



RIGHT TO HEALTH

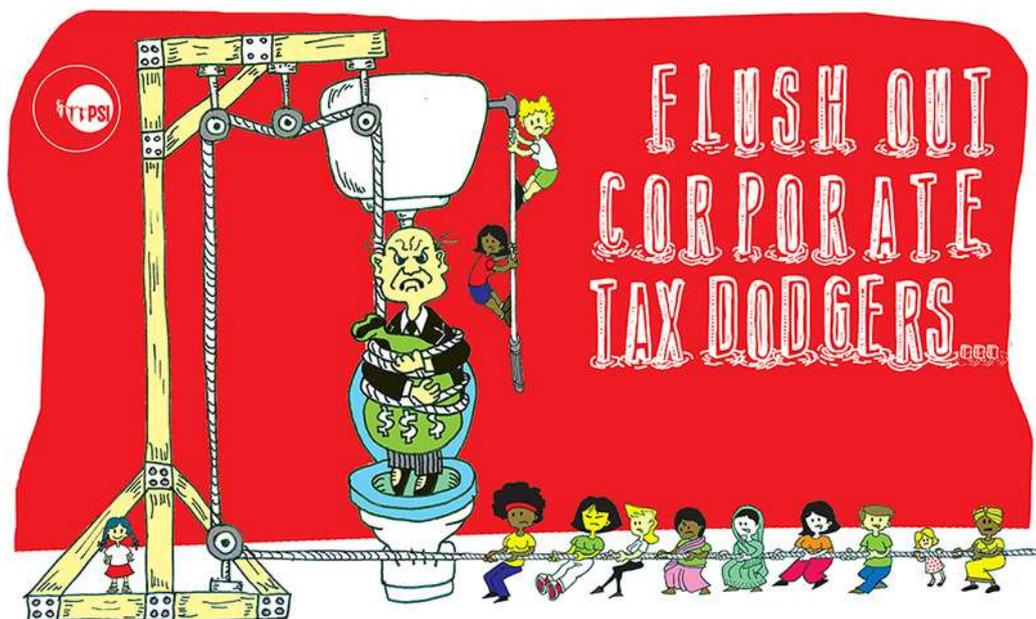
#PublicHealth4All

Issue 1, March/April 2017

Public Services International

It's time to unite and fight for Health for All

"The enjoyment of the highest attainable standard of health," was declared a human right, back in 1948, when the World Health Organization was established to help implement it. This principle is reflected in the constitutions of many countries. Significant improvements were made after this declaration, particularly in industrialised countries, but despite several inter-governmental covenants on universal health coverage, we remain very far from ensuring the human right to health for all.



...to fund public water and sanitation

More than 1 billion people live in poverty and have no access to drinking water, while 2.6 billion have no access to sanitation. One thousand children die each day from waterborne diseases, which also fill half of the hospital beds in the world. Wars, internal conflicts and climate change continue to claim tens of thousands of lives, leaving millions more in utter misery. Health workers pay with their lives for being at the forefront of the fight against natural, man-made, and epidemiological disasters, often working without adequate protection or remuneration as the Ebola, Zika and MERS outbreaks have recently demonstrated. Overworked, with shortages of staff in proportion to populations, contracting work-related illnesses as hazards, health workers' sacrifices have been too heavy and are no longer acceptable.

We have seen enormous efforts of privatisation, liberalisation and cuts in the funding of health and social services, driven by an ideological construct, using the tools of 'free trade' and conditions for 'aid' and loan facilities from international financial institutions. All of them are backed with

promises that ‘markets’ can do better than states because they are supposed to be more efficient and less bureaucratic. The policy space for maintaining the modest level or improving health services was constrained in the developing world due to the structural adjustment programmes of the 1980s-1990s. However, it is now recognised that these measures have led to increasing inequalities and have worsened the quality of health services. Persisting with this policy will overturn the significant improvements in health conditions and life expectancy registered in the past decades, particularly for much of the population in developing countries.

Due to the underfunding of public health services, hundreds of millions of poor people must pay out of their pocket for health services. According to the WHO: “about 100 million people globally are pushed below the poverty line as a result of healthcare expenditure every year”. In short: a lack of basic provision of healthcare contributes to higher inequality and extreme poverty in society.

This is a clear pointer to the critical need for universal public health coverage, for health as a human right to be realisable. However, what we have seen is quite the contrary. Over the past few decades, the health and social care sector has been one of the main targets in significant restructuring, with increasing for-profit private interests’ involvement in the provision of health services, with explicit support of governments formulated as health reforms.

Such support often takes different forms of privatisation, including Public-Private Partnerships (PPPs) as well as policies that foster transnational corporations’ expansion into health services insurance delivery and pharmaceutical production. These health reforms are part of three-dimensional fiscal reforms: involving tighter systemic fiscal controls, new priorities for the allocation of governments’ resources spurred by a limited sense of growth, and improvement in the use of resources, leading to the creation of the ‘lean state’.

There are windows of opportunity for bringing back the narrative of health policy to one that places people over profit. These include the Sustainable Development Goals and the Five-Year Implementation Plan for Health Employment and Economic Growth. But for these institutional footholds to be effective, trade unions, civic organisations and our communities have to actively engage the process and unite behind an agenda for universal public health.

This is the contextual background for the PSI Human Right to Health global campaign, which was launched at the PSI Health and Social Services Task Force meeting at Geneva in December 2016. Our affiliates in different regions of the world have started taking action, moving the campaign forward. The Right to Health newsletter is our voice, bringing to you news and perspectives on the campaign and struggles around the world to realise health as a fundamental human right.

I encourage you to subscribe to the newsletter and send your stories to us. Now is the time for us to unite and fight for health for all, as a significant domain of our struggle for people over profit. And this means sharing our experiences and ideas. United and determined, we will win.



Rosa Pavanelli
PSI General Secretary

International health news

Towards a renaissance of the World Health Organization



WHO DG candidates at The Graduate Institute's debate, Geneva. Photo: PSI

The World Health Organization (WHO) is at a critical juncture in its history, and set for a new Director General (DG) to take office on 1 July 2017. The world has changed a lot since its formation in 1948, with a strong mandate to direct and coordinate international health. While there has been significant improvement in the health status of people, generally, with economic growth and technological development, this has not been sufficient to meet the goal of health for all.

In recent times, the world has become characterised by “mounting challenges with profound health implications.” Global governance has become more complex with increasing influence of big business and weakening of democratic institutions. The governance of global health has become more political, while the WHO faces increasing funding challenges.

Meanwhile there are opportunities for “health for all” to be more than a mere slogan. There is enough wealth in the world to make this possible. But this requires structural changes in countries, as well as a World Health Organization which is strong, credible and bold in advancing the cause of public healthcare for all. This is the context

within which the World Health Assembly will elect the next DG in May.

PSI has joined 27 other civil society organisations to send a message to Member States of the WHO and the world at large, on *The WHO we want and the leadership WHO needs* (see <http://g2h2.org/posts/nextdg/>), with the aim of influencing the debate, as non-state actors. Recognising the leading voice WHO has among international and multilateral actors in pushing the agenda for universal public healthcare, signatories to the statement have called for WHO to redouble its efforts in setting priorities and deciding on strategy implementation from a global public health perspective rather than being guided by individual donor interests and priorities.

The civil society statement also called for a WHO which reinvigorates Member States' protagonism and commitment to public health, including by providing sufficient non-earmarked contributions and adequately protecting the organisation from private interests.

The civil society organisations strongly believe that the new WHO DG must be a strong and recognizable leader who is a public health champion. S/he must be both a diplomat, who can focus attention on the political, economic, social and environmental determinants of health, promote health justice, diversity, democracy, and accountability, and be a capable manager who can introduce transversal initiatives and effective decision-making processes.

