

Public health sector unions and deregulation in Europe

by

Jane Lethbridge

j.lethbridge@gre.ac.uk

April 2003

Presented at: INTERNATIONAL ASSOCIATION OF HEALTH POLICY EUROPE CONFERENCE
SOCIAL AND ECONOMIC DESTABILISATION IN EUROPE: IMPLICATIONS FOR HEALTH 21-24
May 2003, Stockholm, Sweden

Funded by: EUROPEAN FEDERATION OF PUBLIC SERVICE UNIONS (EPSU)

Public Services International Research Unit (PSIRU), School of Computing and Mathematical Sciences,
University of Greenwich, Park Row, London SE10 9LS U.K.

Email: psiru@psiru.org *Website:* www.psiru.org *Tel:* +44-(0)208-331-9933 *Fax:* +44 (0)208-331-8665

Director: David Hall *Researchers:* Kate Bayliss, Steve Davies, Robin de la Motte, Kirsty Drew, Jane Lethbridge,
Emanuele Lobina, Steve Thomas

Most of PSIRU's research is published on its website, www.psiru.org. It is centred around the maintenance of an extensive database of information on the economic, political, financial, social and technical experience with privatisation and restructuring of public services worldwide, and the multinational companies involved in these processes. This core database is financed by Public Services International (PSI - www.world-psi.org), the worldwide confederation of public service trade unions.

PUBLIC HEALTH SECTOR UNIONS AND DEREGULATION IN EUROPE.....	1
1. COMMERCIALISATION/ LIBERALISATION AND ITS EFFECTS	3
1.1 WHAT DOES COMMERCIALISATION/LIBERALISATION INVOLVE?.....	3
<i>Public-private partnership/ private finance initiatives.....</i>	<i>3</i>
<i>Contracting out of services - from ancillary to clinical services.....</i>	<i>3</i>
<i>Development of diagnostic services.....</i>	<i>4</i>
<i>Corporatisation of health care institutions.....</i>	<i>4</i>
<i>Opening to trade and competition, via EU internal market, GATS</i>	<i>5</i>
<i>Changing role of government in health care provision.....</i>	<i>6</i>
1.2 ARE THERE NATIONAL SIMILARITIES / DIFFERENCES?.....	6
<i>Differences</i>	<i>6</i>
<i>Similarities.....</i>	<i>6</i>
1.3 WHAT IS THE IMPACT ON HEALTH WORKERS?.....	7
<i>Western Europe.....</i>	<i>7</i>
<i>Eastern and Central Europe.....</i>	<i>7</i>
2 TRADE UNION RESPONSES.....	7
2.1 HEALTH SERVICE TRADE UNIONS ALONE.....	8
<i>Italy.....</i>	<i>8</i>
<i>Lithuania.....</i>	<i>9</i>
<i>Spain.....</i>	<i>9</i>
2.2 WIDER TRADE UNIONS.....	10
<i>Czech Republic.....</i>	<i>10</i>
<i>UK.....</i>	<i>10</i>
2.3 TRADE UNIONS AND SOCIAL MOVEMENTS.....	11
<i>Finland.....</i>	<i>11</i>
<i>UK.....</i>	<i>12</i>
2.4 EUROPEAN FEDERATION OF PUBLIC SERVICE UNIONS.....	13
3 CONCLUSIONS AND RECOMMENDATIONS FOR THE FUTURE	15
3.1 CONCLUSIONS.....	15
3.2 RECOMMENDATIONS.....	15
<i>Trade unions.....</i>	<i>15</i>
<i>EU level.....</i>	<i>16</i>

INTRODUCTION

This paper sets out to explore how trade unions are responding to the changes in deregulation and liberalisation of health services in Europe. Starting with an outline of some of the changes taking place in public health care services that can be characterised as the commercialisation of health care, the paper outlines some of the effects of these changes on health workers. Recent trade union responses are analysed in terms of the different alliances made by health worker trade unions. The paper concludes with a series of recommendations for lobbying and action.

1. COMMERCIALISATION/ LIBERALISATION AND ITS EFFECTS

1.1 What does commercialisation/liberalisation involve?

Public-private partnership/ private finance initiatives

Commercialisation and liberalisation involve expanding the role of the private sector in the public health care sector. The private sector is being drawn into operating within the public health sector through a series of mechanisms. One of the most influential, in terms of redefining public and private sector relationships, are public-private partnerships (PPPs). This covers a wide range of possible relationships, from contracting the private sector to supply goods (e.g. drugs) or services (e.g. cleaning), through to arrangements where a private company may manage a public hospital (e.g. St.Goran's Hospital, Stockholm) or finance a new hospital in return for a long-term concession to provide services (e.g. hospitals built through the Private Finance Initiative (PFI) in the UK). Although usually developed at national, regional or local levels, they also exist at an international level.

