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TIME FOR QUALITY

REVOLUTION IN HEALTH CARE

ISSUE 5 - November/December 2018



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Right to Health is a bi-monthly electronic newsletter published by Public Services International (PSI), in furtherance of the PSI Human Right to Health Global Campaign.

For more information on the campaign and to subscribe to *Right to Health*, visit our webpage: <http://www.world-psi.org/PublicHealth4All>. You can also send us stories, or make further enquiries. To contact us, Tel: +33(0)450406464; Email: baba.aye@world-psi.org. www.world-psi.org.



Time for Quality Revolution in Healthcare

A major focus of this edition is the need to go beyond the tokenism which favours profit-making for health companies of different sorts over the provision of quality health for all, presented as “universal health coverage”. A position the PSI has held for several years is that quality health for all is what we need, and this is possible only when it is publicly delivered.

The report of the Lancet Global Health Commission on High Quality Health Systems in the SDG era (HQSS), which was released in September, reinforces our point. It shows quite clearly that the universal health coverage strategy is not sufficient to improve health in low-income and middle-income countries (LMICs). Provision of good quality health care is essential for the attainment of sustained improvement in health outcomes and the full realisation of the human right to health.

The report, entitled “Time for a Quality Revolution” highlights the importance of strong health systems and the need for governments to invest in designing and building people-centred health systems that deliver safe, effective and quality care.

This perspective buttresses some of the views jointly expressed by the World Health Organization (WHO), World Bank (WB) and Organisation for Economic Cooperation and Development (OECD) earlier in July. In the document “Delivering quality health services A global imperative for universal health coverage,” the three international organisations observed that “better access to care without attention to its quality will not lead to desired population health outcomes.”

They further agreed “that high quality, safe, people-centred health care is a public good that should be secured for all citizens,” emphasising the fact that quality of care is the foundation of people-centred healthcare.

These are positions that Public Services International and its affiliates across the world have upheld over the years, in the face of reforms driven by international financial institutions that undermine the capacities of already fragile health systems. We have always advocated universal access to quality health services. PSI has also continually stressed the obvious: this is possible only as universal public healthcare.

Thoroughgoing reform must be implemented by governments to carry out a quality revolution in healthcare. On this, there is a consensus by all stakeholders in the health and social sector, including PSI. But when it is argued, as in the Bellagio Declaration on high quality

health systems, that “these reforms will not succeed without including the private health sector and other sectors,” a seeming truth acquires ominous undertones.

The question is not so much about involving the private sector, it is about how this is to be done. PSI has affiliates in the private sector which it represents. It might not be realistic to wish away some level of private sector involvement in healthcare delivery, but such involvement must take due cognisance of health as a fundamental right of all persons in truth and in deed. Consequently, it must be appreciated that health care is not a commodity, even when delivered through private providers. The marketization of health services must be curtailed, to make quality health universally accessible.

Starting from the 1980s as Private Finance Initiatives (PFI), and later through other forms of Public-Private Partnerships (PPPs), private sector involvement in public health, including through contracting out of services and staff, contributed to the crisis of quality we face today.

Pharmaceutical corporations and health insurance companies, which are giants of the private sector such as global health and social care companies, have also skimmed off billions of dollars that could have been invested into providing quality public health services, as rents – well beyond what could legitimately be considered as profits. Quite a few multinational health companies have equally been involved in tax evasion.

Besides, quality healthcare delivery by private providers is priced beyond the reach of the vast majority of the population, particularly in low-income and middle-income countries. The only way these people could have access to quality healthcare is with governments being firmly in the saddle of driving the process.

As I said at the time of the launch of the report:

“Health is a fundamental human right. The responsibility to ensure that every woman, man and child has quality health rests squarely on the shoulders of governments. It is worrisome, as the Lancet Global Health Commission observed, that we lose not less than 8 million people every year due to poor quality of care. We thus need to go beyond the dominant perspective of universal health coverage.

The challenge before governments all over the world is to put people over profit. Ordinarily this should not be a challenge, because governments are supposed to serve the people and not big business. But, the questionable influence of multinational corporations over governments and multilateral international organisations’ decision-making processes has become so pervasive in re-defining otherwise lofty goals. “Universal health coverage” for example, has not meant universal access to quality health.

Governments must invest adequately in the public health system, and promote concerted tripartite social dialogue in the sector, as agreed upon in the Working for Health: Five-Year Action Plan. They must also make sure that the private health care providers uphold quality standards in terms of service delivery and the working conditions of health workers”.

Public Services International and its affiliates will continue advocacy for universal quality public healthcare. We will work with governments, international organisations and civil society organisations to make sure the future of health is genuinely people-centred. Thus, we will lay the foundations for a healthier, better world, as envisioned in the sustainable development goals.



Rosa Pavanelli

PSI General Secretary

Quality Public Health for All: Time for Action

Last year the UN General Assembly officially established 12 December as an international day, making 12 December 2018 the first International Universal Health Coverage Day. For PSI, it provides an opportunity to reflect on the unacceptable health inequities between and within countries across the world. Considering the abundant wealth available to humankind and major advances made in healthcare delivery, this situation is indefensible.

12 December was first marked as Universal Health Coverage day several years ago by UHC 2030, a multi-stakeholder partnership. This was subsequent to the United Nations General Assembly's adoption of the resolution on global health and foreign policy (A/RES/67/81) which recommended the inclusion of universal health coverage in the discussions on the post-2015 development agenda. Attaining universal health coverage by 2030 was subsequently included as Target 3.8 of the Sustainable Development Goals, in 2015.



"The enjoyment of the highest attainable standard of health" is a fundamental human right. But half of the world's people have no access to basic health services and about 100 million people globally are pushed below the poverty line as a result of healthcare expenditure every year.

The immense majority of these are in low- and middle-income countries, with women and children bearing the brunt of poor access to health.

Over the last decade of global economic crisis, millions of poor people in high-income countries have also not been able to enjoy quality health services as a result of austerity measures, liberalisation of health services and commodification of health.

Health for all is not only desirable, it is possible. But this requires categorical political decisions by governments which challenge the dominant neoliberal model of development. The responsibility for accelerating humankind's "transition towards universal access to affordable and quality healthcare services" rests squarely on

governments as recognised in the United Nations General Assembly resolution A/RES/67/81.

In the third quarter of the twentieth century, major advances were made towards the attainment of health for all. This informed the Alma-Ata Conference's vision of "Health for All by the year 2000", forty years ago. At the heart of this tendency towards achieving universal healthcare was the generalisation of a strong, well-funded and people-centred public health system. It was cut short with the turn towards neoliberal globalisation, accompanied by funding of health and social services, privatisation and marketization.

Over the last four decades, private for-profit interests have expanded in healthcare delivery. They include multinational corporations and national conglomerates in the pharmaceutical industry, health insurance, hospital services and social care. For them, health and social care is nothing but another economic sector; and a growing, lucrative one at that, estimated at US\$5.8 trillion per year.

To set and maintain the normative context which protects business interests, multi-stakeholder partnerships are promoted, often by foundations. Whilst these foundations might not have direct ties with for-profit entities and thus could formally be said to have no conflict of interest in pushing for public-private partnerships in healthcare delivery and the international health policy process, they are essentially philanthro-capitalist mechanisms that undermine the capacity and vision needed for states' commitment to universal public health care.

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There is no doubt that all hands have to be on deck to ensure health for all becomes a reality. But, the primacy of public health-care delivery as the bedrock of universal healthcare cannot over-emphasized. This is often missing or at best accorded passing attention in the universal health coverage discourse. Whilst it is argued by proponents of universal health coverage as a multi-stakeholders project that the role of the private sector in moving towards a government-led UHC is unclear, what is clear is that businesses stand for profit maximization.

In line with the human rights-based approach to health, the mobilisation of communities and civil society to hold governments to account for realisation of the right to health is sacrosanct. Ensuring that multinational corporations pay their fair share of tax to ensure adequate domestic resource mobilisation for the provision of quality health for all is essential. Development cooperation must contribute significantly to enabling poorly-resourced countries fund public health. Health employment and decent work in the sector must also be promoted to ensure quality care delivery.

A better future with health for all underlines the SDG Target 3.8. Two years ago, PSI kicked-off its global campaign for the Right to Health, convinced that this will be achieved as universal public healthcare. PSI, its affiliates and allies will continue to campaign for universal health care, built on strong public health systems that unambiguously put people over profit, and thus actually ensure that no one is left behind. □

In the week of 15- 19 November 2018, over a thousand delegates, including grassroots health activists, civil society organisations, academic institutions, NGOs and policymakers from across the world, including a delegation from Public Services International, gathered in Savar, Dhaka, Bangladesh for the fourth People's Health Assembly (PHA-4).

Convened in the year marking the 40th anniversary of the Alma-Ata Declaration, the 4th People's Health Assembly provided a unique space to analyse global health, share experiences, mutual learning and jointly strategize for future actions towards winning Health for All. The Alma-Ata Declaration for today's world was critically discussed during several sessions.

Factoring in shared experiences and the realities from different regions of the world, making comparative analysis of Comprehensive Primary Health Care (CPHC) and other global initiatives such as the SDGs 3 and 5 aimed at tackling the health needs of the world, and considering the available statistics, the

4th Peoples Health Assembly holds in Bangladesh

by George Poe Williams

Assembly acknowledged the level of progress made over the last four decades towards the attainment of Health for All.

However, PHA-4 observed with dismay the slow pace at which these gains are made at the expense of millions who die of preventable conditions, especially in low and middle income countries, while policymakers forge selective healthcare plans under neo-liberal schemes that exacerbate inequality and do not conform to the principle of Primary Health Care - the availability of quality health care that is accessible and affordable to all.