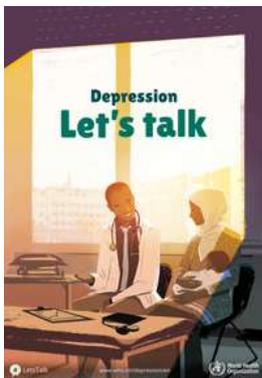
The three WHO DG candidates are: Sania Nishtar from Pakistan, David Nabarro from the United Kingdom and Tedros Adhanom Ghebreyesus from Ethiopia. PSI and several other organisations who are signatories to the civil society statement participated at the moderated discussion on political

leadership for global health organised for the candidates at The Graduate Institute, Geneva, by Chatham House, United Nations Foundation and The Rockefeller Foundation.

Each of the candidates is a brilliant and experienced medical and health practitioner and policy-maker. It was, however, disheartening that they all stopped shy of committing to take a firm stance in curbing

the growing influence of private interests, including philanthropies, on WHO. This could reflect fears of the power that such interest could have on the horse-trading involved in the election process. It also shows that the civil society movement must equally build on its advocacy and mobilisation of public opinion in the unfolding period, to win a renaissance of the WHO and the aim of health for all.

Depression: Let's Talk



World Health Day 2017 poster. Photo: WHO

Confronting Major Depressive Disorder (MDD), often simply called depression, will be the theme of this year's World Health Day on 7 April. MDD is a state of low mood in a person, characterised by two weeks or more of persistent sadness, low energy and general loss of

interest in activities that the person would normally enjoy.

This state often leads to anxiety, a sense of hopelessness and low self-esteem, affecting one's relationships with family members and friends. MDD can affect everyone. The causes of MDD are unknown. Vulnerability to this condition likely reflects a combination of nature (genetic disposition) and nurture (social and physical environment).

The pressures of work and, worse still, the precarity of life for people in flexible and poorly-remunerated employment or without any form of livelihood, predisposes millions more to falling into depression now, than at any other time in human history. The consequences of this ticking time bomb can be fatal.

Every 40 seconds, someone dies by suicide. Of those, 60% suffered from depression or other related forms of mood disorder. Suicide is preventable if we pay attention and can talk with our sisters, brothers, friends, neighbours and co-workers and urge them to get medical help if we notice signs of depression.

Post-natal depression affects one in every six women after childbirth. This can be treated with professional help. Talking and caring by family and friends is also invaluable at such moments.

Greater concern for mental health, including funding and professional training and re-training of care providers would go a long way in making professional help available for people battling with chronic cases of depression.

Further, placing people before profit, building a more humane society where the social and economic determinants of health are justly distributed are important for lifting the psychological and mental burden arising from debilitating material existence that triggers depression in so many people.

You can download posters depicting the message in different regional contexts here: <http://www.who.int/campaigns/world-health-day/2017/posters-depression/en/>

How Community Health Workers contribute to the SDGs



Prof. Anthony Mboye, Director General of Health Services, Ministry of Health, Uganda. Photo: PSI

The 1st International Symposium on Community Health Workers (CHWs) was held in Kampala, Uganda on 21-23 February 2017. The symposium was organised by the Makerere University School of Public Health Sciences and Nottingham Trent University, and had as its theme *Contribution of Community Health Workers in attainment of the Sustainable Development Goals*.

There were over 450 participants from more than 20 countries. With 140 oral and poster presentations, three keynote addresses, 13 panels and two workshops, it was a veritable platform for discussions on a broad spectrum of concern regarding the work of Community Health Workers in pursuit of the goal of universal healthcare.

PSI participated actively in the symposium, delivering a presentation titled *Towards Realising the Human Right to Health: Community Health Workers, and Health Employment in the SDGs Era*.

Putting the evolution of CHWs in perspective from the training of Chinese village farmers, who later became known as “barefoot doctors” in the 1930s, to the current situation where full-time CHWs are considered as “volunteers” in many countries, the PSI Health and Social Services Officer, Baba Aye showed that the paradigm shift to a neoliberal model of development had adverse effects on primary healthcare in

general and particularly the conditions of CHWs.

The momentum generated around the Primary Healthcare movement stirred by the 1978 *Declaration of Alma Atta* was stifled in the 1980s with privatisation, liberalisation and cuts in public funding of healthcare. There is, however, renewed commitment to bolstering the role of CHWs for the realisation of universal healthcare, with the SDGs and more recently, the Five-Year Implementation Plan for Health Employment and Economic Growth. CHWs serve as important bridges between rural and peri-urban communities and the health systems in many developing countries.

Most participants shared this view. After rounds of discussions, they adopted the *Kampala Statement*

http://www.hifa.org/sites/default/files/publications_pdf/Kampala_CHW_symposium_statement-v23.02.17.pdf) which noted that “Community Health Worker programmes can be a huge driving force to attain at least seven SDGs, namely SDGs 1 (ending poverty), 2 (ending hunger and ensuring food security), 3 (health and wellbeing), 5 (gender equality), 6 (clean water and sanitation), 10 (reduce inequalities), and 17 (partnerships for global health).”

Integration of Community Health Workers into the formal health system structure is crucial, while tailoring CHW programmes “to meet needs and priorities that are culturally and contextually appropriate.” Although it was generally agreed that CHWs should be supported with incentives provided, the statement is not clear on remuneration of CHWs who work full-time but are formally “volunteers.”

Ensuring health for all would be a mirage outside social justice and decent work for workers who provide health services. Where CHWs work normal working hours, they should earn decent wages. This was the norm in virtually all CHW programmes before the 1980s, and with a significant number of ongoing CHW programmes across

the world. The absence of regular and predictable remuneration, sufficient to meet such full-time CHW needs, jeopardises their ability to ensure their full commitment.

The symposium will be a biennial event. Decent work and the social protection of CHWs will continue to be a source of concern, which PSI will advance at this forum

In Brief

Tax the Rich and Fund Healthcare

There is consensus that health for all is critical for sustainable development. Lack of resources is often presented as the major challenge to achieving this. But the problem is not one of inadequate resources, it is a lack of political will to change the situation.

Oxfam recently showed that just eight men own the same wealth as half the world, that is 3.6 billion people (see <https://www.oxfam.org/en/pressroom/pressreleases/2017-01-16/just-8-men-own-same-wealth-half-world>).

The report confirmed that “across the world, people are being left behind,” despite the Sustainable Development Goals. Millions of people cannot live healthy lives because they are deprived of basic needs like water, food and shelter.

Multinational corporations report huge profits, while some of them pay as little as 0.005% tax on these (see <http://www.eldiario.es/desigualdadblog/Im-puestos-derechos-mujeres-6-619498084.html>). The Panama Papers further revealed just how murky the waters of fiscal injustice are. US\$3 trillion disappears annually into the black hole of tax havens. These funds could go a long way in lifting hundreds of millions of people out of poverty, providing them better lives with improved health.

PSI stands firmly for tax justice to block these leakages of revenue for development. PSI affiliates in different parts of the world will participate actively on 1-7 April in the global week of action

as an important, integral element of the quest for universal healthcare. Discussions with a broad array of researchers and practitioners, including members of PSI affiliates, will continue on the Health Information for All (HIFA) (<http://www.hifa.org/>) and CHW Central (<http://www.chwcentral.org/>) platforms.

(<http://www.globaltaxjustice.org/en/action/global-week-action-endtaxhavens>)

to #EndTaxHavens! ending on World Health Day. We also seize the opportunity to demand decisive political action in mobilising resources for public healthcare, by putting people over profit. Corporations and the obscenely rich must pay their fair share.