In Europe there are a growing number of example of hospitals managed by private health care companies. Stockholm County Council contracted the management of St.Goran's Hospital, Stockholm to Bure Health Care in 1994 which in 2000 became Capiro, a company floated on the Stockholm Stock Exchange. In Spain, the Valencia Generalitat gave a consortium of four companies (including Adeslas) that had formed the Union Temporal de Empresas (UTE) the concession to build and manage a public hospital for 10 years. Health workers had to accept new terms and conditions under this concession. The Omega Hospital, Piedmont, Italy, has recently given the French health care company Generale de Sante a contract to manage the hospital. In Portugal the Jose de Mello group, the largest private health care provider in Portugal, has been managing the Amadora Sintra Hospital for 5 years but is now subject to a legal challenge.

Private Finance Initiative (PFI) is a form of public-private partnership where a government contracts to purchase services on a long-term basis in order to use private sector management skills "incentivised by having private finance at risk". This may include concessions on franchises where the private sector partner takes on responsibility for providing a public service, including maintaining, enhancing or constructing infrastructure (HM Treasury, 2001).

Private Finance Initiatives (PFI) are most commonly found in the UK and have been used to build new hospitals. Several private sector companies, usually operating as consortia, build and own a hospital, which is then leased to the NHS for 20 years or longer. The NHS pays for the building's capital and running costs out of its incoming revenue (mainly public funds). Effectively the public sector is subsidising the private sector (The Cornerhouse, 2001).

Contracting out of services - from ancillary to clinical services

The contracting out of services has been taking place in many health sectors for over 10 years. The contracting out of ancillary services began in the late 1980s in the UK and North America.

This process has continued in many countries, with large multinational companies e.g. ISS, Sodexo, selling increasingly complex packages of services, known as facilities management services to different sectors, including the health sector. There is a trend towards greater consolidation of companies which provide support services. Smaller private companies that were set up when contracting started have been slowly bought up by a group of multinational companies such as ISS, Sodexo, Rentkil-Initial and Compass. In the UK, companies already providing ancillary/facilities management, e.g. ISS, have become involved in consortia (partnering with finance companies and construction companies) to bid for Private Finance Initiatives to build new hospitals.

Services that have been contracted out:

- Cleaning
- Catering
- Estates management
- Facilities management
- Clinical services
- Diagnostic / laboratory services

The process of contracting out of services has an impact on how hospitals are structured and managed. Part of a process of corporatisation involves reorganising the financial systems within an institution. This may accompany the initial contracting out of services. The process of tendering, contracting, and monitoring of services requires new skills and a new layer of management.

Apart from the contracting out of ancillary services, the contracting out of clinical services is being considered in the UK. The pressure of more people waiting longer for health care treatment has led to "waiting lists" becoming an increasingly sensitive political issue in Europe. Recent decisions by the European Court of Justice to support the right of patients to seek treatment in other European countries other than their home country is putting additional pressure on governments to delivery services more quickly (Mossialos et al, 2001).

The contracting out of clinical services to the private sector, often based in other European countries has been one of the short term solutions suggested to cut waiting lists. New companies have been set up to deliver teams of specialists to deal with routine waiting lists (The Guardian 25 June 2002). Staff will be mobile and able to move to hospitals that need fast delivery of surgery. In addition, there are plans for longer term contracting out of clinical units to private companies (Department of Health, 2002).

Development of diagnostic services

The development of diagnostic services, e.g. magnetic resonance imaging (MRI), CT scans and other high technology equipment, to diagnose non-communicable diseases is becoming more widespread. This type of equipment requires large capital investment and highly trained staff to operate it. In many health systems, private companies are already providing the equipment and services. Loans from multilateral organisations are often given for the purchase and establishment of this infrastructure (Lethbridge, 2002).

Corporatisation of health care institutions

One of the aims of health sector reform was to introduce more efficient ways of operating and managing health services. This was generally interpreted as introducing commercial business practices to health care institutions. Part of this process often involved changing the management and financial structures of health care institutions, creating separate "companies".

The development of health care institutions within the public sector that operate under business principles has been called "corporatisation". When introduced over a decade ago, the process was considered a first step towards moving towards the privatisation of health care services. It was assumed that once an institution operated like a business, it could be taken over by the private sector.

A major issue that this process highlights is the use of public sector resources to develop organisation that may eventually move to the private sector. The development of new business practices; new systems of governance and training for staff are funded by the public sector. This subsidy of new public/private sector companies by the public sector is found in many countries.

The most recent example of corporatisation is being put into practice in the UK. "Foundation" trusts have been suggested as a way of enabling health care institutions to operate more independently. In the UK they are being described as "public interest institutions" (Department of Health, 2002). They will be able to raise their own capital up to a certain limit (30%) and set up subsidiaries. The new foundation trusts will be "supported" during their setting up period by the Department of Health in practical and financial terms (Department of Health, 2002).

Opening to trade and competition, via EU internal market, GATS

European health care has been most strongly influenced by the concept of subsidiarity with national governments considering national health care systems to be their own responsibility. Health policy has traditionally been caught between the EU Treaties implemented through European legislation and the European Court of Justice (ECJ), and policy making which has been consensual between member states. This has led to a form of policy vacuum in relation to health care policy which has been filled by some of the judgements of the European Court of Justice (ECJ).