On the contrary, it was observed that healthcare is increasingly becoming expensive and inaccessible as healthcare provision is gravitating more towards privatisation than as a public

service. The threat on Obamacare in the USA is a classic example. The intentional underfunding of public health systems in low- and middle-income countries has become a norm simply to render those systems as not workable, as a means to justify their privatisation.

Carefully analysing the statistics, participants clearly pointed out the divide between the rich and the poor and indicated how directly proportional wealth is to health. For example, around the world, under-five mortality rates dropped by 47% from 78 deaths per 1,000 live births to 41 deaths per 1,000 live births during the period 2000 to 2016.

Even so, 5.6 million children under-five died in 2016 as documented in the Global Strategy for Women's Children's and



A cross-section of participants at a workshop organised by PSI at PHA-4

Adolescents` Health (2016-2030). Regrettably, the Global Health Observatory (GHO) data reported that 46% (2.6 million) of those deaths were neonatal (occurred in the first 28 days of life i.e. 7,000 newborn deaths each day of their first week of life!) The statistics indicates children in poor communities to be more vulnerable. Worse of all, 60 countries will not meet the neonatal mortality SDG target by 2030, if there is no change in the current course of affairs.

In the same vein, maternal mortality has decreased by 37% from 2000 to 2015. However, about 303,000 maternal mortalities were recorded globally in 2015 alone. Sadly, the majority of these deaths were due to preventable conditions. It was also recorded that maternal mortality is the major cause of death of teenage girls between 15 and 19 years of age.

It is especially alarming to note that amidst all the progress made thus far, in developing countries, it is reported that only half of women have received the

healthcare they need, and family planning needs are increasing in double digits with population growth, while 225 million women who need family planning are yet to gain access.

All of the above show that something is terribly wrong with the way in which the issue of health is being handled in our world today. But more troubling still is the fact that researchers believe if we continue with the current status quo, it will take 250 years to achieve Health for All!

The world cannot wait that long to stop the preventable death of women and children in their hundreds of thousands and millions annually, especially when we already have a health care delivery model which started off forty years ago. Delegates at the assembly reasoned that if health is, indeed, a basic human right, it should be given the Alma-Ata Declaration's redress which makes it available, accessible, affordable and of quality to all.

The five-day cordial interaction of members from the global community was thought provoking,

educative, objective and demonstrated togetherness in the advocacy for Health for All. The assembly calls for the return to Comprehensive Primary Health Care as prescribed in the Alma-Ata Declaration, an end to the privatisation of health services, increased budgetary support to health care by governments, donors and other partners and the setting up of mechanisms of accountability in the health systems.

The People`s Health Movement and its allies, including PSI, recommitted themselves to the cause of a more robust advocacy for Health for All in the coming years and tasked themselves with the objective of expanding human rights-based health campaigning networks to more individuals, groups and countries.



George Poe Williams is the General Secretary of the National Health Workers' Union of Liberia (NAHWUL)



Salute to Amit Sengupta!

by *Baba Aye*

Dr Amit Sengupta, a leading figure in the global struggle for the right to health, died on 29 November in a swimming accident off the Betalbatim beach in Goa, India, at 60 years of age. For four decades, he committed his life to the struggle for a better world, a struggle which prioritised the furtherance of scientific knowledge and public health for all.

He graduated from the Maulana Azad Medical College in Delhi in the 1980s and established a general practice. This was however just for a short while. Convinced of the need for the expansion of scientific knowledge and making this accessible to the average woman and man, he left general practice to help build the Delhi Science Forum and later the All India People's Science Movement. By the early 1990s, he was involved in the Total Literacy Campaign in India, helping to teach urban and rural poor people how to read and write.

Dr Sengupta left his biggest footprints as an outstanding organiser in the global movement for health for all. The first step in this direction was taken in 2000, when he contributed to founding the People's Health Movement (PHM).

World leaders had promised "Health for All by 2000" at the International Conference on Primary Health Care held at Alma-Ata on 6-12 September 1978. With their failure to deliver on this promise, it became clear that the people had to fight to win universal health care from below. And this could only be as public health for all.

Sengupta was one of the activists who saw the need at the turn of the century to take action in this direction. They organised the First People's Health Assembly at Savar, Bangladesh where delegates adopted a People's Charter of Health. This was where the People's Health Movement was formed.

Over the next 18 years, Amit threw himself energetically into building PHM as a network that now spans 70 countries, bringing together organisations, academics and activists committed to the struggle for a better world with health for all.

He was associate global coordinator of the PHM and editor of the Global Health Watch (GHW) which was launched by PHM in 2005. GHW is the civil society's alternative to the WHO's World Health

Report, which contextualises the global state of health within the social-economic and political dynamics of the world.

Amit was also the moving spirit behind the WHO Watch which brings young health activists and academics together as volunteers during WHO governing bodies' meetings. They analyse items on the agenda of these meetings and document proceedings from a people's perspective, making them available at real time to public health activists across the world, electronically.

In the last two years, PHM has become a close ally of PSI, and Amit a very good friend, brother and comrade of ours. After discussions with him, PSI gladly made the conference hall at our head office always available for the WHO Watch workshops. We were also proud to have had him on the health panel during the 30th PSI World Congress in 2018. And, Amit Sengupta has been the only person from outside PSI to have contributed an article, at our request, for the Right to Health.

His death is a great loss to us. He will be missed not only because of his tireless drive and selfless contributions, but as well for his wittiness, simplicity and rich sense of humour. We will remember his message at the PSI World Congress that we have to fight politically, including marching on the streets to win the full realisation of universal public health care. And we will also never forget the ripples of his soft laughter.

We extend our condolences to his wife Tripta, and son, Arijit. Whilst Amit is irreplaceable, we pray they find solace in knowing his work touched lives across the globe and will continue to inspire many more, until health for all is won. □

Hundreds of people including policy-makers, academics and civil society activists gathered for the Global Conference on Primary Health Care at Astana, Kazakhstan on 25-26 October. This was to commemorate the 40th anniversary of the first International Conference on Primary Health Care, which was held in Alma-Ata, Kazakhstan.

The 6-12 September 1978 conference was a watershed, defining health as a fundamental human right in the Declaration of Alma-Ata. This opened the floodgates for advocacy for primary health-care as an anchor for guaranteeing health for all. The world, however, failed to achieve the aim of “Health for All” by the Year 2000 set by the conference.

The Astana Conference, which like the Alma-Ata Conference was convened by the World Health Organization (WHO) and UNICEF was thus seen as an opportunity to reignite commitment to the spirit of Alma-Ata, “to achieve universal health coverage and the Sustainable Development Goals”.

The Astana Declaration on Primary Health Care, which was endorsed by the WHO Member States at the beginning of the conference, appears to have captured the hopes which Alma-Ata had kindled, with its sub-title “From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals.”

The Declaration, which aims at framing the role of Primary Health Care (PHC) within national efforts to achieve Universal Health Coverage (UHC) and proposing clear actions for achieving progress, is hinged on four pillars to address “today’s challenges and seize opportunities for a healthy future.”



Astana Conference: 40 Years after Alma-Ata

These are: empowering people to take ownership of their health and healthcare; making bold political choices for health; putting public health and primary care at the centre of UHC, and aligning partner support to national policies, strategies and plans.

There were a series of side events organised as “café sessions” by civil society organisations. These included the Medicus Mundi International’s “Calling for a New Global Economic Order - the forgotten element of the Alma-Ata Declaration,” which was supported by PSI.

This session noted that the political core of the Alma-Ata Declaration can be found in its call for a New International Economic Order (NIEO). Forty years later,

this core message is missing in the commemoration of that historic moment. But, without addressing the social-economic context of healthcare delivery, achieving health for all might continue to be a tall order.

The neoliberal model of development which dominates discourse and practice today is a major obstacle to realising the right to health for the immense majority of the world’s population. Winning a new global economic order which puts people over profit is thus central to ensuring universal health care.

The Astana conference also featured audio-visual exhibitions, which included two PSI health videos.

For Decent Care Work: Time to Act

Care work, both paid and unpaid, is at the heart of humanity and our societies". From cradle to grave, as children, adults and elders, directly or indirectly, care work ensures our self-development and the reproduction of social life. More than three quarters of care givers are women and girls. And most of these provide unpaid care work in their families. This contributes significantly to the reinforcing of gender inequality.

There are currently 209 million care workers worldwide. This number is expected to rise to 475 million care jobs by 2030, because of changing family structures, increasing care dependency ratios, and changes in care needs. Increasingly ageing populations across the world, as well as an increase in women's employment outside the home, means that fewer are delivering unpaid care work at home.

However, even this increase is not likely to be enough for the provision of quality social care. In 2015, 2.1 billion people needed care in the world. By 2030, the figure is expected to rise to 2.3 billion. These will include 2 billion

children, 300 million elderly people and almost 190 million people with disabilities.

This means that women as mothers, sisters, daughters and relatives will still continue to bear the brunt of unpaid care work in their families. If the amount of labour time spent as unpaid care work were to be valued on an hourly wage basis, it would reach around US\$11 trillion, which is 9% of the global GDP.

In this context, it will be impossible to achieve the Sustainable Development Goal 5; gender equality. Inability of a significant proportion of the world population to access quality care will equally undermine the achievement of Sustainable Development Goal 3; good health and wellbeing for all.

How can we avert this looming crisis? How can we ensure universal access to quality social care and ensure that millions of women and girls who would otherwise be trapped in the thankless rhythm of unpaid care work can realise their full potential in various fields of human endeavour?

We must take collective action. Social care and care work have to be properly remunerated. The proper value of care work has to be recognised and appreciated by authorities at municipal, regional and national levels in all countries. The ever-widening gender pay gap must be bridged, and this must be done with a sense of urgency. And the conditions under which care is delivered must be humane and mindful of the dignity of care givers.