Future of Health

The Organisation for Economic Cooperation and Development (OECD) organised a Public Forum on the Future of Health in January. This was immediately followed by its Health Ministerial meeting on the next generation of health reforms

(<http://www.oecd.org/health/ministerial-statement-2017.pdf>). PSI participated in the meetings, issuing a joint trade union statement with the Trade Union Advisory Committee (TUAC) (see <http://www.world-psi.org/en/health-ministerial-meeting-joint-trade-union-statement>).

We appreciated the renewed commitment of the OECD to a new generation of health reforms with “people at the centre”, within the context of the Sustainable Development Goals, as declared in the ministerial statement of OECD Member States. For this narrative to have significant meaning in ensuring that no one is left behind requires greater attention in addressing the social determinants of health.

The tightening of health and social care budgets as austerity measures become the norm for governments must be reversed, curbing ineffective spending and freeing more resources for services delivery. This requires structural reforms that cut down

monopoly distortions driven by pharmaceutical corporations and for-profit insurance companies, as identified by the United Nations High-Level Commission on Health Employment and Economic Growth.

A first step towards a new generation of health reforms that puts the people at its centre would be the recognition of health as a fundamental human right. The future of health which puts people over profit is to be found in **universal public healthcare**. Without this, the policy of people-centred care in practice “works against the interests of both patients and health workers”, as the PSI briefing on the future of health (see http://www.world-psi.org/sites/default/files/documents/research/future_of_health_pcc_kb.pdf) reveals.

ILO Health Sectorial Tripartite Meeting

The ILO Tripartite Meeting on Improving Employment and Working Conditions in Health Services will be at the International Labour Office, Geneva, on 24-28 April. (see

http://www.ilo.org/sector/activities/sectoral-meetings/WCMS_508523/lang-en/index.htm). “The purpose of the meeting will be to discuss decent work strategies that effectively address health workforce shortages, as a prerequisite to enable provision of equal access to health care for all in need, with a view to adopting conclusions on future programme development and to inform policy-making on the selected topic at the international, regional and national levels.”

Rosa Pavanelli, PSI General Secretary, will lead the Workers’ group to the meeting. Coming up within the context of the Sustainable Development Goals and the Five-year Implementation Plan for Health Employment and Economic Growth to implement the United Nations High-Level Commission’s recommendations, it is a further opportunity to advance the demands for Health For All and improve the employment and working conditions of health workers.

Africa and Arab countries’ health news

Human Right to Health Campaign in Southern & French-speaking Africa



Leaders of affiliates in the southern Africa sub-region during the launch. Photo credit: DENOSA

PSI affiliates in the French-speaking Africa and Southern Africa sub-regions organised activities to launch the global Human Right to Health campaign on 7-8 February and 3 March, respectively. The Francophone Africa launch was at Lomé, with a seminar on PPPs and the Right to Health, while that for the Southern Africa sub-region took place in Johannesburg, where leaders of the unions

pledged their full support for the initiative, endorsing its framework for advocacy within southern African countries.

The seminar at Lomé brought together over 60 participants. These included: members of PSI affiliates from Togo, Burkina Faso, Mali, Senegal, Benin, Chad, Cameroon, DR Congo, Niger and Guinea Conakry; representatives of all the Togolese trade union centres; representatives of the Togolese ministry of health; academics; leading civic organisations in Togo, and members of the press.

Participants noted that there is an urgent need for African governments to increase health budgetary allocations. It is intolerable that sixteen years after the African Heads of States Abuja Declaration to set aside not less than 15% of annual budgetary provision for health and social services, only two countries

(South Africa and Rwanda) have met this target. In French-speaking Africa, budgetary allocation has been barely 5%, annually. The Lomé declaration was adopted, calling for increased funding for public health and a halt to PPPs.

In Johannesburg, PSI General Secretary Rosa Pavanelli put the campaign in perspective, when she said that, "An important part of the aims of the campaign is to assist affiliates in playing their active role as change agents across the world, mobilising and winning policy influence for the achievement of global health equity, while fulfilling their mandate as health workers in rendering a fundamental human right to citizens."

Stressing the fact that "Health is a human right," she further informed that the campaign will also engage with big businesses globally, challenging the increasing trend of commodification of health.

DENOSA 1st Deputy President, Modise Letsatsi, presented the objectives of the campaign in the region, saying health workers must be at the forefront of

campaigning for good health outcomes and that "spending on health is not an expenditure; it is an investment," as "Universal Health Coverage is impossible without health workers."

He added that health for all cannot be achieved without an accompanying struggle for gender parity. He encouraged affiliates to prioritise health concerns of women in the campaign, as they launch the campaign at the national level "taking into consideration the peculiarities and key challenges faced in realising the right to health in each country."

As brother Modise, who is a member of the PSI Global Health and Social Care Task Force, said: "We need to infuse our own specific issues in the countries so that the campaign finds resonance among communities in our different nations."

Similarly, common grounds for campaigning such as the Abuja Declaration by African Heads of States to commit at least 15% of their annual budgets to public health will be taken up later in March, during the regional launch of the campaign at the PSI Africa and Arab Countries Regional Executive Committee (AFREC) meeting.

Liberia: building a Resilient Healthcare Delivery System on fragile infrastructure?



*George Poe Williams, General Secretary NAHWAL.
Photo: PSI*

At the end of the Ebola crisis in the Mano River Basin, the Liberian government declared its commitment to building a resilient healthcare delivery system. This was the platform which Doctor Bernice Dahn advanced to win support in her bid to

become Minister of Health. But at the time, public health workers cited her role as Chief Medical Officer (CMO) of the Health Sector for nine years in the collapse of the public health system, her poor managerial skills, and lack of rapport with health workers.

One would have thought that with the terrible experience of the Ebola outbreak, the Liberian government would have begun to do things differently with an aim to revise and resuscitate what used to be an underfunded and poorly managed health system. However, as the system's management itself was never overhauled, health workers knew for certain that it would be business as usual. Today, the fears of the National Health Workers' Association of Liberia (NAHWAL) have been justified.

According to the *Parrot*, a local daily in Monrovia (vol. 5 no. 311 Friday January 20, 2017 edition), the ministry of health's 2016 annual report reveals a depressing list of failures: lack of electricity, unsanitary sources of water, and low scores on the General Service Readiness (GRS) index for diagnostics, together with insufficient essential drugs and basic equipment.

It is reported that these deficits were widespread across the country at all levels of the healthcare delivery system. In fact, several patients including medical professionals died due to lack of oxygen ventilators in Emergency Rooms (ER) and Intensive Care Units (ICU).

This surprising confirmation by the Ministry of Health validates what workers have been expressing for years through their union, NAHWAL, which led to the victimization of leaders of the union. One can only wonder why these farsighted worker's leaders, who pointed out these pitfalls long before, are being punished in the first place. Now that the government is admitting to these deficits, is there any justification for the

draconian actions taken against them for speaking to these acute shortages?

NAHWAL continues to point out unfavorable working conditions for health workers such as serving long hours on duty (in some cases, 12 hours per shift), and limited staff on the work floor. Other challenges include denial of annual leave for many public health workers, thousands are working without pay as "volunteers", lack of social security for health workers, huge salary disparities, no occupational health and safety committees at places of work, and the lack of motivational packages for healthcare workers who serve as the cornerstone for a resilient health system.

If the *Parrot's* story is anything to go by, only two things are clear:

1. Liberia's objective to build a resilient health system is in jeopardy, and
2. This means that healthcare providers will again pay the price of their lives should anything like Ebola resurface in the country.

NAHWAL calls for global attention to this fragile healthcare delivery system, with the aim of strengthening its infrastructure base.

Corruption mars service delivery at Federal Medical Centre in Nigeria



Com. Ayuba Wabba, NLC President, and other union leaders picketed the Ministry of Health in Abuja. Photo: MHWUN

Corrupt practices by management, in pursuit of PPPs, have marred service delivery at the Federal Medical Centre Owerri (FMC), in south-eastern Nigeria. The trade unions uncovered the action taken by highly placed

officials in the federal ministry of health to cover up a series of malfeasance.

