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Trade unions, civil society organisations and health reforms

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Abstract

This article provides an analysis of resistance to neoliberalism and commodification in the public healthcare sector as seen from a trade union perspective. It uses recent research on social-movement unionism and new labour internationalism to structure a series of case studies examining resistance to different dimensions of healthcare commodification in four countries. The range of alliances trade unions are making do not fit tidily into one model, but give insights into the ***movement*** *elements of trade unionism. This dimension must be strengthened, but can also be in tension with collective bargaining and other institutional processes. How to constantly reconcile these different positions is the future challenge facing trade unions.*

Public healthcare systems have become increasingly commodified in the past fifteen years, with the drivers for this commodification coming from several directions. National governments in high-income countries with aging populations are concerned about the increasing demand for healthcare services, particularly for high-technology treatments. Low taxation policies preclude the raising of more revenue for improved public healthcare services, and these have been reinforced by policies such as the European Union's Maastricht Treaty entry criteria, which set limits for public-sector spending.

National public healthcare systems have developed according to their own specific histories, and these often influence the effects of commodification and the nature of resistance to these changes. In low-income countries, the international financial institutions have imposed funding conditions that have forced government to

introduce reforms of the public healthcare sector (Verheul & Rowson, 2001; Lister, 2006). Trade treaties have contributed to this process by encouraging policies of liberalisation, which have opened up public services to global multinational service companies (Lipson, 2002).

The private sector has entered public healthcare systems through several mechanisms. As a way of preparing the public healthcare sector for competition and marketisation, one of the initial stages of reform is for public hospitals to become 'corporatised' – a process by which they have to operate according to business principles. This contributes to the commodification of healthcare, even if full privatisation does not take place (Sen, 2005; Leys, 2001). Services may be gradually contracted out to the private sector, often starting with catering, cleaning and facilities management before moving on to clinical services; and the development of public–private partnerships to build and manage new hospitals has presented many governments with an apparent solution to short-term funding, though in the long term, governments will be paying the private sector for inflexible long-term contracts (Pollock, 2004).

Thus there is a growing presence of private-sector companies operating in public healthcare systems, as well as significant changes taking place in the role of government in public healthcare systems (Lethbridge, 2005). The impact of these changes on healthcare workers and on healthcare users has been felt in a variety of ways. For healthcare workers, their socioeconomic security has been undermined by either the introduction of corporatisation to public-sector hospitals, or the contracting out of services to the private sector. Changes in wage levels and terms and conditions are the immediate results of the commodification of public healthcare, leading to increasingly precarious employment (Afford, 2003). The lack of investment in public healthcare combined with deteriorating working conditions has resulted in depleted public health services (Laurell, 2001), and it has also led to the migration of skilled health workers from many low-income countries to higher-income countries. For healthcare users, the effect has often been to limit access and worsen the quality of the services delivered (Gilson, 1995; Bloom & Lucas, 1999; Bloom & Standing, 2001; Hilary, 2001). It also creates a feeling of insecurity about the future of healthcare provision. The introduction of user fees has often had a devastating effect, restricting access to healthcare even when there are exemptions for disadvantaged groups (Gilson, 1995; Nyonator & Kutsin, 1999; Jeppsson, 2001).

The nature of healthcare has an important influence on the kinds of resistance to changes that can be seen in public healthcare services. Access to healthcare which is free at the point of access is an important factor in preventing loss of income due to illness, which contributes to the reduction of income inequalities. People use healthcare services throughout their lives, and though the nature of their relationship with healthcare is different to the relationships people have with other public utilities because other factors influence health besides access to treatment, people often have close ties with local healthcare facilities. When these facilities are threatened, people respond with strong campaigns. The relationships between healthcare users and healthcare workers may be strengthened by their campaigning together (Lethbridge, 2004).

Much research into trade union resistance to globalisation has concentrated on the manufacturing sector, and although there has been some specific research into campaigns against the privatisation of public services, models of resistance are dominated by the manufacturing perspective. Healthcare trade unions have been active in campaigns to protect public healthcare services throughout the world, and this article aims to contribute a specific sectoral analysis to resistance to neoliberalism, as seen in the experience of public healthcare services.

This study will explore four examples of resistance to healthcare commodification by trade unions alongside community organisations and social movements. A case study approach was chosen as a way of analysing the patterns of resistance. The four dimensions of commodification considered here are hospital privatisation, hospital corporatisation, a post-privatisation campaign against low pay, and a campaign for access to HIV/AIDS treatment.

The four case studies were chosen in pursuit of a global reach, with examples from El Salvador, Spain, the UK and South Africa. They also showed trade unions taking different roles within partnerships and alliances, and with different levels of involvement with community organisations, social movements and international campaigns.