Trade union organising is central to our taking collective action. PSI affiliates in the care sector will be supported to better defend their members and expand with membership drives that bring larger numbers of care givers into the trade union movement. With increasing union power, we will be better placed to influence policy on care work and care jobs.

Affiliates in all other sectors will also be encouraged to include issues such as childcare in their collective bargaining processes. For example, crèche services should be provided by employers for nursing mothers, but in many workplaces, they are not. In such cases, trade unions should add



this very important item to their collective agreements.

That the time is now for us to take decisive action was driven home by 8,000 women in Glasgow in October. These members of two PSI affiliates (UNISON and GMB) in Scotland organised a 48-hour strike over gender-based pay discrimination in the public services. They included care workers, school staff, cleaners and caterers. And they spoke with one voice, after a 12-year tribunal battle and the repeated refusal of the Glasgow city council to act against gender-based pay discrimination.

It cannot be overemphasized that we need united action to win, in the struggle for decent care work and gender equality. Thus, PSI and its affiliates joined sisters and

brothers from other trade unions across the world for a “Global Unions strategy meeting on the care economy” on 22–23 October in Nyon, Switzerland.

The meeting, which took place just as our sisters in Glasgow were commencing their strike, was organised by the International Trade Union Confederation (ITUC) and five Global Union Federations: Public Services International (PSI), International Union of Food, Agricultural, Hotel, Restaurant, Catering, Tobacco and Allied Workers’ Associations (IUF), Education International (EI), International Domestic Workers Federation (IDWF) and UNI global union, with participation of Women in Informal Economy Globalising and Organising (WIEGO).

The meeting facilitated exchange of knowledge and experiences amongst the Global Unions and their affiliates on the challenges and opportunities for organising in the care sector. It also called for policy-makers to consider care as a common good where investment should be made to ensure quality jobs as a basis for quality social care delivery.

Working in solidarity with other trade unions and the civil society movement, PSI and its affiliates will vigorously campaign for improvement in the wages and working conditions of care workers, and the provision of quality child care as key elements of our commitment to achieving gender equality by 2030. ▣



Financing Social Protection

The international labour movement is examining the question of financing social protection on the national and international levels. PSI and other unions took part in the Global Conference on Financing Social Protection organised by the International Trade Union Confederation (ITUC) and Friedrich Ebert Stiftung (FES), on 17-18 September 2018, in Brussels.

PSI has a long-standing record of campaigning for publicly-funded universal social protection. Realising the need for concerted efforts to attain universal social protection and the importance of social protection floors, PSI was one of the founding member organisations of the Global Coalition for Social Protection Floors (GCSPF) and remains active in the coalition's Core Team, as a Global Union Federation, along with the ITUC.

Social protection floors are relevant to achieving three key Sustainable Development Goals Targets:

- SDG 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable
- SDG 3.8: Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all
- SDG 8.b: By 2020 develop and operationalize a global strategy for youth employment and implement the ILO Global Jobs Pact.

The responsibility for implementing social protection systems and social protection floors rests on governments. It is thus important to challenge perspectives which present private sector-driven means of financing social protection as value-neutral alternatives to publicly provided social protection. The September global

conference was an opportunity to engage in discussions that highlighted the adverse consequences of such "innovation."

Social protection is a human right¹, which is key to achieving sustainable development, including reducing poverty and social inequality and building a more inclusive society. Consequently, governments are bound to take decisive actions nationally and internationally, to realise universal social protection².

The "social protection is not affordable" argument is not tenable, as "there are alternatives even in the poorest countries³". These include: re-allocating public expenditures; increasing tax revenues; expanding social security coverage and contributory revenues; eliminating illicit financial flows; using fiscal and foreign exchange reserves; managing debt i.e. borrowing or restructuring existing debt, and adopting a more accommodative macroeconomic framework.

There are definitely challenges to financing social protection. However, these have to be situated within a broader perspective of the neoliberal “consensus”, with its pillars of cuts in social spending, privatisation and deregulation.

Confronting the challenges to financing social protection requires that we strive for policy influence, including an alternative approach that clearly puts people before profit in the policy process, both nationally and internationally.

Ten years into the global economic and financial crisis, austerity measures have only worsened the sorry state of vulnerability faced by most of the human population, particularly in low and middle-income countries. It is thus essential at this moment for the trade union movement and civil society to send a clear message that sustainable social protection financing is not only possible, but indeed necessary to ensure social stability and economic recovery. The voice of workers and the broader civil society movement must be loud in the development discourse and policy process in pointing out that only a rights-based approach can ensure this.

Thus, we need to be wary of “innovations in social protection financing” which are firmly rooted in the logic of privatisation, such as Social Impact Bonds. They are presented as an “evidence-based solution⁴”. And Colombia’s launch of SIBs in 2017 was heralded as “an innovative PPP” means of social protection financing⁵. This reflects the increasing expansion of SIB projects as the new face of “privatisation by stealth⁶”. But PPPs in general have “widespread shortcomings and limited benefits⁷” and should be rejected in our consideration of social protection financing.

PSI is committed to research work and policy advocacy in line with the ILO Transition from the Informal to the Formal Economy Recommendation 2015 (No. 204), particularly in the Latin

American sub-region. The example of AMUSSOL in the Dominican Republic shows that “encouraging formalisation” is necessary for consolidating gains made in expanding social protection for workers in the informal economy⁸. Related to this is the centrality of public provision of social security for achieving universal social protection.

The 2019 *World Development Report* draft frames universal social protection as a response mechanism to the increasing number of people not covered by contributory schemes, due to the changing nature of work. But the changing nature of work is not merely technical. Precarious work is becoming widespread precisely because safeguards of Labour Market Institutions have been rolled back over the last few decades. In essence, “universal social protection” as envisaged by the report, is more of a renewed form of “targeting” Social Protection benefits and “social safety nets”, on one hand, and the IFIs expansion of Social Protection to “social spending” on the other.

Further, as the International Steering Committee of the Global Labour University correctly points out, “what is proposed in the draft Report effectively amounts to shifting the entire burden of financing social protection to the nation state,” to the benefit of multinational enterprises.

The evidence abounds, as Ortiz et al (Op cit), stressed, that the major challenge confronting social protection spending is not so much a lack of resources but rather public policy choice, including those inspired by international finance institution conditionalities, and tacit support for profit over people by states. The artificial constriction of social protection financing has “been worsened by austerity and earlier labour reforms, including freezing wages or lowering minimum wages, labour market deregulation, social security privatisation and targeted social protection schemes⁹”.

PSI thus urges restraint in consideration of “innovative” ways that are not evidently situated within an anti-austerity, human rights-based logic. At the heart of social protection is the essence of our solidarity as human beings and the primacy of public financing and provision. It thus has to be hinged to other relevant areas of our work geared towards building better and more inclusive society, including tax justice and building people-centred development cooperation. □

- 1 Article 22 of the Universal Declaration of Human Rights
- 2 International Covenant on Social and Economic Rights, ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), SDG 1.3
- 3 Ortiz, I., Cummins, M. and Karunanethy, K., 2015. Fiscal space for social protection and the SDGs: Options to expand social investments in 187 countries., ESS Working Paper 48, International Labour Office, Geneva
- 4 Sharma, A., 2017. Innovations in social protection financing: Impact Bonds. <http://socialprotection.org/learn/blog/innovations-social-protection-financing-impact-bonds>
- 5 Ortiz et al, Op cit.
- 6 NUPGE, 2016. Privatization by Stealth: The Truth About Social Impact Bonds. <https://nupge.ca/sites/default/files/documents/Privatization-by-Stealth-Oct-2016.pdf>
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- 8 Ghesquière, H., 2016. Amussol: informal workers have access to social security in the Dominican Republic!, WSM Thematic Report Latin America No. 2, Wereldsolidariteit – Solidarité Mondiale.
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Eliminating workplace violence in the health sector

by Sandra Massiah

PSI participated in the 6th Violence in the Health Sector conference that was held in Toronto on 24-26 October with the theme “Advancing the Delivery of Positive Practice.” The conference provided a platform for all parties confronted with the phenomenon of violence in healthcare to develop and propose strategies for the implementation of positive practice, that would help them proactively respond to this complex problem.

Positive practice is defined here as practice sufficiently informed by capacities and technologies to minimize violence such that the central task of the healthcare service – delivering the best help to its users – can be achieved.

PSI’s involvement in this and the previous five conferences started with the preparation and 2005 publication of the joint ICN, PSI, WHO, ILO training manual “Framework Guidelines for

Addressing Workplace Violence in the Health Sector.” PSI serves on the Steering Group, working with other international organisations and Oud Consultancy. The health and social services sector is a key sector for the PSI; one third of its affiliates, organising not less than 8 million members, are in this sector. The majority of them are women.

The conference programme was designed to:

1. Advance the delivery of positive practice through understanding the causes and patterns of aggression/violence
2. Examine initiatives to reduce aggression/violence to advance the delivery of positive practice
3. Share resources aiding the advancement and the delivery of positive practice

4. Manage the impact/consequences of aggression/violence

Sandra Massiah, sub-regional secretary for the Caribbean, represented Public Services International at the conference and presented the PSI positions and statements on:

- An ILO convention backed by a recommendation on [ending violence and harassment in the world of work](#);
- PSI’s Right to Health Campaign: [#PublicHealth4all](#)
- Fighting economic injustice and harassment of [Lady Health Workers in Pakistan](#)
- PSI’s [tax justice campaign](#)

The keynote addresses, parallel sessions, workshops, site visits and networking events provided many opportunities to share information, strategies and lessons

learned in tackling violence in the health sector – in developed as well as developing countries. The local organising committee comprising nurses' unions in Canada included many trade union allies who shared their efforts in highlighting the increasing instances of violence in the sector as well as the collective action taken to change the status quo.