Although subsidiarity has been an important principle for European health services the impact of several EU Directives e.g. movement of professionals, insurance, is beginning to influence national health systems directly. In addition, several rulings by the European Court of Justice have made national governments aware of the implications of greater consumer choice. If this is combined with the effect of increasing demand for health care services, often seen through increased waiting lists, then cross-border health care is likely to increase in the future. EU competition policy is also beginning to affect health care systems that have introduced business approaches and techniques and so can be less obviously defined as services of "general interest". National governments are passing competition legislation that opens up national markets to international competition.

The recent ruling by the Appeals Tribunal of the Competition Commission in the UK (August 2002) is an example of how national competition legislation is influencing public health systems. The Commission backed a private company, BetterCare - a residential and nursing company in Northern Ireland, in its claim that the local health trust had an unfair monopoly over the care of the elderly. This is a significant move towards opening up public services to competition (Decision of the Competition Commission August 2002 www.competition-commission.org.uk).

The General Agreement on Trade in Services (GATS) threatens the existence of public health services in both developing and developed countries by pressuring countries to open up their service sectors to international trade (Save the Children, 2001). This will affect the universal rights to services that people experience in relation to public services, including health. The use of commercial and business practices in the health sector make it vulnerable to being considered a business activity and so liable to the same requirements to open its services to competition. If a UK ruling, under its domestic legislation (1998 Competition Act), has decided that commissioning by public bodies is, in some cases, a commercial undertaking, then this will

weaken any opt out clause made by the UK government under the GATS. This will also result in public services being opened to competition with international companies.

Changing role of government in health care provision

Contracting systems and public- private partnerships in the public health system are part of wider changes in the role of government in the health care system. These changes are part of a policy of reforming the public sector which is known as the "new public management". This is an approach which has included: introducing market mechanisms to the public sector, setting performance targets for agencies and public sector workers, focusing on consumers/ customers and improved quality of services, and introducing private sector management techniques (Bemelmans et al, 1999). Moving from being a provider of health services, the public/ government sector has often relinquished direct control over providing health care services and taken on a coordinating and in some cases regulatory role. This is sometimes described as moving from a "provider" to an "enabler" role. This process varies from country to country and has been encouraged directly by many health sector reform programmes.

The combination over the last 20 years of underfunding in some national public health care sectors and the changing role of the government has led to changes in people's perception of the public sector and the private sector. The media has also encouraged these changes in attitude by highlighting the shortcomings of public health systems. This is significant for trade union campaigns against commercialisation of health care because public support for national health care systems cannot always be taken for granted even if it still remains strong in many countries.

1.2 Are there national similarities / differences?

Differences

Reviewing the changes that have taken place in public health systems throughout Europe in the past decade shows that there are differences in the rate of change and in the degree of involvement of the private sector in running public health services. Some of these differences can be traced to different historical structures of provision. In social insurance systems there is already some form of purchaser- provider split mirroring the split between the social insurance fund and the health care providers, some of which may be private health care companies.

Similarities

There are many similarities in the changes taking place in the health care sector in countries in both Western and Eastern Europe. The process of corporatisation of public health sector institutions is widespread. In some countries, it is a gradual process that has been taking place throughout the last decade, in other countries, there are specific policy decisions that speed the transformation of health care institutions into companies e.g. foundation Trusts in the UK, regional companies in Norway.

Purchaser-provider arrangements have also been introduced in many countries. These have often been accompanied by the development of public-private partnerships, which involve the private sector in different relationships with the health care sector.

Another similarity, which has emerged in the last few years, is the introduction of a common system of pricing of health care services, called Diagnostic Related Groups (DRGs). This approach provides a way of pricing a series of health care interventions which are focused around a specific condition or disease. It enables both public and private health care providers to be considered on the same terms.

The similarities show that the process of commercialization of health care is one that is affecting all European countries. It suggests that national trade unions need to consider the benefits of coordinating campaigns with other national trade unions.

1.3 What is the impact on health workers?

Western Europe

The impact of the different forms of commercialisation of health care on health workers is extensive. The corporatisation of health care institutions is often accompanied by attempts to develop local pay schemes for health workers and break up national collective bargaining agreements and pay structures.

The contracting out of catering and cleaning and other facilities management services has resulted in changes in terms and conditions of employment, increasing insecurity and casualisation. The introduction of "flexible" working has also affected health workers.

Eastern and Central Europe

In Central and Eastern Europe, the impact of health sector reforms on health workers has been more dramatic. There has been downsizing of the public sector, which has directly affected health workers. Decentralisation and changes from tax based to social insurance systems have led to changes in the size and allocation of budgets. Privatisation of services has taken place in some countries but is not as widespread as in Western Europe. There has been an increase in part time workers, which is associated with increased economic insecurity in many CEE countries (Afford, 2001).

Pressures to reduce costs have led to payment of low wages often many months in arrears. The introduction of user fees, has included informal fees that health workers charge in order to generate some basic income. Health workers often work through periods of ill health because of inadequate sick pay (Afford, 2001).

A lack of investment in the health sector has led to a deterioration of working conditions in hospitals with poor equipment affecting health and safety conditions (Healy and Humphries, 1997). Although the demand for new skills and experience is increasing with demands that the health sector meets the needs of patients and users more effectively, the provision of training and continuing education has become more erratic.