- The Salvadorean case study features a trade-union-led campaign against the privatisation of hospitals in El Salvador in 2002, which built on other campaigns against the privatisation of other public services.

- The Spanish case study examines the campaign of the *Federacion para la Defensa de Salud Publica* (FADSP) against the

corporatisation of hospitals in Galicia, a region of Spain. This was chosen as an example of a campaign against one aspect of commodification, led by a broad-based campaign consisting of trade union members and other players.

- The UK case study examines an example of a trade-union–community campaign for improved wages for health workers in services that have already been contracted out. In this case, the campaign takes place in the post-privatisation period and illustrates what actions can be effective after privatisation has taken place.

- The South African case study is an examination of the alliance between the Confederation of South African Trade Unions (COSATU) and the Treatment Action Campaign (TAC), which campaigns for improved access to HIV/AIDS treatment. The TAC is the lead organisation.

Material was gathered through a review of public documents, local and national press coverage and the publications of organisations involved in the campaigns. The conceptual section develops a framework of analysis for the four case studies, and this follows below.

New models of trade unionism

Over the last two decades, trade unions have had to deal with falling membership, the rapid movement of capital, and increasingly precarious employment accompanied by a hostile environment for organised labour. The search for new strategies that will strengthen trade unions has focused on the development of community alliances and an increased international perspective. These have informed new forms of trade union organisation and activity. This paper examines some of the themes emerging from studies of the changing relationships between trade unions and civil society organisations. The discussion will start by looking at *social-movement unionism*, *new labour internationalisation* and *health activism.*

Social-movement unionism

Social-movement unionism is characterised by unions taking action on issues by effectively combining collective bargaining activities and collective action (Hyman, 1997; Moody, 1997). This

may involve campaigns for housing, social services, health, education and other basic public services. Union democracy is an important feature of social-movement unionism. Social-movement unionism is also different from *political unionism* in that rather than its being linked to a political party, it is involved in broad-based social movements. Unions fight for power and organisation in the workplace as well as reaching out to other unions (locally, nationally and globally), community organisations and other social movements (Hyman, 1997; Moody, 1997), and the issue of political party involvement is one of the more contentious elements of social-movement unionism.

The South African experience has exerted a strong influence on the conceptual development of social-movement unionism. In the 1980s, labour-movement and civil-society organisations worked together to promote the cause of democracy, bringing workplace and community struggles together. COSATU worked with the African National Congress (ANC) to mobilise for elections in the early 1990s (Hirschsohn, 2007).

Some of the problems facing trade-union–community collaboration in South Africa and elsewhere can be seen in the relationship between the Western Cape Anti-Eviction Campaign (AEU) and the South African Municipal Workers Union (SAMWU). Different membership systems and decision-making structures pose a barrier to collaborative working between AEU and SAMWU, so that although SAMWU has a commitment to working with social movements, and SAMWU members live in the same districts, Xali (2006) found that few SAMWU members were active members of the AEU.

Different attitudes to the ANC government and to the promotion of municipal authorities and services led to SAMWU's questioning the campaigning activities of AEU, which were seen as anti-government and damaging to public services. AEU supported community projects because they created low-paid jobs, but they also undercut municipal services. The provision of resources and external funding were also identified as problematic (Lier, 2005).

Greer (2006), in one of the few studies of social-movement unionism in the healthcare sector, examined the experience of the city of Hamburg over a ten-year period that covered the transformation of public hospitals into corporate institutions and their subsequent privatisation. External factors such as the loss of power of the Social Democratic Party in the municipal government forced the trade union to develop alliances with local community organisations (Greer, 2006). At the moment, there is no evidence to show that this strategy has been a success. There have

been no noticeable improvements in collective bargaining and wages, and the new private-sector owner of the hospitals has imposed a wage freeze (Greer, 2006). However, in Germany, with its long history of trade union social dialogue with management, the change to social-movement unionism is a fundamental one.

There is other evidence to show that social-movement unionism does not lead to immediate successes in challenging neoliberal policies. In the USA, the United Electrical workers (UE) worked with local community groups, but it was not enough to stop large layoffs in the workforce. And in a 2007 analysis of Moody's account of social-movement unionism, Schiavone found that although the rank and file played an important role in these alliances, Moody underplayed, in his view, the role of professional union organisers and union leadership at all levels.

Wills (2001) explores the concept of *community unionism* and the potential for trade union renewal in the UK. In order for trade unions to work with community organisations on issues of social justice, she argues that the trade union movement would have to address the issue of how to recognise difference while encompassing equality (Yuval-Davis, 1999). UK trade unions had been relatively silent on these redistribution issues, but trade unions need to identify economic issues that they can work on collaboratively with other groups, as well as reorganising themselves, if they are to develop successful alliances with political and community groups. The recent experience of the East London Communities Organisations (TELCO) indicates that some of these issues are being addressed.