“As nurses, we reject violence as ‘just part of the job’ and we will be part of the solution!” - CFNU President Linda Silas said in a discussion paper by the Canadian Federation of Nurses' Unions (CFNU).

The CFNU is Canada's national federation of nurses' unions, representing close to 200,000 frontline care providers and nursing students. “Enough is enough” issues a national Call to Action to provincial and federal governments, employers, unions and frontline nurses themselves to work together to put a stop to violence in healthcare.

In her keynote address, Christiane Wiskow, ILO Sector specialist in Health services, shared tools and resources. She highlighted the increasing attacks on health workers in emergencies and conflict situations,

“Violence is a human rights issue and particularly the deliberate targeting of health facilities has drawn attention as it is a violation of international human rights and humanitarian laws.”

The conference ended with a Special interactive plenary session and debate about the current achievements and future required initiatives. PSI used the opportunity to highlight the work of affiliates and especially the updated report “Tackling Violence in

the Health Sector - A Trade Union Response.” The study, updated in 2018, integrates the latest achievements of PSI's affiliates in the health sector.

PSI urged all present to be allies with trade unions in calling on their governments and employers to support the ILO convention and recommendation on ending violence and harassment in the world of work. □

References

- [Proceedings of the 6th Violence in the Health Sector conference “Advancing the Delivery of Positive Practice”](#), Toronto, Canada 2018
- [Proceedings of previous conferences](#)
- [Framework Guidelines for Addressing Workplace Violence in the Health Sector](#) (English, French, Spanish and Russian versions available for download). The Training Manual is a complement to the Framework Guidelines. Taken together they should facilitate dissemination and effective utilisation of the Framework Guidelines. The Manual is intended for a wide range of operators in the health sector, including health personnel, members of professional associations, trade unionists, administrators, managers, trainers, decision makers and practitioners in general.

Sandra Massiah is the PSI sub-regional Secretary for the Caribbean



Healthcare in South Africa - #NoToXenophobia

Speaking at a meeting of the National Educational Health and Allied Workers Union (NEHAWU) in November, the South African Health Minister, Mr Aaron Motsoaledi said the country's health system is overburdened by foreigners. This is a dangerous playing up of the xenophobic card, to deflect attention from the major challenges facing public healthcare delivery: inadequate funding; poor governance, and sharp social inequality which reinforces health inequity.

Public Services International defends access to quality healthcare services as a fundamental human right. Human rights cannot be reduced to the citizenship status of persons. Over the years, South Africa has been a leading voice in Africa and globally, in calling for "Health for All". The statement by Mr Motsoaledi is thus a step backwards, which should be frowned at.

As noted by Shenilla Mohamed, Executive Director of Amnesty

International South Africa, Mr Mostoaledi is trying to scapegoat migrants instead of taking urgent steps to improve access to affordable and quality health care for all persons in South Africa. This is a demonstration of contempt for several international covenants the South African government has signed, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.

The South African deputy public protector, Mr Kelvin Malunga, rightly pointed out that the health minister made "a desperate statement after failing to address the systemic issues" confronting public health.

It is particularly worrisome that the minister of health made this statement at a time that the South African government is in the process of fashioning out a National

Health Insurance (NHI) scheme. The gazetted National Health Insurance Bill limits the rights of refugees and asylum seekers to: emergency health care services; services for notifiable conditions of public health concern, and; paediatric and maternal services at primary health care level. Undocumented migrants are excluded from any form of care under the Bill, reflecting the mindset expressed by Mr Motsoaledi.

PSI submitted a memorandum addressing this and other salient issues in the NHI Bill. A key marker of the realisation of the right to health is universality of access to health services. This requires the strengthening of public healthcare delivery and not discrimination against migrants, many of whom contribute significantly to the growth and development of the South African economy. □



Environmental Health and Universal Health Care in Nigeria

The health situation in Nigeria is similar to that in many other countries, where insufficient funding is allocated to environmental health and universal health care and people suffer as a consequence. **Femi Abolade**, an Environmental Health Officer and a member of the Medical and Health Workers' Union of Nigeria, denounces the situation not only in his country but across all continents.

"Health, it is said, is wealth. Governments thus have a responsibility for ensuring the soundness of mind and body of the populations they serve, for their countries to be prosperous. Poverty reigns where health outcomes

are poor. The spread of emerging infectious diseases, particularly in low- and middle- income countries, points at the need for greater concern of governments to preventative health.

From Africa to Asia and the Americas, there is still so much room for progress to be made to ensure health for all. Disease burdens remain unacceptable. Maternal and child morbidity and mortality are still too high. Poor environmental sanitation and lack of basic hygienic facilities are some of the reasons for this terrible situation.

Most governments have not given environmental health, an important aspect of preventive

healthcare, the priority it deserves. Despite verbal commitment to primary health care, more resources are used on curative care in practice. Further, the importance of environmental health as an integral element of primary health care is often not recognised.

Air, soil, water, microbes, plants, animals and humans are major components of the environment. Imbalances in the relationship of one of these with the others may have a catastrophic effect on them all. Management of the environment in such a way that there is healthy balance between its different components, contributing to the prevention of outbreaks

of disease, is what environmental health stands for.

Making the environment less hazardous for humans is at the heart of sanitation and environmental health. It is an art as well as a science. It deals with the prevention and control of disease factors in the environment, because prevention is cheaper and better than cure.

Components of environmental health include: housing sanitation, water sanitation, food hygiene and safety, health education, school health services, air pollution control, care of the dead, sanitation of markets and business premises, prevention and control of communicable diseases, and control of noise pollution.

It is without doubt that environmental health, if properly harnessed, will contribute significantly to achieving universal health care.

In Nigeria today, as in many other developing countries, a significant number of homes lack basic hygienic facilities such as toilets and potable water, exposing them to grave health risks and dangers. Solid waste is not properly managed. People (most often young girls and women) travel more than five hundred metres to get water which is often not clean enough to drink.

Young girls face significantly increased risks of sexual harassment, including rape, in homes without toilets, especially when they have to go out to ease themselves at night. Malaria remains

the highest killer of children under five in sub-Saharan Africa, due to the presence of stagnant water that encourages the breeding of mosquitos. Incidences of diarrhoea, typhoid fever, Lassa fever and Ebola virus diseases are all heightened by neglect in sanitation and hygiene.

Air pollution from industrialised areas is a major cause of climate change. It also poses a serious threat to health and can lead to cancer and other infections, leading to early death. All these show that we have neglected our commitment to environmental health. It is now time to turn the tide.

Universal access to potable water should be a major concern to governments at all levels in Nigeria. Never again should women and children need to travel far in search of safe water.

Open defaecation in and around our communities must be discouraged and stopped to prevent the continued outbreaks of preventable diseases such as cholera and diarrhoea. Governments must help ensure that there are no households where toilet facilities are lacking.

Governments must, as a matter of urgency, improve on the development of critical infrastructure, especially in rural areas. These include good roads and proper drainage to help channel waste water and prevent breeding of malaria-transmitting mosquitoes. This would also help to enable access to an improved waste management system.

In summary, we must understand that the health of one person is by extension, the health of all. The economy of a nation thrives only when its citizens are healthy. Diseases, no matter how insignificant they may seem, affect productivity, social wellbeing and collective prosperity.

We must therefore work together as individuals, groups and governments to expedite actions on promoting environmental health in order to achieve universal health care.” □



Honourable M. Anwar Husnoo, Minister of Health & Quality of Life

Collaborating for quality health in Mauritius

The Government Services Employees Association of Mauritius (GSEA) organised a Health Day on 9 August 2018 at the GSEA headquarters in collaboration with the Ministry of Health and Quality of Life. It was an awareness-raising programme, which a huge participation of members of the Association and the public.

In his speech at the opening ceremony, the Minister of Health and Quality of Life, Hon. Anwar Husnoo, stressed that eradicating or reducing non-communicable diseases needs joint action by the Ministry, development organisations, trade unions and NGOs. The collaboration with GSEA, he thus noted, is essential.

He explained the high cost to tax payers of treating patients suffering from non-communicable diseases (NCDs) such as diabetes and renal failure, and that

concerted efforts of the government, health workers and other stakeholders could contribute to lessening costs.

In his address, Brother R. Sadien, GSEA President, said that the union will mobilise the support of health workers in Mauritius for all public health initiatives aimed at reducing the burden of non-communicable diseases.

“As a trade union, GSEA is concerned with improving conditions of service of its members. We recognise that this is inseparable from efforts aimed at realising the right to health of all people resident in Mauritius. This is necessary for building a better and more inclusive society,” he said.

The United Nations High-Level Commission on Health Employment and Economic Growth report also shows that improving employment and working conditions of health and social

workers is central to ensuring better health for all as well as economic growth and development.

Apart from the discussions held during the event, the GSEA organised free health screening activities for breast cancer and cervical cancer, and blood donations. Non-communicable disease (NCD) profile tests were also done for free.

Following the positive response from those present, the GSEA plans to organise similar activities across the country and reach a wider audience with the message of intensified collaboration to make quality healthcare available to all Mauritians. □

Fighting for a People's National Health Insurance in South Africa

by Naadira Munchi

On 29-30 August 2018, the PSI Southern African Sub-regional Office hosted a Conference entitled "Towards a People's National Health Insurance". The conference was an initiative of PSI Young Workers, and brought together approximately 27 trade unions, civil society organisations and progressive academics to debate and wrestle with the National Health Insurance (NHI). The main objective of the conference was to create alliances with other CSOs that support social justice to push for a National Healthcare policy that guarantees universal access to quality healthcare.