One example of the immediate effects that trade unions have experienced since deregulation was introduced can be seen in the Czech Republic. There has been an increase in the number of casual and self-employed workers in the health sector, affecting both men and women but especially women. Many workers involved in the trading of pharmaceuticals and medical equipment are now self-employed. Although trade union rights remain the same, it is more difficult to put them into practice. Trade union organisation has become weaker since privatisation. Training and further education has improved in larger hospitals but become worse in smaller hospitals. Pensions and housing benefits remain the same but health care and travel benefits have worsened (PSI survey, 2002).

2 TRADE UNION RESPONSES

Examining the responses of trade unions to deregulation raises questions about what the most effective ways of challenging a process that is affecting all countries in Europe and that is also being influenced by European Union-wide competition legislation. Are national trade union

responses or pan European wide approaches most appropriate? There is considerable debate about the role that trade unions should take in challenging capital that is increasing mobile.

Recent research commissioned by the European Trade Union Institute has tried to address the issues faced by trade unions in Europe. Some of the debates include trying to define the role of trade union actors in the internationalisation of the economy when most trade unions are organised nationally or how "to develop a common policy option on the European and international level" (Hoffman 2003, Jacobi and Kowalsky 2002). Exploring the need and logistics of European wide collective bargaining has also emerged through these discussions. Dolvik and Waddington (2002) discuss some of the challenges faced by European trade unions "arising from the growth and diversification of employment in private sector services" and relate them to processes of trade union renewal.

Trade union responses to liberalisation will be approached by examining actions of:

- a) National health service trade unions alone
- b) Health trade unions working with other trade unions nationally
- c) Trade unions and social movements nationally
- d) European level trade unions

These are not mutually exclusive categories but this framework will help to illustrate some of the issues involved in trade unions challenging liberalisation. A series of examples has been chosen to illustrate different approaches.

Trade unions have used a variety of approaches/ techniques to challenge the results of liberalisation at national/ local level. These include:

- Campaigning at local, regional and national level
- Lobbying politicians, professional organisations, other interest groups
- Involving the public through leafleting, public meetings
- Developing alternative health policies
- Strike action - right to strike for health workers available in some countries
- Making legal challenges to changes in the organisation of health care delivery

2.1 HEALTH SERVICE TRADE UNIONS ALONE

Italy

The reform of Italian health services began in 1993 when regional governments were given managerial and financial autonomy for health services. Central government sets a level of financing due for each citizen, which provides a minimum level of funding for each region. Any excess expenditure or additional services must be financed through regional taxes or patients' cost sharing.

The Berlusconi government is proposing new health reforms, which will build on regionalisation. One of the projects being implemented at the moment is the corporatisation of regional hospitals or the "transformation of Institutes of Hospitalisation and Treatment of a Scientific Nature, currently public and under the control of the Ministry of Finance into Foundations which will be mixed public-private" (AEMH, 2002).

A second fundamental reform that has been proposed is the change in legal status of employed doctors. Until now, doctors have been able to choose between two types of contracts. An exclusive contract with the national health system (SSN) allows doctors to manage hospital wards, services, departments and once chosen is not reversible. A non-exclusive contract allows doctors to practice outside the public sector but with salary deductions and they are not allowed to manage hospital wards, services or departments. In effect these contracts prioritise doctors

who opt for an exclusive contract with the public sector. Currently even those who have non-exclusive employment are allowed to carry out private practice only after having carried out activities to reduce waiting lists. The government has proposed that the choice of exclusive employment with the national health system is reversible and that doctors currently working on non-exclusive contracts will be able to manage public hospitals.

One focus of current trade union campaigns is a challenge to the health and local government authorities which are refusing to renew a collective agreement that was introduced in 1994 and is due to expire in 2004. Local and regional authorities feel that a 1993 Protocol is no longer appropriate and so have not set up any negotiations with trade unions, implying that the government is planning new arrangements. Three trade unions FP-CGIL, CISL-FPS and UIL FPL, each with different political party links, came together to call a national strike for 8 May 2003 and a national demonstration on 19 May 2003. Between 8 and 19 May there has been a campaign to inform and mobilise health workers. This campaign complements a wider campaign to support the National Health Service which drew a large demonstration in April.

Lithuania

In Lithuania, health trade unions have used conferences, public leafleting and the press and media to raise awareness of the potential effects of privatisation and deregulation. They have developed alternative strategies and solutions. However, health unions have not joined wider campaigns against privatisation or against specific companies, nor were they part of wider election campaigns (PSI survey, 2002).

Health worker trade unions developed alliances with a wide range of other groups in the health sector, including doctors, nurses and groups of health service managers. Unusually, health services managers played a campaigning role against privatisation. Trade union actions succeeded in delaying decisions in Lithuania (PSI survey, 2002)

Spain

The Federacion de Asociaciones para la Defensa de la Sanidad Pública (FADSP www.fadsp.org) has led challenges to the privatisation of health services in Spain. FADSP is a federation of professional associations related to health (doctors, nurses, administrators, economists etc) interested in defending and improving the public health system.

The case of the first public hospital in Spain to be managed by a private company led to a specific trade union challenging the legality of the arrangement. This is an example of how trade union action has used legal challenges.

