This section attempts to draw a strategic choice framework for unions based on the work of Weil (2005) on 'Strategic Framework for Union Decision Making'. In doing so, some of the main concepts of the strategic choice will be discussed in this part and also the possible ways of using it.

The process of union revitalization calls for, among other things, an internal process of unions to evaluate "current and future strategic directions" and "to evaluate ongoing choices in the context of core objectives" (Weil, 2005). Instituting in unions "a decision making framework that considers day-to-day challenges facing a union in light of central objectives and long-term efforts to improve representation of workers" (Ibid) is essential if fundamental changes are to occur. The same author argues that two important dimensions characterise the strategic situation for unions: strategic leverage and organisational capacity and they highly influence "the ability of the union to achieve its long-term objectives" (Ibid) considering the dynamics of these two dimensions.

Weil highlights that the factors influencing unions' strategic leverage can be influenced from unions' action in the long run, but in the short to medium term they remain outside union control. According to him, "the strategic leverage arises from the external environment in which the union operates" (importance and structure of the sector, labour market regulations etc). The union's organisational structure "determines how an organisation commits its resources (people and money in a union) towards its objectives" as well as "helps to determine a union's ability to translate its explicit governance intentions into organisational action" (Ibid).

In the same line, resource allocation and strategic choices, which for a long time have been problematic for unions, are “inextricably linked” and constitute a “major implication for the strategic choice framework” (Ibid).

A careful analysis of the strategic leverage and an assessment of the organisational capacity allow unions to make the right choices to attain their long term objectives. Clearly, making strategic decisions means dealing with “the tension between short-term costs and long-term benefits” (Ibid)). Figure (8) shows how unions can strategically plan and implement their actions using the two dimensions of Weil’s strategic choice framework.



Source: Weil, 2005.

Weil’s strategic framework is quite useful when trying to describe the health unions’ approach at different levels. An assessment of the health trade unions’ situation worldwide is beyond the scope of this study. Nonetheless, describing some of the dynamics in the health sector and in human resources’ debates sheds light on the problems and challenges that labour unions face internationally. Despite some successes, many unions have shown that they lack the ability to influence or counteract tendencies in health policies, such as privatization and outsourcing, health budget cuts and policies impacting on human resources. A PSI Health Policy Statement (2005) emphasized the fact that the decisions on reform and restructuring the health sector are taken without any consultation with trade unions. The organizational capacities of the unions have not been at the required level to make a considerable impact on these developments. The progress of market-led reforms from the other side has further weakened the trade union organizations.

Based on the analyses of Weil, it can be argued that unions with weaker organizational capacities can use the strategic leverage of the sector to reinforce their organizational capacity and increase their ability to influence external factors. The HRH political momentum can be used in favour of the unions to strengthen their organizational capacities (moving horizontally) and also to move upwards towards a higher strategic leverage. Clearly, building unions' strategic leverage would require, at the same time, coalition building and strengthening the alliances. Moreover the HRH platform can constitute a powerful incentive for the trade union unity at the national level, contributing to processes of stronger cooperation and maybe even of mergers. The process has financial implications, but involvement in the HRH debate represents a unique opportunity for health unions. They need to make a strategic choice and move away from the reactive approach of dealing with problems which are the consequences of the HRH crisis.

7.6 Areas for Action for Unions

Building a country strategy: A country-led strategy is the key concept when speaking of intervention in HRH. "Multilateral and bilateral organisations, regional networks, global health partnerships and initiatives, national governments, civil society, health worker representatives and donors will collaborate to develop comprehensive, multi-sector coordinated, and country-owned solutions" (GWHA, Business Plan, 2006). Moreover the strategies need to be tested, monitored and reviewed and no one better than workers can tell how the strategy works. It is clear from here that the role of the unions in this process is essential. This holds true both for the process of strategy design and implementation. The HRH strategy calls for a multi-sectoral approach, opening up an excellent opportunity for unions to collaborate on ever wider issues around HRH. The country strategy calls for intensive and extensive participation from the unions. This may increase the political visibility of the unions and their strategic leverage.