In June 2018, the South African National Department of Health published the NHI Bill, which outlined government's intention to create a National Health Insurance Fund to act as single public purchaser and financier of health services, as well as related official bodies to administer the NHI in South Africa. The Sub-Regional Office in Southern Africa welcomed the Bill with cautious optimism and submitted comments on how the Bill in its current formulation, reproduces class divisions and discrimination rather

than providing a framework for equal access to health care for all.

In the market economy, health care has become a commodity. A recent inquiry into South Africa's health system highlighted the deep inequality between private and public provision of health services. A privileged 16% of the population who have access to medical insurance, are serviced by 70% of the country's doctors in the private sector, with an excess of bed capacity. In contrast, the public health system battles with a devastating shortage of beds, equipment, medicines and staff.

PSI General Secretary Rosa Pavanelli opened the conference and introduced PSI's Right to Health Campaign. She spoke about the importance of a progressive taxation system, and the need to end fiscal breaks or incentives for corporations in order to fund the NHI and invest in public facilities. This is particularly pertinent as the NHI Bill is accompanied by legislative Bills that undermine the principles of Universal Health Care and as well the notion of an equal and single benefit package for all.

The transitional model proposed by the government towards full implementation of the NHI also imposes medical aid schemes packages on formal sector employees, throwing a lifeline to medical aid schemes. In addition, the Medical Aid Schemes Amendment Bill aligns the schemes with the NHI. This is an example of how the private sector has used lobbying to influence government policy.

In a discussion on migrant rights, it was resolved that the NHI should return to its initial position in the White Paper, which gave migrants full access to NHI benefits packages. Under the current Bill, undocumented migrants have no rights to access even emergency care.

There is also inequality between the responses to rural and urban health needs: rural health requires urgent overhaul as mismanagement, corruption, staff shortages and lack of funding have depleted its capacity to provide effective services. The NHI Fund will only purchase health services from service providers who comply with the Office of Health Standards Compliance (OHSC).



This will foster continued health inequity as few audited public health facilities have been able to meet those standards, due to many years of being underfunded. This means that the NHI is more likely to contract services from private health care providers, entrenching inequality in the system. Unfortunately, the Bill remains silent on how services will be improved in the most marginalised areas.

PSI and its affiliates called for more accountability and transparency and the inclusion of labour and civil society representatives on the various decision-making Boards of the institutions and bodies that have been created, to ensure that the interests of the people who are to use the fund are raised from a position of experience and not assumed knowledge. This is where labour and community voices are essential.

PSI made the following recommendations on the Bill:

1. Medical Aid Schemes must be unlinked from the NHI. The NHI Fund must be a single tax-funded system, which purchases a single comprehensive package for all users of the NHI irrespective of class, race, gender, sexuality and nationality.
2. The Board of the NHI Fund must be subject to greater accountability and oversight mechanisms.
3. The Minister must immediately cease the implementation of and promotion of transitional funding arrangements.
4. There must be greater investment in Public Healthcare.
5. Health workers must obtain improved employment and working conditions.

Public Services International will continue to work with trade unions and civil society organisations to push for a public healthcare system that guarantees universal access to quality healthcare in South Africa. The PSI Southern African sub-regional office is prepared to act as a catalyst of joint campaigns and actions to push for quality and equality in health.

Naadira Munchi is the PSI Project Officer for the Southern Africa Sub-region.



India: is “Modicare” the answer?

The Indian government launched what it describes as the largest health insurance scheme in the world, in September. Prime Minister Narendra Modi said the ‘Ayushman Bharat -Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY)’ programme will provide health cover to the tune of 500,000 rupees (\$6,900) a year for the poorest 100 million families in the country.

AB-PMJAY, which has been dubbed “Modicare” by both the government and mainstream media in India, will replace previous programmes. It actually comprises two components. The Ayushman Bharat which is meant to create 150,000 health and wellness centres for the provision of Comprehensive Primary Health Care (CPHC), and the Pradhan Mantri Jan Aarogya Yojana (PMJAY) apparently designed to provide access to secondary and tertiary care for the poor and most vulnerable through a network of Empanelled Health Care Providers (EHCP).

Considering that half a billion people are meant to benefit from this scheme, it should ordinarily be a welcome development. But the devil is in the details. While the scheme is projected to cost US\$1.6bn annually, the amount set aside for the first-year budget of the scheme is just US\$300m. This is not significantly larger than the amount set aside for health insurance in previous budgets. It is barely 27% of what the government used to bail out the country’s ailing sugar industry during the year.

It is also a mere 0.01% of the Indian GDP. Grossly inadequate funding of public health has been a major handicap. While the Indian constitution guarantees free treatment for all, the government spends just over 1% of GDP on health - 70% of all healthcare in India is provided privately and paid for out of patients’ own pockets. So the rich who can afford the high charges of private hospitals access quality health services, whilst the poor are condemned to

substandard health services.

A well-funded public health system is therefore important for improving health outcomes and reducing health inequities. But Modicare is not geared in this direction. On one hand, it is obvious that it will be underfunded. On the other, the EHCPs include private providers who will be paid the market price for services provided.

The main beneficiaries of the scheme might thus turn out to be private health insurers and private health providers, and not the poor Indian people. It is also plausible to consider the scheme as an electoral gimmick, considering the timing of its launch as the country enters an electoral cycle.

Indeed, Sanjay Nirupam a leader of the opposition Congress Party said “this is going to be another scam. It will benefit only private insurance companies. The citizen of the country will realise later that it is nothing but an election gimmick.”

What is needed in India today, for the achievement of quality health for all, is strengthening the public health services and not a model of privatisation of healthcare, which is essentially what Modicare represents.

In this regard, Jan Swasthya Abhiyan (JSA) an Indian coalition of civil-society networks that forms part of the global People's Health Movement (PHM) and is an

ally of PSI lists a range of public policy innovations which are urgently needed to ensure health and health care for all the people in India, which we share. These are:

- public systems to ensure adequate supply of free medicines
- upgrading of Primary Health Centres and Community Health Centres

- community accountability of public health services
- strengthening of primary health care in rural and urban areas linked with District health systems, and
- establishment of Right to Health Care.

Unions defend aged care in Australia

by Michael Whaites

Australian PSI affiliates' campaigns in aged care are gaining momentum as the industry comes under significant and broad scrutiny.

In a report entitled *Who Cares*, the popular TV news programme '4 Corners' exposed industry-wide cases of elder abuse and neglect in aged care facilities. The programme backed the Australian Nurses and Midwives Federation's call for improved staffing.

Over the last 30 years, residential aged care in Australia has shifted from being a mixture of publicly-owned and charitable institutions, to an increasingly private, for-profit industry. And the public sector has practically disappeared in most states. Changes to the funding mechanism, which previously allocated funding specifically for staffing, coupled with decreased funding projections from the Federal Government, have seen staffing levels reduced to unsafe levels, as companies chase profits.

The night before the TV programme aired, the Federal Government announced a Royal Commission (RC) into the aged care industry in an attempt to avoid adverse political fall-out. Although RCs in Australia can compel witnesses to provide

evidence, and criminal charges can follow, recommendations made from an RC are not enforceable. The Government's announcement has been considered hasty, with the terms of reference unknown when it was made.

On the other hand, the announcement is also seen as a delaying tactic, with politicians hoping the heat will fall out of the issue before the RC is finalised in 18 months' time. This has led unions to call for action now and not await the outcome of the Aged Care RC. Brett Holmes, General Secretary of the ANMF NSW Branch, said that ratios need to be implemented into law as the first step. "We cannot wait for the conclusion of yet another Royal Commission which extends the timeframe for politicians to have to make a decision," he stressed.

The Australian Nurses and Midwives Association (ANMF) NSW Branch has been fighting to have legislated career-to-resident ratios introduced into aged care. The Federal ANMF commissioned the National Aged Care Staffing and Skills Mix Project Report 2016 that showed the care hours allocated to residents by employers are inadequate (2.84hrs per resident per day instead of the recommended 4.18).

The study made recommendations for an appropriate skill mix of careers, and minimum hours. Nursing unions are calling for the recommended hours and skill mix to be legislated.

This is a call the government, and employers in workplace agreements, have been rejecting for years. However, the recent exposés have seen progressive politicians begin to pledge their support in the lead up to the Federal Election due by May 2019.

The Health Services Union has been calling for an increase in funding, which it says should go towards staffing and improved wages. The Federal Government has cut \$2billion from projected funding on aged care, a move the HSU says has led employers to cut staffing and refuse decent wage rises. Gerard Hayes, General Secretary of the Health Services Union, says, "It is not acceptable for our workers to be told to wait until a person's incontinence pad is 70 percent wet before changing, or that they are only allowed one set of gloves per shift, or that only \$6 a day is spent on food for residents."

The two campaigns, along with the exposure of abuse and neglect, have built strong community support for improvements in aged



care, and for increased accountability by the aged care providers to ensure that any increased funding flows to resident care. This call for increased accountability has been bolstered through a Tax Justice Network Australia (TJN) report, commissioned by the ANMF Federal Office.

The report by Jason Ward, who is now the Principal Analyst for the Centre for International Corporate Tax Accountability & Research (CICTAR), exposed the tax minimisation practices of major for-profit aged care providers in Australia. Global health industry player BUPA was amongst those named.

In Australia, aged care operators receive funding from government depending on the level of care needed per resident, and they can charge additional fees for services. The providers also require residents to provide bonds. These are so high as to force families to sell the family home in order to access care. The bonds are returned to the family, minus some fees, and the company keeps any interest earned on the amount. This practice has been referred to by some as an enforced privatised death tax.