This led to a series of mass actions to press for the judicious use of funds in the health facility and ensured transparent process of investigation of the allegations, including an occupation of the Federal Ministry of Health's headquarters at Abuja, on 26 January.

For almost two years, health sector unions faced stiff opposition from officials of the ministry of health, as they established a case of wanton corruption as "business as usual" in the FMC, under the Medical Director, Dr Uwakwem's, watch.

The response of the ministry of health was to deny any financial wrongdoing on the part of the medical director. Rather it stressed the workers' opposition to Dr Uwakwem's introduction of Public Private Partnerships in

the Centre, supposedly “to entrench transparency and accountability.” But what it failed to grasp is that PPPs are often related to corruption. The situation at FMC Owerri is only one more example confirming this.

Based on the whistleblowing efforts of the unions, the Economic and Financial Crimes Commission (EFCC) conducted its independent investigations. Based on its findings, it arraigned Dr Uwakwem before the High Court on 11 October 2016, having established a prima facie case of corruption against her.

It is rather strange that the ministry of health reinstated her, with brute force, using the police. The trade unions have pointed out that there is more to this than meets the eye. They earlier alleged that Dr Uwakwem appeared to have collaborated with senior officials in the ministry to successfully misappropriate monies budgeted for the Centre. The PPP she promoted, like many a PPPs, was also a conduit pipe for diversion of much-needed public resources to private ends.

When resources meant for health services are diverted into private pockets, the adverse impact on millions of the most

vulnerable people is horrendous. Resources that could otherwise have been used to employ health workers, procure drugs and provide much needed healthcare services are lost to a few greedy persons. Ironically, this self-serving development is then used to justify the introduction of PPPs, which amount to furthering corruption and subsidising private profits with public funds.

As a principle, PSI stands against corruption in all its ramifications. It is especially condemnable when it appears that institutions that should stand as safeguards against such nefarious actions are being manipulated. This action undermines the anti-corruption campaign of the federal government of Nigeria.

PSI salutes the courage of its affiliates and other trade unions in Nigeria for standing against this anomaly, and in defence of quality public services untainted by corrupt officials.

PSI has equally noted this as an added case in the long list of PPP failures, expanding the robust body of evidence that PPPs do not work, and rather further corruption.

With reports from Biobelemoye Josiah, Ojonugwa Ayegba (MHWUN) and Samson Eze (NANM)

Asia and Pacific countries' health news

PSI launches Human Right to Health campaign in the Oceania sub-region



Demonstration in Auckland. Photo: #YesWeCare coalition

On 15 February, one of the busiest roads in Auckland, New Zealand saw a united union movement launch the PSI Human Right to Health campaign in the Oceania sub-region, with the slogan “Yes We Care”. Members of PSI affiliates, other unions and civil society

allies rallied with two hundred life-sized cut-outs representing the employment gap of 20,000 healthcare workers within New Zealand alone.

According to the New Zealand unions, the 20,000 missing healthcare workers are a result of an estimated NZ\$1.85 billion-dollar hole in the national health budget. The burden of this under-spending is not just borne by the existing healthcare workers who have to work harder to fill the gaps, but by the communities and particularly the indigenous Kiwi peoples.

* One in nine Kiwis can't afford to see a doctor. That is half a million people.

* Surgery waiting times have increased by 35% to 304 days, since 2013.

* 170,000 Kiwis who need surgery are not on a waiting list.

* Mental health crisis referrals have increased by almost 300% in the past five years. People working in mental health are struggling to cope.

* \$1.85 billion is the equivalent to 7,400 missing doctors or 27,750 nurses who can't help save lives, or 111,000 missing hip operations

Glenn Barclay, one of NZPSA's National Secretaries said that a recent Consumer NZ's Cost of Living survey found healthcare costs were New Zealanders' greatest concern after housing.

"YesWeCare" as a united stand is calling on the Government to restore health funding and ensure every Kiwi gets the healthcare they need when they need it."

PSI Oceania affiliates agreed this was consistent across the region. The Fiji Nurses Association is working with the NSW Nurses and Midwives Association and the New Zealand Nurses Organisation to build the case for better pay for Fiji nurses. Lower pay

and outdated pay scales mean that Fiji nurses are looking to work overseas, making retention of the workforce difficult.

Salome Moala of the Tonga Nurses Association talked of the impact that a shortage of doctors was having on nurses who are increasingly being asked to fill the gaps. In Australia healthcare workers are fighting against the privatisation of public hospitals and disability services which will see the loss of enforceable minimum staffing (nurse to patient ratios) and the fragmentation of specialist services.

In New Zealand and Australia social services workers are seeing cost cutting impact on the services they can provide, leaving their communities more vulnerable. One worker said that the reality is that they don't have the money or the resources that they need to do their work.

This highlights the need for PSI's global Human Right to Health campaign that calls for governments everywhere to invest in a better future for our communities by investing in public healthcare and social services.

With reports from Michael Whaites, Sub-Regional Secretary Oceania

Australia's push to private healthcare is making citizens sick

By Michael Whaites



*Australia: scratch the surface, and all is not as it seems.
Photo: Caroline Taleb*

The Australian healthcare system is often projected as one of the most efficient and effective in the world, with its universal

Medicare system. Medicare is a universal insurance scheme that initially allowed free healthcare at point of access, regardless of income; funded through the country's taxation system.

A recent comparative review by The Common Wealth Fund found that Australia ranked fourth out of eleven wealthy nations (http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2_014.pdf). And the regimen of Medicare kept the cost of healthcare for government and citizens comparatively low, over many years. But scratch the surface, and not all is as it seems.

The Common Wealth Fund's review also ranked Australia ninth out of the eleven

when it came to cost related barriers to accessing healthcare. An increasing number of co-pays, and higher co-pays is starting to see healthcare affordability slip in Australia. This is occurring because successive governments have taken a neoliberal view of healthcare provision; one that pushes responsibility (costs) of healthcare onto individuals. This is in stark contrast to union values of solidarity with which we know we are stronger as a community.

As part of the state's neoliberal policies, Australians are financially "encouraged" to take out private health insurance. This sees higher premiums progressively applied at 2% per year if you commence private health insurance after the age of 30 and higher tax rates applied if you don't take out private health insurance. To encourage participation, the government then reimburses citizens through tax returns (Private Health Insurance Rebate Scheme). The rebate is now costing government nearly AUD \$6billion per year

(see <http://www.abc.net.au/news/2016-03-30/dumping-private-health-insurance-rebate-could-save-billions/7285428>).

Money that could be spent on delivering healthcare rather than feeding the profits of private health insurance companies.

In 2014 a budget proposal was introduced to increase the co-pays for Medicare, a move that many rightly saw as an attempt to undermine the universal healthcare system and a further shift towards privatisation. The proposal was defeated through repeated and sustained public pressure.

However, a growing trend by State Governments, particularly the New South Wales (NSW) State Government, to privatise the healthcare system is the latest attack on Australian's Human Right to Health.

PSI affiliate the NSW Nurses and Midwives' Association (NSWNMA) is currently fighting the privatisation of six public hospitals amidst a raft of other services

(See <http://www.nswnma.asn.au/get-involved/mapping-privatisations-in-nsw/> for a map of privatised healthcare services in NSW). The privatisation is occurring despite

the State being in economic surplus and the Government having sold off its profitable electricity transmission network to "pay for infrastructure". The government is handing over five public hospitals to be privately run and a further two are being consolidated into one privately owned and operated hospital.