Articulation of a clear platform on the HRH issue from the unions is the stepping stone to enter the governance process. Country strategy design and implementation can be successfully used by the unions to strengthen the democracy in their structures through involvement and participation of members. Study circles can be

activated to facilitate the brainstorming process and voice workers' problems and inputs.

The HRH debate is strongly recommending the need for 4 million workers in the health sector worldwide to ensure wider access to basic health care. This implies good opportunities for the unions to shore up and expand their membership in the future. A membership recruitment campaign should follow the involvement of the national unions in the HRH platform.

Mapping out the civil society groups which are active in health should be at the heart of alliance building, where unions can take the initiating role. As argued earlier, the transformation of HRH intervention into a national platform for health for all can be a powerful tool for unions to regain their key role in society.

Regional strategy: The regional networks take an important role in the governance of the HRH crisis with a clear involvement in priority interventions, especially on accelerating the work at the country level. Whereas the unions' venue for interaction with civil society might be limited in the national level, depending on the strength of civil society at this level in the countries where the global initiative will start to work, the regional and international level provides more venues for unions participation.

The regional offices of PSI should actively engage in the regional initiatives and collect all the possible information on initiatives and networks emerging at national and regional levels. Towards this end, the necessity of a distinct research and coordination unit is imperative. This unit is envisaged to gather basic information from the unions at the national and regional levels as well as on the existing and new partnerships with international civil society. The research unit may have also a consultative role on the most appropriate alliances at different levels.

The Global strategy: The role of Global Union Federation PSI: The HRH governance urges a different approach of labour internationalism. Even though the academic debate has not yet reached a general agreement on new labour internationalism's

“boundaries, features and potentialities” as Ghigliani (2005) puts it, its main characteristics are already articulated.

Ghigliani describes some sets of characteristics based on the work of different academics. Accordingly, “Networking and information sharing communication, new recruiting targets and new concerns for gender and consumer issues, the environment and human rights” (Ibid) are to be important issues for labour internationalism. Other characteristics are “an opening attitude towards social movements and community groups and, consequently, by increasing role of the politics of alliances and coalitions” (Ibid). The new dynamics require “a more ‘social movement’ unionism” which would involve “a complex interaction of local, national, regional and global responses” (Ibid). Clearly, the realization of these changes would lead to what Ghigliani highlights a linkage and “a greater concern for rank-and-file needs, bottom-up organisation building and the extension of grassroots activity” (Ibid).

In short, Ghigliani argues that the new reality urges labour internationalism to “pursue a complex interaction between local, national regional and global actions, establishes narrower relationships with other social movements, and goes beyond the conventional, diplomatic and ritualistic interchanges of the past” (Ibid).

Ghigliani’s analyses of labour internationalism constitute an effective sunshine factor which contributes to the success of union strategies addressing challenges posed by the HRH crisis. For example, PSI’s role in some of the national campaigns to stop privatization has been crucial in the success of the campaigns. PSI has played an important role in the World Social Forum movement, in particular through the WTO/world trade-focused *Our World Is Not For Sale* network. The global outreach of PSI and its vast networks, the political pressure PSI may exercise through international bodies, as well the engagement of experts and resources that they can mobilize are crucial for the effective participation of unions at different levels.

To date, PSI has already been active cooperating and coordinating actions with some NGOs and global movements such as the Peoples' Health Movement, Oxfam, Health GAP, Physicians for Human Rights, World Development Movement, World Social Forum Movement, Public World, Our World is Not For Sale Network, Third World Network. It is important to create a clear picture of the global civil society through the mapping of players, contacting and cooperating with global social movements and initiatives. The exchange of information between NGOs and trade unions at national, regional and international levels is very important. Here PSI could play a leading and a supportive role.