The Valencia Government was one of the first regional governments to use private management methods in the public health sector. On 1 January 1999, Adeslas, a Spanish health insurance and health services company took over the management of Alzira Hospital, previously the publicly owned Hospital de la Ribera, Valencia. Adeslas (51%) together with two banks - Bancaixa and the Caja de Ahorros del Mediterraneo (45%) - and two construction companies - Dragados (construction and services) and Lubasa (2% each) - formed the Union Temporal de Empresas (UTE), which was given the concession to build and manage the public hospital for 10 years. The group was paid a set amount per head of population each year, initially 34,000 pesetas per head (El Pais, 21 January 1999)

Before the hospital opened, trade unions were challenging the lack of transparency about the arrangements for terms and conditions of employment at the new hospital. The new system of pay and conditions that was finally introduced was one of the main innovations of private management. Each specialty had its own salary scale and its own set of objectives. The rest of

the 700 workers would receive a fixed pay rate (El Pais 12 December 1998). All staff would be contracted.

In November 1999, trade unionists from the General Union of Workers (UGT) demonstrated against the dismissal of a doctor who headed the list of candidates in the union elections in the hospital. A member of the committee of the UGT Federation of Public Services called for "the end of anti-trade union practices in the Health Committee of the company UTE - Aseslas" which was in charge of managing Alzira Hospital (El Pais 18 November 1999).

A year later in December 2000, the health worker section of the national trade union Confederacion Sindical de Comisiones Obreras (Federacion Estatal de Sanidad of CC OO) challenged the legality of the concession for the management of the Alzira hospital arguing that the arrangement had led to the privatisation of the hospital and was outside the terms of the law 13/1995 of the Contracts of Public Administration. The union argued that the removal of the medical personnel from the public hospital had led to "an illegal transfer of labour" to Adeslas (the company managing the hospital) "as means of production and profit". The Constitutional Tribunal did not uphold the trade union challenge. It argued that, "the character of the public system would not be influenced by the form of management or private responsibility" (El Pais 22 December 2000). Although the challenge was unsuccessful, this was an example of trade union challenging the legality of one aspect of the liberalisation of the public health system.

In November 2002 the Valencia government announced that it would compensate the group of companies who had taken over the concession with €43.9 million, the value of the remaining 6 years of the contract. From 1999 - 2002 the group of companies (UTE) have operated the hospital at a loss. However the Valencia government has not abandoned the use of private companies to manage public facilities. Adeslas has expressed interest in managing primary care in Valencia and is looking for new commercial partners.

2.2 WIDER TRADE UNIONS

In some countries, health service trade unions have also joined other trade unions as part of wider anti-privatisation campaigns, e.g. Germany. In some cases this has been because anti-privatisation campaigns were already taking place in other sectors.

Czech Republic

In the Czech Republic, health trade unions have used petitions, expert communications, press conferences, demonstrations, and strike action to challenge the plans for liberalisation and privatisation of the health sector. They joined wider campaigns against privatisation as well as campaigns against a specific company e.g. Sodexo. However, Czech health trade unions were unable to develop alliances with any key civil society groups because there was widespread support for privatisation in the country and among other health groups.

Trade unions campaigning led to some successes. The privatisation of some hospitals was cancelled. In other cases where privatisation is continuing, there will a transfer of employee rights onto the new owners of the units that are going to be privatised, thus providing more protection for health workers (PSI survey, 2002).

UK

In the UK there have been both broader campaigns by alliances of trade unions to support and promote the public sector as well as specific campaigns by individual trade unions representing public sector workers including health workers.

The campaign "Keep Public Services Public" has brought together a range of trade unions from all parts of the public sector to defend public services. By spring 2003, two issues had become central to the campaign: a) to end the two tier workforce where workers in services that have been privatised have lower pay and conditions than those employed directly by the public sector; b) the call for an independent review of the value for money aspects of the Private Finance Initiative (PFI). The campaign has won one victory in getting legislation to end the two tier workforce in Local Government, passed on 13 March 2003.

This campaign has also been complemented by individual trade unions also running campaigns to promote public services e.g. UNISON Positively Public. UNISON has a large number of health workers as members. It has commissioned research to highlight some of the problems of the Private Finance Initiative (PFI) as well as showing how accountancy firms influence and profit from privatisation policy. It has developed campaigning materials for local branches and a campaign website. A briefing pack "What's Good about the NHS and why it matters who provides the service" sets out the arguments for the NHS and public services. An example of how this has been used by local UNISON branches will be dealt with in the next section.

These campaigns need to be seen in the context of a government that in April 2002 announced that it would increase funding to the NHS over the next 5 years. This represents a five year commitment to a publicly funded health service (The Guardian 17 April 2002, 26 April 2002). There has also been some rhetorical support for public services. At the same time the government is actively encouraging private sector participation in the NHS as a way of improving services. This has increased since the announcement of extra funding for the NHS.

2.3 TRADE UNIONS AND SOCIAL MOVEMENTS

Finland

A specific example of a trade union being proactive in stating its belief in the importance of working with other civil society organisations can be seen in the case of KTV, a Finnish trade union for the municipal sector, which recently published a book entitled "Everything at stake - safeguarding interests in a world without frontiers" (Artto, 2001).