The NSWNMA says that the community is rightly concerned about the privatisation of their public hospitals. "The community is beginning to understand that when you privatise you lose control, you lose the ability to hold government accountable" says Judith Kiejda, Assistant General Secretary of the NSWNMA and PSI Asia Pacific Health & Social Services Network Coordinator.

Amongst the union's concerns is that crucial minimum safe nurse to patient staffing levels will not be protected under a privatised system. In 2010, the union ran a strong campaign that mobilised members, secured public support and lobbied politicians, culminating in a nurses' strike and bed closures around the state. This action won minimum safe nursing and midwifery staffing levels for most public hospitals, forcing the government to recruit to an additional 1,400+ full time positions.

"This is now under threat with the private providers only having to maintain these minimum safe staffing provisions for two years," says Judith, explaining that the provision only exists in one private hospital at this stage. "So along with a loss of job security, lower wages and conditions for public sector nurses, the community will lose evidenced-based care standards through a gradual reduction in staffing."

But the union is campaigning strongly to prevent the privatisation going ahead. Nurses and midwives are going out into their communities, raising awareness and building support. They have been doing this via public forums, attending local markets and fetes and holding community rallies. Union members are also lobbying their local politicians, putting pressure on them to get the decision reversed.

In fact, there is growing anger against privatisation in Australia. A recent editorial in the Australian edition of the Guardian (<https://www.theguardian.com/commentisfree/2017/mar/06/from-public-good-to-profit-margin-how-privatisation-is-failing-our-communities>) reported on a joint PSI initiative *The People's Inquiry into Privatisation*. The report from the inquiry is due in April/May this year but it is already clear that the Inquiry's independent panel uncovered deeply worrisome consequences

Malaysia: protecting healthcare workers in the private sector



Malaysian nurses' workshop: Quality health for all!
Photo: MNU

Malaysia boasts of providing for its population one of the best healthcare services in the world in terms of quality and accessibility. While it continues to improve on its healthcare services to the people, the escalating cost of maintaining its quality services is proving to be a financial burden.

Public services are currently provided at a very low cost and under the government's initiatives through its economic transformation programme, accessibility to good healthcare services is further enhanced. Current healthcare facilities are being upgraded and more clinics are being built to ensure no one is deprived access to healthcare services based on inability to pay.

While healthcare workers in government health facilities are well represented by trade unions looking after the welfare of

of privatisation. For example, evidence provided to the Inquiry reveals that, to date, the privatisation of seven public hospitals has failed, requiring them to be returned to being state run.

It will be up to the unions and our civil society partners to harness the community's anger about privatisation, and our common hopes for a better world, if the trend of the privatisation of healthcare in Australia is to be reversed. There is every indication that working-class people are up to the fight.

their members, this is not so for healthcare workers in the private sector. Much organized effort must be undertaken to have this category of workers protected by unions. As of now there isn't a national union in existence to look after the interests of health workers in the private sector.

Private healthcare facilities have mushroomed in the past several years and this has seen many more workers being recruited from within and outside the country. Not much is known about these workers and there is no known initiative to get them under one umbrella union. This has caused much concern among these healthcare workers.

There must be a real concerted effort by the national labour centre to consider the formation of a union for private healthcare workers as the country's healthcare sector continues to grow, especially through the promotion of medical tourism.

Even though Malaysia has a national legislation on minimum pay for workers in the country, there is still a need for unions to play their role effectively for workers to continue to enjoy good working conditions and remuneration in providing quality public healthcare services to the population.

Report by Nor Hayati Abd Rashid President of Malaysian Nurses Union (MNU), Malaysia

In Pakistan, Community Health Workers get their issues across

By Susana Barria



Shama Gulani, General Secretary ASLHWA, addresses the public meeting in Karachi. Photo: PSI

On 30 January, the All Sindh Lady Health Workers and Employees Association, PSI and Workers' Education and Research Organisation organised a public meeting in Karachi on "Socio Economic Impacts of Delayed Wages on LHWs and their families" and "Sexual Harassment of Lady Health Workers on the Job and Field" to share the findings of two studies to be published very soon.

Researchers Moniza Inam, senior journalist from the daily *Dawn* and Sohail Javed, from the Applied Economics Research Center of the University of Karachi, presented striking findings of a research that looked at two critical aspects of LHWs' lives and work.

Lady Health Workers (LHWs) are part of the National Programme for Family Planning and Primary Healthcare, started in 1994. Under this programme, women provide family planning, pre-natal and neonatal care, immunization services and other key child and women health services in the community. It has been shown that maternal and infant mortality rates are lower in areas where LHWs are active.

Findings include that 63% of the respondents are the sole breadwinners of the family. However, they reported an average monthly

income of PKR 15,245 (137 euros), whereas their monthly expenditures stood at PKR 29,567 (265 euros). Uncertain job descriptions, long working hours and erratic traveling are other issues faced on a regular basis. Wages are generally not paid on time, and the All Sindh Lady Health Workers and Employees Association (ASLEHWA) has been instrumental in pressurizing the government in releasing salaries.

The programme is a major employer of women in the non-agricultural sector in rural areas. There are 125,000 LHW in Pakistan, out of which 22,576 are in Sindh.

Their work makes them step over the gender division of public and private space in a society with strong patriarchal traditions. Painfully, this has led to LHWs facing humiliation and verbal abuse by members of the communities they serve, domestic violence at home and sexual harassment at work by their colleagues in the health system and in the field by members of the community.

Most of these instances go unreported due to the fear of repercussions. In many instances, LHWs reported being worried that their families would ask them to leave the job or even disown them. Cases of extreme violence include orchestrated murders by religious fundamentalist groups, estimated at 22 deaths since 2012.

Recommendations included revising salary structures commensurate with qualifications, awareness campaigns among LHWs and their colleagues in the health system on laws and mechanisms relative to the protection against sexual harassment. Mechanisms should also be set up in the districts to monitor violence and sexual harassment cases by community members.

European countries' health news

Our health is not for sale!



Public sector unions at the 2016 European Day of Action demonstration. Photo: EPSU

Public sector trade unions will demonstrate actively across Europe on 7 April, World Health Day, in the second European action day against commercialisation, marketisation and privatisation of healthcare. World Health Day has been “chosen by Health users and workers, citizen collectives, trade unions and NGOs to demonstrate against Health commodification.” (see <http://www.altersummit.eu/accueil/article/april-7-european-day-of-action>)

Tens of thousands of women, men and youth demonstrated in almost a dozen cities and towns last year, heeding the call issued by the European Network Against the Privatisation and Commercialisation of Health and Social Protection. Many more are expected to take part in mass actions to press home respect for health as a fundamental human right, which can be realised only with universal public healthcare.

As affiliates of PSI in Europe, who are members of the European Federation of Public Service Unions (EPSU) rally with civic

organisations and NGOs “against the impacts of privatisation, marketisation and commercialisation of health and social care on the workforce in the sector, on the patients/users/citizens and on our societies” in different European countries. EPSU will be organising a public event in Brussels.

This will be a roundtable discussion with the Belgian unions and other organisations fighting against the marketisation and commercialisation of health and other care and for the human right to healthcare (see <http://www.epsu.org/article/european-action-day-against-commercialisation-marketisation-and-privatisation-health-care-2>). The discussion will provide evidence from a trade union perspective on the negative impact of the commodification of healthcare on the fundamental human right to health.

Discussants will also take a step further, to highlight what trade unions have done and could still do, as workers’ organisations and in conjunction with other civil society organisations, to roll back the neoliberal regimen, which is undermining gains made in promoting universal public healthcare, over several decades.

Now more than ever, trade unions and other civic organisations should argue and mobilise around the slogan “OUR HEALTH IS NOT FOR SALE”, and fight to realise the right to health, as a fundamental pivot of our wellbeing as humankind. This is a struggle for people over profit.