Conclusion

This study has attempted to draw a picture of the governance debate on HRH crisis, its dynamics and the main actors taking part. Whereas the global debate on governance of HRH has involved governments, international institutions, academics, NGOs and other networks, it actually misses the direct participation of workers and worker representatives. The study argues that the absence of workers has limited the governance debate in its form, content and therefore, its legitimacy.

Much of the reasons for this absence are attributed to external factors, largely to the neo-liberal agenda which has yielded undesirable changes that are harmful to people in general as well as to health workers. However unions may have also contributed to their own exclusion. The study has analysed the unions' response to the dynamics of the HRH governance debate, elaborating on some of the tendencies which may have influenced the unions' (non) participation in the process. Unions' absence in this debate may be well attributed to a host of internal factors: unions' reactive approach, lack of strategic analyses and action on the global level, limited financial and human resources to deal with increasing challenges in the international level, as well as lack of a clear articulation of a proactive sectoral strategy. Although the study did not specifically analyse the unions in the health sector, the extensive academic literature discussed explaining the general responses and strategies of unions in the last decades may well apply in the case of health sector unions.

A change in the prevailing ideological paradigm of health governance is at the heart of transforming the crisis into an opportunity. Social justice and social inclusion as an alternative to the predominance of neo-liberalism should underpin all the dimensions of the debate: political, economic and social. Moreover, social justice and sustainability are strongly linked. Addressing social justice means addressing sustainability.

The study has argued that the HRH crisis can be effectively used and transformed into a unique opportunity for trade union development at all levels. The unions embody the missing dimensions of the actual governance debate - health as a

human right and as platform for democratic participation. Unions have a more holistic and comprehensive approach to the health crisis. As espoused by PSI, ill health results from income inequalities, poverty, exploitation and injustice. Improving health would thus require changes in economic and political priorities and the development of comprehensive social policies with full public participation. In this light, the involvement and participation of worker representatives is crucial to bring legitimacy to the governance process. The strategies and interventions will be sustainable, only if workers' involvement and participation is ensured. While this study does not question the importance of present initiatives outside the unions tackling the health and HRH crisis, sustainability issues may be raised in terms of the institutional consistency of the actors involved. Unions, on the other hand, have the capacity to sustain their initiatives because of their "broad outreach, local chapters, face-to-face majoritarian mobilization, and staying power" (Clawson, 2003).

At the same time, the HRH crisis can spur a process of union revitalization and democratic development for the society. This revitalization initiative, however, would necessitate a proactive union approach, strategic analyses and action on the global level, mobilization of financial and human resources at all levels in order to deal with increasing challenges and a clear articulation of a grassroots-oriented and membership needs-based sectoral strategy. While the study recognizes the importance of the unions' critical engagement with the political actors, such engagement should be underpinned by a powerful mobilization and strengthening of the unions at the grassroots level aiming at a more social movement unionism.

Recommendations

*"What we do or fail to do, will shape the future of global health system."
-JLI, 2004*

In the light of the findings and results of the study, the following recommendations are proposed for serious consideration by trade unions:

- (a) Establishment of a small research unit which can follow the developments on the HRH governance debate and elaborate political positions and strategies for the unions at different levels;
- (b) Massive information and education campaign on the HRH crisis for local unions;
- (c) Conduct a parallel high level international forum or conference tackling the HRH issue drawing as much participation from trade unions all over the world. This would also serve as a venue to enhance the unions' political visibility on HRH;
- (d) Preparation and articulation of a proactive sectoral, grassroots union-driven and workers' need-based approach, which is anchored on social justice and a philosophy of social inclusion and which encompasses health as a human right and as a platform for democratic participation. This will serve as an 'entry pass' for the unions in the HRH governance debate and initiatives;
- (e) Official participation and direct and indirect (through ILO) interaction with GHWA and WHO. Unions should ensure their involvement and participation in the GHWA Forum as the highest level of GHWA open to all the concerned stakeholders. Task Forces and Regional Networks are potential areas of union involvement;
- (f) Development of a more integrated approach to HRH issues that brings together PSI work being carried out on health worker migration, HIV/AIDS, workplace violence and quality health services;
- (g) Working closely with PSI staff in regional and sub-regional offices in order to identify regional, sub-regional opportunities for trade union representation at key HRH policy and planning meetings;
- (h) Strategic analysis on the overall actions to be taken in all the levels including:
 - Establishment/strengthening of alliances with other social movements, networks and initiatives involved in HRH debate and health issues;
 - Mobilization of additional resources for work on HRH which will be used for research, policy development and communications;
- (i) Conduct a complete survey which can give a comprehensive view of the: unions' level of awareness and perception on HRH crisis; governments' response to the crisis; unions' involvement in the governance process at the national level and their responses. The survey will provide useful insights on the actual national situations and help to build feasible strategies and interventions at this level; and
- (j) Political involvement of PSI in the EU and US Strategy for Action on the HRH crisis.