The President of KTV states in the introduction, "even the most powerful multinational enterprises and other elements of international capital are not immune to pressure. People around the world can influence these forces in many roles: as employees, as consumers and as public activists". He calls for the "renewal of international collective bargaining by the trade union movement" and emphasises the common cause that developed and developing countries have in this struggle against global capital. This call for international collective bargaining is significant in that it shows that a national trade union recognises the value not only of international solidarity but of international bargaining and negotiating structures.

One of the recommendations of the book is that: "The trade union movement will achieve the best results by engaging in broad co-operation with non-governmental organisations, experts and policymakers - and on an equal footing - also with employers". This represents an important policy position for KTV, which will form the basis for future campaigning with civil society organisations. It is currently developing a campaign with non-governmental organisations (NGOs) to fight the privatisation of municipal services.

UK

The process of challenging the effects of liberalisation is one that continues after the policies have been implemented. An example of a campaign run by The East London Communities Organisations (TELCO) in partnership with UNISON shows how low pay, which is the result of contracting out of cleaning and catering services in the NHS, has been taken up by both trade unions and local community organisations in East London.

Founded in 1996, TELCO is made up of 37 organisations in five districts of East London. Its members include churches of all denominations, mosques, a Buddhist Centre, community centres, schools and trade union branches. It aims to bring together these diverse communities into an effective alliance to "press power-holders, in the public and private sectors, to act for the benefit of families and communities in East London." It "trains leaders from its member organisations to be "skilled, capable citizens who can act collectively for the common good and take their case wherever it needs to be heard" (Telco, 2003)

The campaign started two years ago and aims to highlight the poor pay and conditions offered to contracted out staff in hospitals in East London and the impact of these low pay rates on "household poverty, the health of staff, the quality of services delivered to the public, turnover and management of ancillary services." Telco has also pointed out that the majority of contracted out staff in East London are women from ethnic minority groups and "their second class pay and conditions are inconsistent with the obligation on public bodies to actively promote racial equality under the Race Relations Amendment Act" (Telco, 2003).

Telco's main proposal is that the Strategic Health Authority adopts a policy on contracting which would require contractors to undertake that "new employees will receive the same terms and conditions and pay as existing NHS employees and improvement to NHS Whitley terms and conditions will apply to all transferred and new staff". More recently, local government has agreed the Code of Practice on Workforce Matters in Local Authority Service Contracts which states "where the service providers recruits new staff to work on a local authority contract alongside staff transferred from the local authority, it will offer employment on fair and reasonable terms and conditions which are, overall, no less favourable than those of transferred employees. The service provider will also offer reasonable pension arrangements" (Telco, 2003).

The chief executive of the North East London Strategic Health Authority (12 November 2002) "expressed sympathy with the campaign's objectives, arguing that financial considerations were the primary obstacle facing Trusts in eliminating the injustice of a two-tier system of pay". She referred to the Health Authority's campaign to secure additional funds from central government in order to address health inequalities in the area. TELCO supported the Health Authority in its campaign for extra money which was successful. Central government has since given health authorities in East London the largest increases in funding in England with increases in 12% per year for 2 years followed by 10% (Telco, 2003).

In March 2003 the North East London Strategic Health Authority (SHA) issued a press release that stated its position remains as stated on 12 November 2002. "The SHA is encouraging Trusts and PCTS to work with local trade unions and independent sector contractors as contracts are negotiated, to discuss improvements to base rate of pay and terms and conditions of employment for staff not covered by NHS terms and conditions". The results of this process will be awaited with interest.

This campaign is important because it has brought together trade unions and local community and faith groups, covering both health workers and health service users. It uses arguments that support the national strategy to reduce health inequalities. In the UK, there has been a growing awareness in the last two years of the role that the NHS (and local government) play as major

sources of employment in disadvantaged areas. NHS managers and economic development agencies are beginning to recognise the role that the NHS can play in economic regeneration by providing employment with good terms and conditions.

2.4 EUROPEAN FEDERATION OF PUBLIC SERVICE UNIONS

The European Federation of Public Sector Unions (EPSU) is a confederation of public sector unions throughout Europe. Whilst supporting its members in actions at national level, it has taken action at a European level in ways that show there are new ways of challenging the processes of deregulation and representing the interests of health sector workers. It operates with mechanisms that are available to trade unions and other groups at European level. There are currently three major initiatives:

- Developing a policy on access to quality health care
- Setting up a process of social dialogue in the hospital sector in Europe
- Working towards implementing the EU Working Time Directive in the Health care sector

Quality health care for all

Trades unions at national level have sometimes developed alternative health policies that address some of the problems faced by the health sector but present future options that promotes the interests of both health workers and health users. Alternative health policy documents are useful campaigning tools.