With reports from Mathias Muncher, EPSU Health and Social Services Policy Officer

The NHS is in crisis – and it’s a disaster of the government’s own making

by Dave Prentis, General Secretary, UNISON



UNISON members at the 4th March national demo.
Photo: UNISON

In May 2015 the Conservative government in the UK was elected after promising to properly fund the NHS. Since then, ministers have repeated – time and again – that enough money is being provided for our health service.

With nearly half a million members in healthcare, we know that is simply not true, and the cracks in the facade are beginning to show.

Recently, it was revealed that nine out of 10 hospitals faced overcrowding this winter – a sure fire sign that government underfunding is beginning to affect patient care. Waiting times are up. And there’s a widespread cash shortage forcing difficult decisions on staff around the country. Meanwhile, the number of applicants for nursing courses has plummeted following the axing of the NHS bursary, storing up further long-term

problems and exacerbating an already worrying nursing shortage.

The pressure on the NHS is greater still because social care – which has been cut in real terms by the government since 2010 – is creaking under the weight of an aging population and a shortage of resources.

That has an impact on the NHS, with more elderly patients stuck on wards because they can’t be cared for elsewhere.

And of course, there’s the pernicious and damaging pay cap that holds health workers’ wages down, damaging morale and recruitment at the same time.

The word crisis is often overused, but for our National Health Service in 2017, it’s a perfectly reasonable description. This scenario was entirely foreseeable – it is a disaster of the government’s own making. And then on top of all of these, there have been reports that changes to business rates could cost the NHS £600m, as the likes of Amazon save money. At a time when our NHS needs real help and resources, the government is delivering stealth cuts to budgets.

These are just some of the reasons why UNISON branches all over the UK participated actively in the NHS National demo on 4 March in London – opposing privatisation and cuts in our health service and fighting to save it for future generations who will need it just as much as we do.

Looming Social Welfare and Healthcare Reforms in Finland



Providing social care Photo: JHL

The health and social care sector in Finland is on the pathway to major reforms. Provision

of services by the 313 Finnish municipalities are to be transferred to 18 autonomous regions (Social and Healthcare (SOTE) areas) to be created by 2019. The reforms will also include expansion of private for-profit interests in health and social care services delivery, with adverse consequences for the population.

The reform agenda was unveiled by Prime Minister Juha Sipilä last June, in a 600-page legislation package. It reflects the aim of privatisation of public services and comprehensive participation of private service providers in public healthcare.

Supporting services like food service and cleaning will be handed over to companies owned by the SOTEs, and greater reliance on private providers will be promoted.

Publicly-funded universal health and social care has been a major pillar of the Finnish welfare state. Finns attest to the high quality of healthcare delivery, with an average of 88% of the population expressing satisfaction with the country's health system compared with the EU average of 41.3%.

This is not surprising, taking into consideration the country's health status. Life expectancy has improved remarkably over the past decades, rising to 84 years for women and 78 years for men. Infant mortality and maternal mortality are also amongst the lowest in the world. The vaccination programme is equally excellent with 99% of children under 2 years being vaccinated against whooping cough and measles.

Despite these resounding successes of universal public health, arguments have been raised for reforms since the 1990s. Far-reaching steps to effect these were envisaged in 2008, but could not be successfully implemented.

Advocates of reform appear committed to addressing social inequalities. There are long waiting lists for some specific medical procedures in public healthcare facilities, which high-income groups avoid by utilising private providers and with fast-lanes for occupational healthcare which benefits professionals.

Increasing healthcare expenses, partly due to population aging has also been an excuse presented for the reforms. This has resulted in an increase in healthcare spending in relation to the GDP from 6.9% (€14bn in fixed 2014 prices) in 2000 to 9.6% (€21bn) in 2015. But this is just slightly higher than the OECD average of 9.1%. The state's argument, however, has been that the reform is expected to save €3bn annually *by 2030*.

These are lofty aims; the reform has some useful elements. For example, the SOTEs, which build on the existing secondary health

structures of regions would help consolidate the pooling of resources together for services delivery. KELA-reimbursements (Social Insurance Institution), by the state to private providers for residents' medical expenses would be abolished, ending the subsidy of private care from public budgets.

But, there is cause for concern with the envisaged role of private providers under the new regime of the health system. They are likely to be in the driving seat, supposedly with increased "choice" between accessing care from private or public providers. Meanwhile, many of the private companies in social and health services are owned by international capital funds and some are also known for their preference for tax avoidance and tax havens. (see

http://www.jhl.fi/portal/en/jhl_info/news/?bid=6441)

What the new administrative structure for healthcare delivery would become also remains uncertain, as does the impact of the changing face of administration on the terms and conditions of employment of workers. Trade unions like the JHL and Tehy believe that this could "result in salary and benefit cuts."

What is certain is that health services delivery would now be based on the logic of competition, rather than the rights-based approach informing the entrenchment of universal public healthcare since 1929. The companies to be established by the SOTEs must compete with private healthcare providers, opening the room for commodification of healthcare.

This would be a step backwards. It is essential that the Finnish state consolidates coordination and funding of public social welfare and healthcare services. Liberalisation of the health system, just like the liberalisation of the economy in the 1980s, is likely to lead to adverse consequences for most Finns.

The wave of re-municipalisation with over 100 municipalities having to cancel outsourcing contracts with private providers due to issues of quality and price, provides

insight on the dangers that loom ahead if necessary safeguards for public health are not established.

It is also instructive that just five big multinational companies control 72% of the health and social services outsourcing market that currently amounts to €5bn. It is obvious that what would emerge in these circumstances is an oligopoly of big business in health, driven by the for-profit motive.

Ensuring efficient and secure staffing in French public services



Nurses are being strangled: Let us breathe! Photo: doubichlou14

Patients' health, safety and well-being depend primarily on the reliability and accuracy of health staffing methods. This may seem obvious and yet ...

Public Services International sounded the alarm in June 2015, and the European Trade Union Federation of Public Services (EPSU) organized a first meeting on the subject in Berlin in November 2016. This meeting enabled trade unions from different countries to exchange views on staffing issues from an international perspective. The fact remains that most health staffing systems are used primarily to cut costs.

In a context of austerity policies and budget cuts, hospital administrations are increasingly under pressure to significantly reduce staff costs. As a result of this, health professionals' ability to provide safe and reliable health services have become severely constrained. Staff-to-patient ratios are below safety thresholds, and this is exposing patients to significant risks and contributing to burnout among the staff.

Action must be taken now to ensure that the right to health for the immense majority is not sacrificed in Finland on the altar of reforms that benefit private interests. Now is the time to have a critical engagement with the reform agenda, and reject its components that bear this looming danger.

With reports from Eveliina Petälä & Heikki Jokinen (JHL) and Sari Koivuniemi (Tehy)

Experience shows that poor staffing generates a high staff turnover, absenteeism and bad working conditions. On-the-job staff try to compensate for extra work to the detriment of their breaks and meal times, or work overtime (sometimes unpaid), contributing to the general malaise of not being able to do their job properly.

Effective and safe staffing must take into account the size of the workforce, but also the combination of skills and cadres that reflect local variations in health needs. The system must be simple to implement, obligatory and must be monitored. In the face of a chronic recruitment and retention problem, Australia and New Zealand have established specific criteria for assessing workload per service. Most hospitals in Finland use a tool that gives information on staff needs per patient every 24 hours. Safe and effective staffing is an opportunity to redefine work organization to ensure decent work conditions.

Staffing:

- is closely linked to the quality of services in healthcare facilities
- lies at the heart of advocacy for better working conditions for professionals
- can play a leading role in accreditation systems.