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Interviews

Leather, Alan, Public Services International, Deputy General Secretary and responsible for health. Interviewed via e-mail, on September 3, 2006

Appendix - Questionnaire/Interview Schedule

SUSTAINING TRADE UNION STRATEGIES TO ENHANCE UNION INFLUENCE AND INVOLVEMENT ON THE HUMAN RESOURCE FOR HEALTH DEBATE

Respondent's Name: _____

Name of Union: _____

Address: _____

Email: _____ **Tel.** _____

Date of Interview: _____

I. Union Profile

1. Union membership (federation data)

	Male	Female	Total
Total members			
Dues paying			

2. How long has the union existed? ____ years

II. Awareness of HRH crisis

1. Is there an HRH crisis confronting your country? Yes No

2. Is there an official recognition of HRH crisis by your government?

Yes No

a. If yes, what has been the government's response? (Please check all applicable responses)

additional investment for human resources development in the health sector

provide incentives to balance the distribution of health workers (rural/urban, public/private, south/north, east/west)

more comprehensive human resource planning for the health sector

more efficient labour market information system on the health sector

cooperation with other governments in tackling HRH crisis

cooperation/collaboration at the regional and global level

privatization of public health care systems

outsourcing

promotion of health workers as "volunteer" workforce

other, please specify

b. Which sector/interest group has the government involved in addressing the HRH crisis? (Please check all applicable responses)

- | | |
|---|--|
| <input type="checkbox"/> professional groups | <input type="checkbox"/> academe and research institutions |
| <input type="checkbox"/> media | <input type="checkbox"/> NGOs |
| <input type="checkbox"/> trade unions | <input type="checkbox"/> private health institutions |
| <input type="checkbox"/> public health institutions | <input type="checkbox"/> other, please specify |

III. Unions and HRH crisis

1. Is your union aware of the HRH crisis?

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> very much | <input type="checkbox"/> not much |
| <input type="checkbox"/> much | <input type="checkbox"/> not at all |
| <input type="checkbox"/> somehow | |

2. What has been the response of the union? (Please check all applicable responses)

- involvement of rank and file membership in agenda and strategy-setting addressing HRH crisis
 - networking and information sharing and communication (e.g. internet)
 - new recruiting/organizing targets (women, young workers, white color workers)
 - putting HRH issue in the union national agenda
 - lobbying with interest groups
 - actively advocate for additional allocation for HRH
 - information campaign on HRH crisis
 - cooperation with the government in tackling HRH crisis
 - cooperation/collaboration with other unions at the regional and global level
 - other, please specify
-
-

none

3. If the unions have not responded, why? (Please check all applicable responses)

- lack of adequate information on HRH issue
 - limited human and financial resources to deal with HRH issue
 - HRH issue not considered/perceived as priority
 - lack of platform or venue, made available by government, for union involvement at national level
 - other, please specify
-
-

IV. Areas for union involvement/influence in HRH crisis

Which areas do you think can unions have more influence in the HRH debate and in effectively addressing HRH crisis?

(Please use additional sheet if necessary)

THANK YOU VERY MUCH!