EPSU has worked in partnership with another pan-European trade union federation - the European Trades Union Confederation (ETUC) to develop a policy document on "Quality health care for all". EPSU started by commissioning some research on the impact of internal market legislation on national health systems. The results of this work were presented to the EPSU Health and Social Services Standing Committee in March 2002. The research showed that although the concept of subsidiarity applied to health care policy within the EU, in reality, national health systems were beginning to be influenced more strongly by EU competition legislation. The recommendations were for EPSU to lobby for a specific health policy component in a future EU treaty, so that health care policy would be given a European wide remit, similar to social protection within the Lisbon Treaty. This caused extensive debate on the Health and Social Services Committee because national trade union representatives felt that to lobby for health care policy within a new treaty was abandoning the principle of subsidiarity for national health care policy.

The next step towards developing the "Quality Health Care for All" policy was a joint training seminar with ETUC in May 2002. A draft policy was drawn up and discussed by a wide range of representatives from across Europe. It consisted of an outline of how competition policy is influencing health services and a series of recommendations about health care policies that could be incorporated into different European policy mechanisms. This draft policy was then revised and eventually agreed in autumn 2002 by both organisations. It is now being used as a campaigning tool. For example EPSU is a member of the European Health Policy Forum, which was set up by the European Commission to bring together a diverse range of organisations involved in health in Europe to discuss policy issues. It uses this arena to raise health care policy issues. However some of the issues about recognising the limitations of subsidiarity in health care are still not resolved within EPSU.

Social dialogue in the hospital sector

EPSU has worked over the past two years to develop a social dialogue in the hospital sector. Social dialogue is a concept that has been adopted by the European Union. The Amsterdam Treaty states: "Social partners have rights to be consulted on proposals in the social field and to opt for agreement-based rather than legislative measures". EPSU has been involved in

identifying and working with key actors on both the trade union and employer side. EPSU is the recognised trade union side organisation. Three other European wide unions (Standing Committee of Nurses of the EU (PCN), the Standing Committee of European Doctors (CP) and the Permanent Working Group of Junior Doctors in Europe (PWG) all participate as observer organisations.

The employer side organisations are the European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest (CEEP) and the Council for European Municipalities and Regions Employers' Platform (CEMR-EP). The two observer organisation are the Union of Industrial and Employers' Confederations of Europe (UNICE) and the Standing Committee of the Hospitals of the European Union (HOPE).

"The challenge for the actors is to identify a system, which allows for dialogue to take place in a way, which is both practical and representative (Lene B.Hansen Vice President EPSU Standing Committee for Health and Social Services 25 September 2002)). Through identifying topics for discussion, the social partners can "develop a process whereby common positions can be negotiated and adopted, with a view to clarifying and improving social conditions in the Hospital sector in the EU". An initial conference in May 2000 identified common themes for discussion between social partners. These included modernisation of the hospital sector, quality developments and changes of work organisation, involving users/ patients in improving health care quality. A website was set up for all the partners which helped to make the process transparent.

A second conference in February 2002 led to a decision to set up a joint representative task force "to take the necessary steps to formulate a working programme as a basis for future social dialogue". The task force has met four times over the last year. It is submitting a project proposal to the European Commission to examine recruitment and retention from different perspectives. The trade union side has suggested that standards for international recruitment could be developed. Employers would like to focus on part time work and policies for an ageing workforce. It has also been proposed that social partners in the hospital sector should be identified at national level. However, one of the main challenges is "to convince participants of the advantages of the social dialogue process in a sector, which has traditionally been the preserve of the member states". Once again the issue of whether subsidiarity in health care policy precludes wider European wide trade union initiatives in health care has arisen.

European Working Time Directive

As part of a more direct campaign, EPSU is campaigning for doctors in training to be covered by the EU Working Time Directive. The Working Time Directive was approved by the European Commission in 1993 and implemented three years later. It aims to set minimum health and safety requirements for the organisation of working time and sets minimum periods of daily and weekly rest and annual leave. Several working groups are excluded including doctors.

The focus of the EPSU campaign is on the health sector because "it is at the fore front of working-time development, setting precedents and providing a role model for other occupations and sector" (Carola Fischbach-Pyttel General Secretary EPSU www.epsu.org). The campaign is targeted at employers, health workers, general public and politicians. It will raise awareness of working time issues in Eastern and Central Europe. EPSU's working time policy "highlights the primacy of collective agreements in the 'restructuring and reduction of working time at both the national and European level'. A recent ruling by the European Court of Justice (1998) states that on-call duty shall be deemed working time. This will also be promoted by EPSU as part of its campaign.

These three initiatives show how the future influence of trade unions in the health sector is being addressed through the use of both institutional instruments and direct campaigning. EPSU

feels that there are three main instruments that will help to safeguard the interests of health workers in the future. These are:

- Social dialogue
- Funding to develop social dialogue processes at local, national and European level
- European Works Councils which companies with more than 1000 workers in two European countries are responsible for setting to provide a forum for worker-management negotiations. In the case of health care companies expanding throughout Europe, this will be an important structure for negotiating improved conditions.

3 Conclusions and recommendations for the future

3.1 Conclusions

Liberalisation and deregulation are not a static processes and are gradually evolving. Trade union challenges against the impact of deregulation and liberalisation in Europe will have to adopt a range of approaches at local, national and European wide level. Different approaches will need new types of skills and expertise. These range from monitoring and regulation, legal challenges to operating within a context of social dialogue. The importance of operating within alliances will become increasingly important.