With 75% of their income coming straight from government, one would expect that the companies would be good corporate tax citizens, and for there to be

The largest company, BUPA, had almost \$7.5 billion in total income in Australia (2015-16) but paid only \$105 million in tax on a taxable income of only \$352 million.

- ***BUPA's Australian aged care business made over \$663 million in 2017 and over 70% (\$468 million) of this was from government funding.***
- ***Funding from government and resident fees increased in 2017, but BUPA paid almost \$3 million less to their employees and suppliers.***

Tax Avoidance by For-Profit Aged Care Companies: Profit Shifting on Public Funds. Proposals for Transparency on Government Spending (2018) TJN. p. 5.

transparency in their financial accounts. However, complex company structures and the use of stapled trusts have seen their tax bills drastically reduced. BUPA, given its corporate structure, has the least transparent financial practices of those named in the report.

The TJN report was received with alarm, triggering a Senate Inquiry into Financial and tax Practices of for-profit Aged Care Providers within two days of the TJN report being released, somewhat of a record in Australia. The Inquiry has revealed that BUPA is amongst many aged care providers that are being investigated by the Australian Tax Office. The recommendations from the report seek changes to Australia's tax laws, removing some of the loopholes

companies use to avoid paying their fair share of tax.

A newspaper report exposed the seven figure pay packets of for-profit aged care company CEOs. With workers earning considerably less, some being amongst the lowest paid workers in the country, the community is clearly getting the message that aged care is seen as profitable for some, but that it is at the expense of residents' and workers' rights.

The unions are clear that the providers can afford decent pay and improved staffing. Their members continue to be active in taking the message to their communities and the politicians. □

Michael Whaites is the PSI sub-regional Secretary for Oceania

From challenge to success – Organising hospitals in the Philippines

PSI has been providing solidarity to the Alliance of Filipino Workers (AFW) to build power by organising new members. PSI asked its affiliate the SEIU, the largest health sector trade union in the USA, to partner with the AFW to transform their approach to growth amongst hospital workers with positive results now emerging.

AFW represent healthcare workers in 12 private hospitals. The 12 hospitals have had AFW led collective agreements for up to 45 years and AFW has been servicing members there on a regular basis. AFW has documented examples of healthcare workers being paid starvation wages, facing violence from employers and being forced to act as unpaid personal carers and labourers for hospital management. While workers in unionised hospitals enjoy better conditions, stronger solidarity and, importantly, a voice in their workplace, AFW has not grown for several years. The Executive Committee made the decision to expand their organising capacity and resolved to unionise “green-fields” or non-unionised hospitals. But success did not come easily.

The decision to move to an organising model was made democratically, involving members and officials, passing a vote at AFW Congress. The union resolved to create a dedicated organising

fund (15% of total dues) and hire dedicated staff. They identified potential hospitals to organise and selected the Asian Hospital. The plan was to test a new procedure for obtaining “recognition” through a worker petition. Although they initially obtained over 60% support, Government officials administering the process turned a blind eye when management began pressuring workers to withdraw. The union was forced to go the more traditional route of an election. Even then, hospital management launched an aggressive wave of threats and intimidation. Ultimately, their attempt to unionise was unsuccessful as they failed to get the 50% required by law. But rather than let their disappointment stop their plans, they carefully analysed what had gone wrong and came up with a list of seven lessons learnt - a list that still stands prominently in the office.

The key lessons were:

1. We should have 75% worker support to the union before vote
2. Political Education about unions and employer responses is needed
3. Must have unions leaders in all departments
4. Precision in numbers

5. One plan, One direction
6. 100% Mapping of the target hospital
7. Registered nurses must be 50% of the leadership

One of their key findings was that nurses had not been sufficiently organised and yet are the backbone of hospitals. They recognised the need to give nurses a stronger, independent voice in the union and any hospital they covered. So the AFW created the RN Taskforce – a network within AFW that would specifically champion the rights of nurses and act as an informal branch of the union. The initial members of the RN Taskforce, drawn from the membership and governance, undertook a ‘listening tour’, going to all AFW hospitals to better understand the concerns and demands specific to nurses.

The listening tour was a success. It gave AFW a more solid base to organise nurses, identified further union leaders and delegates and also allowed nurses to raise collective concerns with management following the meetings.

Another key lesson drawn from the initial failure was that organising needs to start with a core team of union leaders and respected workers in every department of the hospital before proceeding. Using these lessons, the

AFW team targeted Providence Hospital, a hospital that included staff who had transferred from one of the unionised hospitals covered by AFW. These workers proved indispensable, being able to provide the story of hope – of what a unionised hospital could achieve – to other workers and bring together a group of like-minded colleagues to ignite the campaign and complete the mapping needed.

The earlier failure also gave the team a better understanding of the possible tactics of management to undermine the union and they used this to inoculate workers prior to the vote. One of the most hostile union busting tactics used was to sack or suspend union activists within the hospital. The union immediately brought these cases to the Department of Labour and Employment (DOLE) and were successful in having a number reinstated. The union continues to fight for justice for two of the dismissed union leaders.

Management circulated hostile disinformation about a unionised workforce, including bizarre claims that unions “discourage individuality” and loss of freedom and urged workers to vote no. But the organisers were ready and had inoculated the workers against the claims and scare tactics. Consequently, the management campaigns and attacks on union members often back-fired, serving to create outrage amongst workers and increased the frequency of conversations. The union campaign was now front and centre of most coffee break and informal conversations.

The team came up with a range of creative ways to reach nurses in the hospital. One of the most

popular was to provide 3 in 1 coffee packs with information about the vote yes campaign printed on them. Almost all the nurses drank coffee during their shifts and the packs spread around quickly.

The initial team of core organisers continued to map the hospital and identify actively interested colleagues who became information points and created conversations with other colleagues in informal settings. Eventually all staff had conversations with the expanding team and were being updated on the campaign, and invited to be active in it, on a regular basis. This was important because the suspension of some of the core team would have seriously undermined the campaign if they were the only workers able to talk about the value of unionising.

Finally, when the day of the vote arrived, the team was nervous but proud that they had run a well organised campaign and they could feel the solidarity of the staff growing, particularly across the nurses. They won the vote with 63% yes votes - well in excess of the 50% required. With a strong

team of organised delegates and members they are confident that they can quickly move to a member-driven collective bargaining process and agreement.

The success of unionising Providence Hospital strengthened the resolve of the AFW leadership to continue with the organising approach and they have already identified two further hospitals with members ready to lead a campaign. The organising drive has the potential to radically transform the lives of healthcare workers for the better as well as the quality of care offered in a country with large healthcare needs, and PSI and SEIU are continuing to support the strategy to ensure health workers enjoy the rights and collective power they are entitled to. □

* PSI's affiliates Vision (Sweden) and UNISON (UK) also contributed support towards this organising initiative.





Fiji nurse questions privatisation at World Bank's Annual Meeting in Bali

Twenty thousand Government and global financial leaders met in Bali, Indonesia, as the World Bank and the International Monetary Fund held their Annual Meeting on 12-14 October 2018.

Amongst civil society attendees was Fiji Nursing Association's National Council Executive member Mr Isimeli Radrodoro Tatukivei. Speaking at a meeting on Public Private Partnerships, Mr Tatukivei raised questions about the effectiveness of PPPs in healthcare, concerned that Fiji's Government is proposing to privatise two public hospitals.

"As nurses we have a responsibility to know what the impact of PPPs might be for our communities and the workers" said Mr Tatukivei. His inquiry comes at an important time as Fiji enters into National elections in mid November.

PPPs have received bad press in recent times with several reports showing that PPPs in healthcare are failing. Taking Back Control, a report from an inquiry in Australia, outlined failures in over nine examples of healthcare PPPs and wholesale privatisations. And a report by Eurodad, History RePPPeated provides a case study of hospital PPP failures in Sweden and Lesotho.

According to Eurodad, Lesotho's experience supports international

evidence that health related PPPs can be extremely risky and costly. The report suggest that health-care PPPs should be avoided, especially in low-income, low-capacity contexts where they can constitute a threat to the entire health system. The Taking Back Control report demonstrates that when healthcare privatisations fail it comes at great costs to the community, in both health outcomes and financially as the state is left to pick up the pieces.

It's not just the usual suspects denouncing PPPs. The International Monetary Fund's own analysis demonstrates that the benefit of privatisation is usually only an "illusion" and highlight that privatisation has left the UK in a poor fiscal position (see reports in the Independent and the Guardian for further comment). The IMF has repeatedly come out and said there is not a good business case for PPPs as they create hidden liabilities for governments.

And yet the World Bank continues to push privatisation and PPPs, making it a condition of loans and key reform targets.

"We don't know why our government has been recommended to privatise Lautoka and Ba hospitals through PPPs" said Mr Tatukivei. "We are often told the PPPs are not a form of privatisation, however the information

I have gathered from attending these meetings make it clear that PPPs are a version of privatisation. The community and health-care workers in Fiji don't know enough about what PPPs will do to healthcare. I will take this information back to Fiji to discuss with the unions, communities and relevant government ministers." □

More information:

Read full articles:

- Press Release: [Report exposes how PPPs across the world drain the public purse, and fail to deliver in the public interest](#)
- Independent: <https://www.independent.co.uk/news/business/news/britain-public-finances-worse-than-gambia-uganda-kenya-imf-report-a8577671.html>
- The Guardian: <https://www.theguardian.com/society/2018/oct/10/uk-public-finances-among-weakest-in-world-imf-says>

France: What care model do we want for the elderly?

In France, EHPADs are residential establishments for elderly dependent people, sometimes known as retirement homes. EHPADs house elderly people over the age of 60 who have lost some physical and/or mental faculties and are no longer able to live at home. There are 7,200 EHPADs and 10,000 home care services in France. They house or provide support for 1.4 million elderly people and employ more than 700,000 workers.