To obtain adequate safe staffing, "count us in real time"

Inspired by a survey carried out for several years by UNISON (UK), the Federation CFDT Health-Social (France) will this year launch a survey of health staff to know about their

working conditions in a 24-hour period. Both at national and European level, we need to continue to share our experiences on staffing

in order to build a strong trade union negotiating position.

Germany moves closer to safe and effective staffing for health



"You don't look too good, shall I call the nurse?" – "I am the nurse." Image: ver.di

A step further towards safe and effective staffing for health was taken in Germany, in the first week of March. The expert committee on "nursing staff in the hospital" of the Federal Ministry of Health issued a report upholding the fact that quality of patient care is impacted by staffing levels. It further called for binding minimal nursing staff levels to ensure safe and effective care in hospitals.

This represents a validation of the campaign of Ver.di for Safe and Effective Staffing for Health (SESH). The union's Federal Councillor Sylvia Buehler welcomed this development, emphasizing that market competition cannot lead to setting such necessary standards for quality healthcare delivery (see <https://gesundheit-soziales.verdi.de/themen/mehr-personal/++co++34a3015c-033e-11e7-badc-525400940f89>). She also noted that the position now taken by the Federal Ministry was to a great extent a result of the evidence-based advocacy and numerous protest actions of Ver.di.

The union submitted a petition to government in 2015 demanding a statutory assessment of personnel needed for quality healthcare delivery. Apart from organising activities for members and government officials in Germany, it also hosted a European Federation of Public Services Unions (EPSU) workshop on Safe and Effective Staffing for Health in November 2016. At that workshop, health and social services unions from different countries in Europe as well as health ministry officials shared experiences and views on the benefits and need for legally binding minimal staffing levels.

With thoroughgoing research by experts, ver.di established a gap of 162,000 full-time positions in German hospitals, of which 70,000 are nurses. While the step by government towards addressing this gap is commendable, it is not comprehensive. Scaling up staffing levels, from the perspective of the report is to be limited to areas which the expert committee noted as being sensitive for care delivery, such as intensive care units and night shifts. But the conditions of work in hospitals in general are becoming ever more precarious with nurses and other health professionals being overworked, because of inadequate staffing levels.

Ver.di is calling for the implementation of minimal staffing levels in line with international staff-to-patient ratios for safe and effective healthcare delivery. PSI fully supports this demand as a pivotal point for upholding the right to health in Germany.

Inter-American countries' health news

The right to public health

by Sandra Massiah



Lloyquita Symmonds, BPSU, Bermuda, co-chair of the Caribbean HSS Steering Group, presents views and proposals to 2017 SUBRAC Photo: PSI

The PSI's Right to Health campaign provides an all-important platform for Caribbean affiliates to galvanise their attention and action on the myriad issues facing health workers and Caribbean peoples. Having achieved noteworthy advances in the health status of Caribbean populations over the years, providing quality health services with ever-increasing costs of drugs and care results in greater challenges. This situation is fuelling the call from development partners for more Public-Private Partnerships (PPPs) in health.

During the 2017 Sub-Regional Advisory Committee (SUBRAC) meeting in Kingston, Jamaica, PSI's affiliates representing workers in all disciplines of healthcare reviewed and discussed the outcomes of the December 2016 meeting of the Health and Social Care Task Force. Affiliates whole-heartedly support the Right to Health campaign, noting especially that health-care financing in the Caribbean is a central issue. Affiliates also recognised the central and coordinating role played by national governments as well as the Caribbean Public Health Agency (CARPHA) (<http://carpha.org/>). As a first step in its work, the sub-region's Health and Social Care Services Steering Group will foster PSI's relations with the Agency, defending the agenda for public healthcare in the Caribbean.

The Caribbean Cooperation in Health (CCH) is the regional framework through which Member States of the Caribbean Community (CARICOM) cooperate with each other, regional institutions, and development partners to improve the health and wellbeing of Caribbean peoples. The aim is to promote collective and collaborative action to solve critical health problems that are best addressed through a regional approach. In 2016, Caribbean health officials and other stakeholders agreed on priority areas for a new phase (Phase 4) of the CCH:

1. Health Systems for Universal Health Coverage
2. Safe, resilient, healthy environments to mitigate climate change
3. Health and well-being of Caribbean people throughout the life course
4. Data and evidence for decision-making and accountability
5. Partnership and resource mobilization for health

This phase is also aligned to the sustainable development goals as well as regional development plans for the achievement of the global goals, especially Goal 3 (see <https://sustainabledevelopment.un.org/sdg3>).

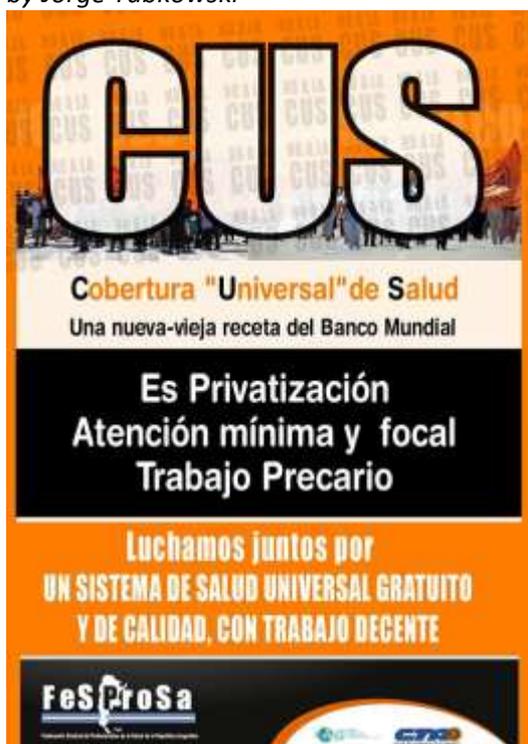
Winnifred Meeks (JALGO), the sub-region's health and social care representative on the HSSTF says,

"We all have our individual country issues and we do recognise that country action is very important. At the same time, we cannot ignore the fact that decisions made at regional level and the resulting regional policy, guide what happens in our individual countries. Therefore we plan to approach this campaign at the CARICOM level as well as at country level."

July 2 is the Caribbean Public Health Day. Caribbean PSI affiliates will formally launch their campaign on that day.

Argentina: National Health Sector Strike And “No to CUS” Campaign

by Jorge Yabkowski



The "NO to CUS" coalition composed of the ATE, CTA, FESPROSA, the General Medicine Federation and other organisations met in Buenos Aires on 9 March, only 48 hours after the national health sector strike against the wage ceiling, and in support of a wage increase in line with inflation and unrestricted negotiations. The health sector strike on 6-7 March coincided with a teachers' strike and a general strike.

What's the problem with the CUS?

Universal Health Coverage (CUS) is the policy advocated by the President Mauricio Macri-led government which rode to power with a slogan of "change." The World Health Organization

(WHO) and the World Bank have promoted this policy since 2005. The term "coverage" is synonymous internationally with insurance. The CUS is a minimum insurance policy with payments based on a basket of basic goods.

It aims to help families avoid "having to pay devastatingly high costs for health events". This is the WHO's central idea. However, this would mean that "families" have no access to a free quality healthcare system in the event of illness. We are fighting against the World Bank's insurance coverage policy and instead, call for a government-funded service in which government institutions provide healthcare that is free, of good quality, universal (for the entire population) and comprehensive (from primary care to transplants).

What do we stand for?

The system we advocate can be summarised in the slogan "everyone has a right to health and it is the state's duty to provide healthcare." With CUS, the wealthy will have private and luxury healthcare while the poor will only have access to minimum benefits. Moreover, the big financial players (for example, MAPFRE) will see health insurance as a major business opportunity. For FESPROSA, HEALTH IS A RIGHT AND NOT A COMMODITY.