Trade unions at national and European level will also have to educate their members about the complexity of health care policy as it affects national health systems and the range of different types of action that will be needed to work towards a health care systems that both meet the needs of users and health workers. The use of alternative policy documents such as EPSU/ETUC "Quality health care for all" that address the need for policy within a European context, will help this process.

More research and campaigning are needed to identify measures to protect and strengthen the public health sector. In Italy, some doctors currently have contracts that are exclusively to work in the public health system. Exclusive public sector contracts and other incentives to remain in the public sector will be needed when more private health care companies are seeking to recruit health staff. Incentives may be both financial and non-financial but need to be in place as soon as possible to retain public health sector staff.

There are an increasing number of studies that have looked at mortality and morbidity rates in public and private health care sectors. These results will become increasingly important in future to demonstrate the safety rates of different types of health care provider. This type of research can form the basis for campaigns supported by broad based alliances.

One of the arguments that are used to limit funding for the public health sector is that the money will "only" go towards health worker pay. This issue of the high labour costs of health services needs to be explored by campaigners in relation to the "added" value that well paid health workers contribute to health services. In the development of alliances between trade unions and other civil society groups this is perhaps one of the most important issues to be addressed.

3.2 Recommendations

Trade unions

- Monitor the impact of EU legislation and rulings on health care provision and health care institutions

- Lobby national governments about need for a new EU wide health policy and improved coordination of existing policies and rulings
- Recognise the threat to mutuality posed by insurance Directives and document recent challenges
- Raise awareness about the impact of EU competition law on health care institutions and ways in which health care institutions can remain providers of services of general interest
- Make EPSU/ ETUC a strong voice in this process

EU level

- Review existing health and health care policies together with ECJ rulings and publish in a new framework
- Work towards a new Treaty that includes health and health policy in the same way as social protection - integral to economic growth and development
- Strengthen the Health and Consumer Affairs DG to address wider health and health care policies across other Directorates

National government level

- Member states to adopt a more proactive approach to EU health and health care policy, recognising that subsidiarity is not viable for the future development of health care systems
- Member states should work together on:
 - Common problems of health care provision and financing
 - Defining a common set of aims and objectives for health care systems
 - Pricing of pharmaceutical and medical devices
 - Developing common agreements on voluntary medical insurance
- National governments to develop guidance for national health care institutions about the impact of EU competition law and ways of remaining providers of services of general interest
- New health care policies to address the impact of competition law
- Develop measures that provide incentives for working in the public health sector
- Develop ways of motivating health workers to take on new types of skill mix and responsibilities

References

AEMH (2002) Annual Report of the Italian Delegation of the Association of Senior Hospitals Doctors / Association Europeenne des medicines des hopitaux (AEMH)

Afford C W (2001) Failing Health Systems: Failing Health Workers in Eastern Europe SES Paper ILO-PSI

Artto Juhano (ed.) (2001) Everything at stake - safeguarding interest in a world without frontiers, KTV Finland

Bemelmans-Videc M.L. et al (1999) Renewing Government; a Tale for all Times in Renewing Government Innovative and Inspiring Visions (eds.) Nelissen N., Bemelmans-Videc M.L., Godfroij A. and de Goede P. International Books; Utrecht

Competition Commission (2002) Decision of the Competition Commission Appeal Tribunal August 2002 www.competition-commission.org.uk

Department of Health (2002) Statement by the Rt.Hon. Alan Milburn MP, Secretary of State for Health to the House of Commons about delivery the NHS Plan 18 April 2002
<http://www.doh.gov.uk/speeches/apr2002milburnbudget.htm>

Department of Health (2002) A Guide to Foundation Trusts, London

Department of Health (2002) Growing Capacity A new role for external healthcare providers in England, London

HM Treasury (UK) (2000) Public Private Partnerships The Government Approach, Stationery Office, London

Lethbridge J. (2002) Private investment and International Finance Corporation investment in health care www.psiru.org

Mossialos E., McKee M., Palm W., Karl B., Marhold F. (2001) The influence of EU law on the social character of health care systems in the EU A report submitted to the Belgian Presidency of the European Union Brussels 19 November 2001

PSI (2002) Privatisation of health services - experiences of health workers survey

Save the Children (2001) Press Release 'Trading in health - New report calls for 'health check' on WTO agreements' 5 November 2001

TELCO (2003) Funding the Poorest in the NHS: the Case for East London, London: TELCO

The Cornerhouse (2001) Trading Health Care Away? GATS, Public Services and Privatisation Briefing Paper 23

El Pais 21 January 1998, 12 December 1998, 18 November 1999, 22 December 2000

The Guardian 25 June 2002 Milburn offers Europe slice of NHS

The Guardian 17 April 2002 NHS set for huge funding rise - Michael White

The Guardian 26 April 2002 NHS Finance 2002-3: the issue explained

The Guardian 26 July 2002 'Ministers split over foundation hospitals' Simon Parker

Websites

www.gmb.co.uk

www.unison.co.uk

www.telco.org.uk

www.fadsp.es