Unfortunately, the elderly persons sector in France faces structural problems that pose a threat to quality care provision. The CFDT Health and Social Care sector is campaigning against serious understaffing and deteriorating working conditions. A survey on staffing levels conducted in September 2017 was repeated in June 2018 and the results were just as damning. Of the 1,723 responses, 35% felt that staffing levels on the day of their response to the survey did not ensure safe and quality care or dignity for patients.

All trade unions agree that care provision for the elderly has deteriorated to an unacceptable level

and that the human and financial resources currently allocated to the sector are not enough to provide the elderly with adequate care and dignity. Recruitment problems and high turnover are exacerbating the staffing situation. The sector no longer attracts people who feel they have a vocation for this kind of work.

Staff working with elderly dependent people speak of the “lack of dignity”, “institutionalised abuse”, “staff burnout” and of staff “feeling responsible for poor quality provision”. The sector’s employers and EHPAD managers make the same kind of observations. Everybody is agreed on the urgent need to ensure more dignified housing, support and care for the elderly.

On 30 January and 15 March 2018, tens of thousands of workers from retirement homes, EHPADs, long-term care and home support throughout France came out in support of national strikes backed by the entire trade union movement. The strikes were well-supported because workers are at the end of their tether. All categories of workers have reached breaking point, and

many took to the streets to express their frustration.

CFDT Health and Social Care activists chanted slogans saying “Nous sommes une richesse” (We are valuable), stressing the unquantifiable value of care workers for quality elderly care delivery, in response to the politicians who only see health workers as a cost. Families, the elderly, managers and local councillors all joined the movement, with slogans like: “I am here because my grandfather lives at an EHPAD and I agree with your demands.”

The series of social movements that have been taking place since last summer prompted a response from the government, which proposes an increased budget allocation for the sector as part of a “grand plan to meet the challenge of growing old”. But the funds are not enough to meet the needs. The CFDT criticises the government’s tendency to make regular but very small increases in spending, while the unions deplore government announcements that “completely ignore the urgency of responding to the sector’s demands,” namely an increase in staffing levels, better pay and



career structure, improved working conditions and permanent funding for home support.

President Emmanuel Macron conceded that low staffing levels is “a real problem” and “a key issue for today and even more so for tomorrow.” The French government has committed to dealing with the mess that currently characterises care for the elderly and says it will respond to the demographic challenge posed by an ageing population.

CFDT Health and Social Care believes it is urgent to have a comprehensive understanding of the question of care for

the elderly and not just an increase in the budget. The CFDT supports the recommendations made by the Economic Social and Environmental Council (CESE)¹ in its report “Vieillir dans la dignité” (Growing Old with Dignity) published on 24 April 2018:

- Prevent, anticipate and fund the loss of autonomy;
- Adapt residential and service provision to meet needs and expectations;
- Find new ways of working together to respond to the challenge of providing comprehensive and dignified support

and immediately introduce minimum “bedside” health-care worker staffing levels at all EHPADs.

We hope that the French government will adopt a long-term strategy that provides the public with a genuine way forward. The CFDT is ready to put the necessary work in to ensure the emergence of a new model for the care of the elderly. Everyone has a right to health!

¹ CESE : <http://www.lecese.fr/travaux-publies/vieillir-dans-la-dignite>



Turkey: Health workers charged for rendering humanitarian services

Leo Hyde from Public Services International was an observer at the opening of a trial against 14 health workers, accused of supporting terrorists for trying to help civilians during the Turkish army siege of Cizre in 2016. Here's his report from the trial:

If Incilay Erdogan is stressed, she doesn't show it. In the morning, a trial which could put her behind bars for years will begin. But she spends the evening laughing with friends, drinking tea, and breaking into spontaneous dance. "When they told me the court case was here in Mardin, I couldn't have been happier. What a beautiful place to face judgement."

It's not the first time Incilay, who lives in Istanbul, has visited the region. In February 2016 she was part of a group of fourteen health professionals from across Turkey who assembled a voluntary ambulance crew in Mardin. Their goal was to reach the Kurdish-majority town of Cizre, 100 kms to the east.

At the time, Cizre was facing one of the harshest curfews in modern history, imposed by the Turkish army to root out militants of the Kurdish Workers Party (PKK). With hundreds of civilians trapped in the city without access to healthcare or basic supplies, the Trade Union of Employees in Public Health and Social Services (SES) and the Turkish Medical Association (TTB) put out a call for volunteer medics.

"When I heard the phone calls from people trapped in basements, asking us if it was safe to drink their own piss, I knew it was my medical duty to respond," says Sadik Mulamahmutoğlu who joined Incilay on the volunteer team. Apart from their work as doctors, Sadik and Incilay help run a jazz-bar in Istanbul's Taksim neighbourhood. Still, they put all their activities aside to help the people of Cizre.

Just a few years ago a peace deal between the PKK and the Turkish government looked increasingly possible. Erdoğan needed Kurdish

votes to secure power and many Kurdish militants were focusing their attention on the Rojava project, south of the border. However, Rojava's growing strength combined with a changing electoral situation delivered Erdoğan the hand he needed to abandon talks and begin a military operation to stamp out the PKK.

Cizre was one of many villages across the region where young Kurdish activists dug in, building barricades in the streets and refusing government orders to surrender. The response was swift and brutal. A blanket curfew was imposed while heavy military and long-range snipers took positions on the hills surrounding the village. By the end of the 79 day curfew, many parts of the town lay in ruins. "Cizre was a lesson – not just for Kurds but also for those who took part in the Taksim square protests and anyone opposed to the Erdoğan regime," Incilay says. "If you resist, we can and will crush you – that's what the government is telling us."

South-eastern Turkey: a region oppressed

Arriving at Mardin airport the day before the trial, we're swept into a small Renault by Derya, a TTB member and biochemist at the local hospital. She blasts Kurdish ballads from the stereo as we speed along the steep motorway to the ancient fortress city. "My father – Turkish, my mother – Kurdish. Me – confused," she laughs. Derya recently moved back to the Kurdish region to reconnect with her roots after years living in Ankara.

We squeeze into a small Mardin restaurant where the accused workers, union leaders, and NGO representatives have assembled. Sweating over the stove is Mustafa Benli, a former tax officer who lost his job in the purge of public workers launched by Erdoğan after the failed coup in 2015. "We make a point of eating here to support our dismissed comrade," Derya tells us.

Salih, our interpreter, chimes in: "I was also recently fired from my job as Kurdish Professor at the University here.... but at least now I have time to translate books into Kurdish– I just finished translating Orwell's 1984. Now this is a book our people need."

Over lunch, the workers discuss the difficulty of developing a legal strategy for a politically motivated case. The government's claims rest on the fact that, because the requests for health assistance came from the PKK, the volunteer ambulance journey to the region represents a form of participation in a terrorist organisation. However, the health workers announced their plans publicly – and advised the Ministry of Health and the Interior Ministry before their arrival. Despite this, once in Mardin they were detained by police and refused entry to Cizre. They never managed to help the dying civilians who the government says were terrorists.

Serdar Kuni, a medic from Cizre, tears up as he remembers living

through the 79-day curfew. "They would shoot at anything that moved: men, women and children alike. Helicopters, heavy artillery, a full-scale siege. Many of Cizre's health workers perished. The army even converted part of our hospital into a base."

The full scale of loss may never be known. Despite calls from the United Nations for an international investigation, the government consistently restricts foreigners and NGOs from entering the area. Malzumder, a Turkish human rights group which managed to collect some testimonies after the end of the curfew, believes the number of deaths is in the hundreds.

Most casualties occurred in the city's basements. Witnesses claim the army stood by, blocking the entrances as one building with seventy people inside went up in flames. "Their charred remains were removed along with the rest of the rubble and dumped into the Tigris river. Many families received little more than a few burnt bones to bury," Kuni tells us.

Medical ethics on trial

A golden bust of Atatürk, the founder of modern Turkey, sits perched above the courtroom, surveying the scene as the defendants filter in. The judge, a stoic, business-like man in his mid-thirties gently raises his hand for silence. Incilay is the first to take the stand. "Doctors like us have been responding to calls for help since the time of Hippocrates. On trial here today is the very principle of medical ethics," she tells the room.

One by one the workers testify as the judge sits attentive yet poker faced. At the end of proceedings, he announces the trial adjourned and the workers free on bail until December 26. The date of the next hearing is important. On November 13th, the European Court of Human Rights (ECHR) began its hearing of a case brought by survivors of the Cizre curfew.

Many of the accused doctors gave evidence for the case and believe a ruling against the government will strengthen their hand in their own trial.

Incilay seems relieved. "In other cases I've had judges literally snoring while I spoke. At the very least he seemed to be listening!"

The health workers debrief at the SES Union's office in Mardin. The walls of the office are covered with smiling photos of now deceased union activists. One poster displays the faces of over 100 comrades murdered in the 2015 bombing of a union rally in Ankara.

SES Co-President Gönül Erden reads out letters of solidarity from other unions and workers across the world. "We are not alone. The government is under huge economic and diplomatic pressure right now and our international partners will be leveraging this power to lobby for all of these charges to be dropped," she tells the crowd of assembled supporters.

Later, back in Istanbul, we perch on chairs haphazardly arranged in front of Incilay's bar. A stream of musicians, activists, doctors, filmmakers and unionists swarm her with hugs and "welcome homes." She sips on Budweiser, laughing with friends late into the night. As we get up to leave, I ask how she remains so relentlessly positive. In one swift motion she finishes her bottle, throws her bag across her shoulder and cracks a crooked smile. "For us, as long as you believe resistance is possible, you know that hope is possible. The struggle doesn't stop with me, or this case, or with Cizre. The struggle continues."