That is why we are against the government's health insurance policy, even though they have now perversely added the word universal. We were against the World Bank's previous programmes – SUMAR and NACER. We now reject the deceitful slogan put forward by the World Bank and the Rockefeller Foundation: "CUS for all by 2030". We will fight for a genuinely universal, comprehensive, free, quality public health service.

Fresh Attacks on the Right to Health in Brazil



1SAMU Ambulances in Brazil

At a meeting of the Health Committee of the São Paulo Municipal Chamber held at the end of February, workers at the mobile emergency care service (SAMU) criticised the mayor, João Doria (PSDB), for his plan to transfer care to private "social organisations". The SAMU stations that are scattered across the city will be closed down and the personnel will be redeployed to Basic Health Units (UBSs) and Emergency

Care Units (UPAs) and other municipal installations.

This is in effect a step forward in the state's aim of privatising this public service that has served as a health helpline for millions of people in the mega-city. Boldened by the shocking national legislation passed in December to put caps on public funding of education and health services, São Paulo mayor, João Doria, has been vociferous in pursuing his goal to privatise SAMU as well as closing national health service (SUS) pharmacies.

The health committee meeting was an opportunity for workers and members of the communities to express their displeasure at these fresh attacks on the right to health. But, the health secretary, Wilson Pollara, who was to represent the government of São Paulo at the meeting, chose not to attend, unable to defend his indefensible reasons for the steps being taken.

One health service worker, Gláucia Fernandes dos Santos, said that Doria claims the "reform" will double the number of vehicles available. "He says the service will improve, which is not true. It will only improve when there is less overload on hospitals and the emergency services. If this does not happen, who is going to receive and care for the people transported by SAMU?" she asked.

Gláucia said that the proposal demoralises teams that are already working under great stress, with inadequate resources and infrastructure. "The federal government said it would provide resources but they never arrived. What is going on?" she asked.

Eduardo Suplicy (Workers' Party - PT) is against the transfer of management of SAMU to social organisations and is calling on people to sign the petition: "Say No to Privatisation and the Changes to SAMU in São Paulo".

In addition to SAMU workers, members of social movements, members of the Municipal Health Council, other health service employees and trade union leaders attended the meeting to hold Wilson Pollara, to account, and were disappointed by his absence.

The assistant secretary, Maria da Glória Zenha Wieliczka who came in his place did not answer any of the questions put to her. She utilised the stratagem of a lengthy financial report of the last four months, choosing to ignore the extensive list of criticisms and questions presented by people who had registered their wish to speak. She eventually spent just ten minutes to address some of the burning questions raised. After many of those present insisted, however, a new meeting was scheduled for 10 March.

The assistant secretary fielded questions on controversial programmes implemented under the João Doria (PSDB) administration, including the closure of pharmacies at the UBS; the "partnership" with pharmaceutical laboratories for the "donation" of medicines that are about to reach their use-by date in exchange for fiscal benefits; problems obtaining medical appointments under the Corujão programme; and the outsourcing of SAMU.

With support from those present at the meeting, councillors Juliana Cardoso (PT) and Samia Bonfim (Psol) reiterated the need for public hearings to discuss the proposal for commercial pharmacies to distribute medicines and the partnership for the so-called donation of medicines. The Health Committee turned down an official request from Juliana earlier in February.

The situation in Brazil now is quite dire for fundamental rights and in particular the right to health. But Brazilian affiliates of PSI will not be cowered. We will stand with the masses, and do our best to give leadership for reclaiming access to quality public health.

Safety Ratios: a trade union battle for healthcare workers and their patients



Régine Laurent, President of the FIQ. Photo: FIQ

For the healthcare workers represented by the Fédération Interprofessionnelle de la santé du Québec (FIQ), it is absolutely essential to work in the best conditions so as to provide safe, quality healthcare. As a healthcare workers' union, the FIQ has therefore decided to work with its members to promote safe professional patient healthcare ratios in Québec.

Chronic under-funding and major, hasty structural reforms have led to the visible deterioration of the public healthcare service in Quebec. Healthcare workers, then patients, are the first to suffer the consequences of the dismantling of the service. Increasingly precarious working conditions endanger the provision of healthcare to patients.

Respect for the right to health requires, at a minimum, the presence of healthcare workers in sufficient numbers. But budgetary constraints too often require managers of public health establishments to adopt unsatisfactory staffing strategies. These strategies, which include compulsory overtime, have a negative impact on healthcare. It has been shown many times that a chronic lack of staff has considerable harmful effects on patients. Studies on

nursing, for example, show that insufficient staffing increases the risk of hospital-acquired infections, falls, readmissions and pressure sores.

From this perspective, healthcare workers form part of a vital patient monitoring system. However, in the context of a chronic lack of staff, they cannot use all their expertise when taking healthcare decisions. They do not have the authority to decide on the deployment of healthcare teams to provide safe, quality healthcare.

Ratios that require a minimum allocation of healthcare staff, below which the safety of patients would be seriously compromised, would put an end to the current use of arbitrary funding considerations by managers of Quebec's public healthcare service.

In October 2016, in cooperation with the International Francophone Nursing Secretariat (SIDIEF), the FIQ held a unique international symposium on safe healthcare. It brought together female colleagues from Australia, the United States and Quebec to discuss the issue and recent developments in the field. The event concluded that the current health service is not "incurable" and can be treated.

The FIQ believes that the remedy requires trade unions to fight for social change. The introduction of safe ratios in our public healthcare service must be led not only by healthcare workers, but also by the public as a whole.

The FIQ is a trade union that represents healthcare professionals in Quebec, including the great majority of female nurses, auxiliary female nurses, respiratory therapists and clinical perfusionists working in Quebec's public healthcare establishments.

Costa Rica: Quality public healthcare system in danger

by Rodrigo López García General Secretary ANPE



BUSSCO workers demonstrating in April 2016

Since the 1990s, neoliberal policies have claimed victims in the public services sector run by the Costa Rican state. The rise of the neoliberal globalization, which is expanding with free trade, has involved big businesses aggressive pursuit of new sources of profit. This is the reason behind the waves of privatization of public services like water, education, health and others.

The systematic attack on healthcare in Costa Rica focuses on: attempts to undermine health workers' power; lower the quality of public health services as a cost-cutting measure, legitimize the questionable view that private is better and promote the outsourcing of services to private providers.

The trade unions have been able to counter some of these measures, by organising and mobilising. Three years ago, we founded the BUSSCO, which is the Costa Rican Union and Social Unity Block, from which we have developed a series of campaigns to counteract the policies directed against public services and workers delivering these.

Our campaigns have been massive on radio, television, and the internet. We have organized several days of protests. The largest of these were in April 2016 with two days of waves of public employees marching

in their tens of thousands across Costa Rica. We have also put up a series of billboards that identify those who are attacking working class people, and the public utility institutions.

The billboards have been designed to impact on politicians who attack workers, but also to publicize the privatization of the public institutions of the Costa Rican State. The impact is enormous, and it directly confronts the political classes in power.

Internal policies are maintained in the Costa Rican Social Security Institutions, where much-needed health workers are not employed and care programs are reduced, causing chaos in some of the major processes of service delivery. Health is no exception, and has suffered a gradual decline for more than two decades. But for the strong opposition of the unions, the health system would be wholly privatized.

We travel to the regions, organizing meetings to establish BUSSCO on a regional basis, and also maintain a constant lobbying in the congress, stating that we disagree with new laws against public employment, whose purpose is "to reduce labor, preparing the way for eventual privatization."

The process has been very hard, we have partially paralyzed the for-profit initiatives that cause a loss in the value of the wages of public workers, and our campaign for the defense of public services is continuous. Establishing the motto that *Health is a Human Right for All* is part of this continuum.

Our campaign sums up efforts towards winning social information. "Health as a Human Right" is essential for building a better, more just and fully inclusive social system.