Dismissed care workers reinstated in Germany

Carmen Laue and Heike Schmidt were reinstated as employees of the social care company Celenus, by a ruling of the Labour Court in Nordhausen in central Germany, on 17 October, 2018. The two union activists are members of Ver.di, a leading affiliate of PSI and the European Public Service Unions (EPSU).

They had been sacked earlier in April by the management of Celenus, for distributing leaflets as part of a long-running, and continuing campaign for better pay. Celenus, which is a subsidiary of the Orpea social care multinational company, has been making increasing profits without

much improvement in the terms and conditions of its employees.

The victory of Carmen and Heike was not just judicial. It is a testament to the power of workers' solidarity. Workers across countries in Europe where Orpea operates organised series of actions in support of the campaign for the reinstatement of the two Ver.di activists. These included France, Austria, Belgium, Italy and Spain.

An injury to one, as the old trade union saying goes, is an injury to all. This victory will inspire continued solidarity in our struggle in defence of labour and trade union rights. Such solidarity will

become increasingly necessary in the coming period.

The expansion of global health companies has been matched with disdain by these multinational corporations for workers' welfare. Meanwhile, now more than ever, there is a pressing need for promoting decent work and social dialogue in the health and social sector, for the Sustainable Development Goal Target 3.8 to be achieved and health for all enthroned.

PSI, EPSU and our affiliates will continue to fight for the rights and promote the interests of our members. The workers united cannot be defeated. □



PSI warns: transnational companies are bad for your health!

Transnational companies (TNCs) have increased their investments in Brazil's health sector. They have made a big adverse impact, causing deterioration in working conditions and a fall in the quality of services.

TNCs borrow from international financial institutions, supposedly for development purposes. However, the reality is different. They acquire philanthropic and public service organisations and proclaim their commitment to technological innovation, job creation and improved service access and quality. However, they fail to live up to these promises and avoid dealing with the trade unions.

By accessing loans classified as "investments for development", these companies are required to comply with labour legislation and engage in collective bargaining with trade unions. However, there is a lack of accountability because national authorities and

international financial institutions do not monitor compliance with these obligations.

The situation has become more problematic because of the parliamentary, legal and media coup that recently ushered in a new era of neoliberal promotion of private foreign investment, and labour reforms that cut workers' rights and create doubt and uncertainty. The result has been a stream of legal disputes over labour law, especially in the health sector, on issues such as length of working day – increased to a maximum of 12 hours with 36 hours rest – (for which it is uncertain if collective agreements are valid or not), massive reductions in staffing levels, unfair dismissals for minor reasons, failure to pay bonuses for hazardous work (as required by Brazilian legislation on the health sector), etc.

In this context, training, trade union campaigns and action by workers are all crucial for bringing

pressure to bear on companies and raising public awareness about the threat posed by projects funded with these loans and their impact on labour, society and the environment.

In order to make progress in this struggle, we are monitoring information and using new specialised partners, such as the Centro de Monitoramento de Empresas e Direitos Humanos and the International Accountability Project (IAP) to help us scrutinise these loans and to use collective bargaining or complaints to international organisations (ILO, Inter-American Court, OECD, IDB, IFT) to promote more appropriate lending.

Health cannot be treated as a mere commodity to be exploited. Health is a public good and not a product. Onwards with the struggle!



Health care staffing levels: an election issue in Quebec!

For the last few years, the 75,000 members of the Quebec health care workers' union, the FIQ, have been campaigning for the government to allow them to provide quality and humane health care. A lot of problems can be avoided by having stable well-staffed work teams.

Safe staffing levels have been successfully introduced elsewhere in the world, notably in California and Australia, benefitting both patients and health care workers. More time spent with patients and quality care provision mean fewer falls, infections and accidents, etc. It has been demonstrated that safe staffing levels save lives.

The FIQ has long helped its members to denounce inadequate working conditions. For example, it has provided training on advocacy, published a “black book” on

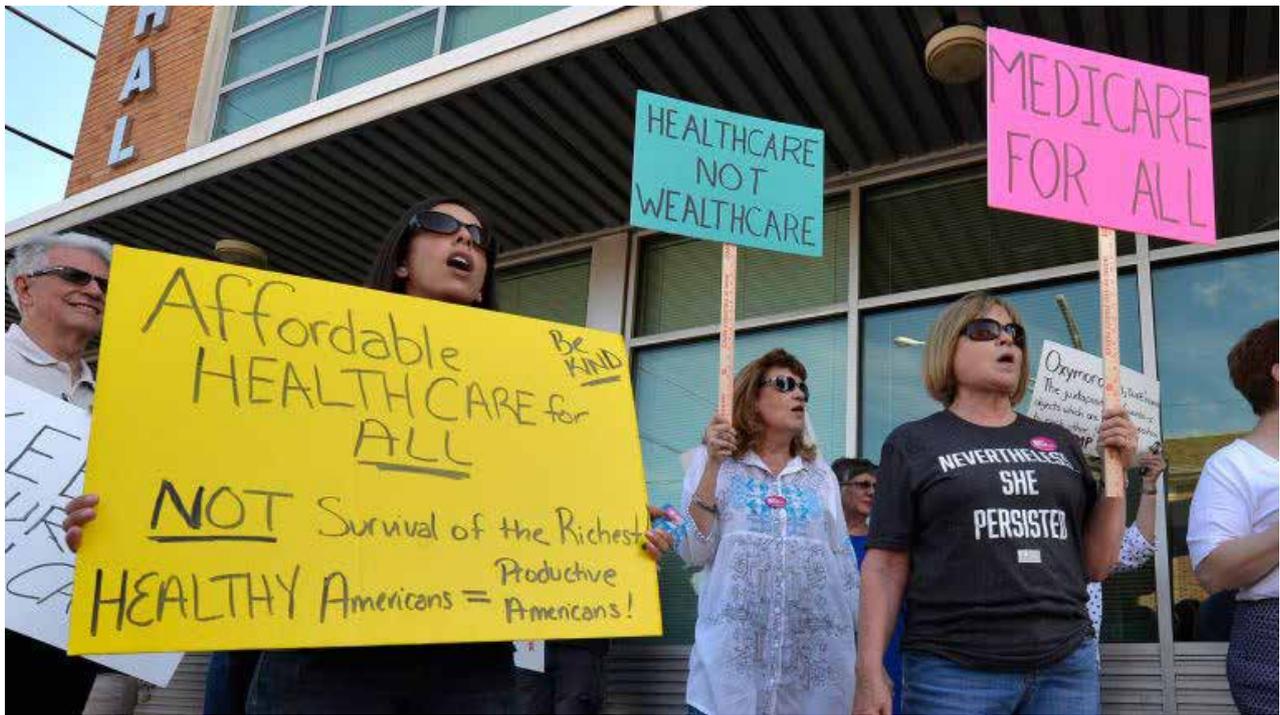
health care safety and developed an online tool for use in highlighting poor working conditions. In January 2018, a young nurse working in long-term care questioned the health minister on social media.

Visibly distressed, she complained about the excessive number of patients she was expected to care for – 70 patients per night – and the effect this had on her work. This triggered a wave of complaints about working conditions in the health care sector in Quebec. The FIQ seized the opportunity and launched a media offensive to raise awareness among the public and decision-makers about excessive workloads and the impact on health care.

The staffing levels recommended by the FIQ set minimum numbers of health care workers per

number of patients with similar health problems. This minimum is then adjusted in accordance with patient needs. Following FIQ's campaign, there have been no fewer than 13 initiatives to determine and introduce safe staffing levels in medicine, surgery and long-term health care residential centres.

Four other projects will be launched soon (emergency services, home care, a private institution, inhalation treatment). These initiatives have a national and local structure based on local joint committees. They are the first step towards the introduction of safe staffing levels throughout Quebec. □



Americans want better healthcare for all

Healthcare is the most important issue of concern to Americans today. In an exit poll conducted by the Cable News Network (CNN) during the mid-term elections, 41% of respondents voted for healthcare as the "most important issue facing the country". Immigration, economy and gun policy received 23%, 21% and 11% of the poll respectively.

This was six weeks after Mr Ban Ki-Moon, immediate past Secretary General of the United Nations denounced the United States healthcare system as politically and morally wrong. He went a step further to call for a publicly financed healthcare system as a fundamental human right in the country.

The United States' health system is the most expensive in the world. Expenditure costs over \$10,348 per capita. At \$3.2 trillion per annum, this accounts for 17.8% of the country's gross domestic product (GDP). But it is also probably the most inefficient amongst high-income countries.

At far less cost, the publicly funded British National Health Service (NHS) for example, provides free quality healthcare for all at the point of delivery. Meanwhile, despite the vast amount of monies sunken into the system in the US, almost 30 million people are not covered by health insurance, leaving them vulnerable to catastrophic health expenditure. These include an additional 4 million people who have lost their health coverage since President Trump was elected.

Vested private interests are the primary beneficiaries of this health system which perpetuates health inequity. These are big pharmaceutical corporations, health insurance companies and chains of health clinics. Their profit comes first before the good health and well-being of American people.

Americans are sending home a clear message to policy-makers, now: enough is enough. Realisation of the right to health is not negotiable. People's health

must be placed over profit for a handful of the super-rich who own the health corporations and determine the pace of service delivery. Universal public healthcare is not only possible but necessary to ensure a fairer and more just USA.

PSI affiliates continue to lend their voices to the need for overhauling the health system in the interest of the American people. They are part of the movement spreading across the Fifty US states demanding qualitative health for all, as a fundamental human right.

This demand is not going to go away until it is heeded. The movement will not abate until the right thing is done. The American people want better health for all. United, as trade unions, civic organisations, community-based associations and the electorate, we will win.

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