In the USA, where social-movement unionism has been widely promoted as a solution to the decline of trade unions, there are also barriers facing its development (Reiss, 2005). In New York, although trade unions have been willing to develop coalitions with community organisations, trade unions have been reluctant to give up their power, and there has been a culture gap between unions and community groups. The process of developing consensus in a diverse movement has been slow, especially in a difficult social, political and economic context, and some younger workers have not promoted social-movement unionism.

Some of the major criticisms of social-movement unionism have concentrated on the concept of *democratic rupture*, which has occurred when trade unions have entered into social partnerships with government after having worked with social movements to challenge previous regimes (Park, 2007). In Brazil, South Africa, South Korea and the Philippines, trade unions had links with the political party that took power and were compromised in their

criticism of the government as a result (Park, 2007). More education for union members might help to develop a consensus between union members and leaders about key national political issues (Hirschsohn, 2007).

Ost (2002) provides an eastern Europe perspective of social-movement unionism and democratic rupture. He argues that social-movement unionism, which developed in the 1980s during the resistance to communism, actually contributed to the decline of trade unions after 1989, with one of its aims being to replace communism with capitalism. Ost sees the key to the future expansion of trade unions in a return to *business unionism*, in which trade unions focus on serving their members rather than on following broader political strategies. Business unionism and political unionism, according to Ost, should be seen as complementing rather than opposing each other, and workplace interests should not be forgotten in wider political struggles.

New labour internationalism

Moody (1997) recognised the importance of trade union action at local, national and international levels, and there has been growing activity among trade unions at the global level, with increased networking and information sharing (Carr, 1999; Waterman, 2005). Labour internationalism is not new. The *old* labour internationalism has a national focus and is based on trade unions in the global North, with internationalism an extension of trade union diplomacy. The new labour internationalism has moved from transnational collective bargaining to a social-movement unionism involving broader coalitions and campaigning for wide labour, environment and social-justice issues (Munck, 2004). Networks and networking can facilitate ways in which workers can articulate their needs in a way that is appropriate in a globalised world (Waterman, 2001).

One of the major criticisms of social-movement unionism is over its lack of systems of representativity of community groups or non-governmental organisations; but Waterman asserts that to criticise them for a lack of democracy or representativity is to misunderstand the nature of the new radical democratic movements (Waterman, 2001: 327). Waterman has instead criticised social-movement unionism for its focus on specific places, rather than searching for global and universal alternatives. This raises questions about the commonality of trade union strategies and experiences across regions and nations. The concept of *labour geography* has been developed to explain the way workers shape

space for their own needs (Herod, 2003, cited in Ghigliani, 2005). The way in which workers organise at different levels has a direct influence on workers' solidarity across space (Ghigliani, 2005). Others have proposed the study of the global labour force *horizontally*, that is, according to different categories and forms of work rather than on a nation-by-nation basis, which demonstrates a recognition of the global–national dimensions (Harrod & O'Brien, 2002: 49).

The term *militant particularism* was first developed by Raymond Williams in order to explore how 'working class self organisation … tried to connect particular struggles to a general struggle' (Harvey, 2001: 172), so that struggles in one place get 'generalised and universalised'. Ashman (2004) considers that neoliberal globalisation has provided a language that can bring many 'militant particularisms' together to create a universal movement, and that there is unity in values of solidarity, community, equity, democracy and diversity. Novelli (2004) provides a useful study of how a regional trade union transformed itself into a social-movement union that operated at many levels, from the local to the global. SINTRA-EMCALI, a Colombian trade union, recognised that it was no longer effective in defending public services under threat from neoliberal policies. Novelli attributes its success in generating local, national and international support to its 'strategic learning', which emerged as a response to changing conditions. This involved action on several fronts: alternative economic plans; effective publicity to counter the effects of the mainstream media; the development of a union–community alliance; the use of occupations to maintain services; and human rights campaigns. The use of research, education and learning to produce alternative forms of globalisation was crucial to the success of the campaign.

Webster and Lambert (2003) provide an account of some of the practical issues involved in drawing different national trade unions together with their analysis of the Southern Initiative on Globalisation and Trade Union Rights (SIGTUR), a network organisation of democratic trade unions in the global South. SIGTUR specialises in online campaigning and organisation, and within it there is no hierarchy, structure or control (p. 7). Webster and Lambert identify several challenges facing the new labour internationalism, including cost implications if conferences are to gather together speakers of different languages, since translation may be required. Decision-making at meetings can be difficult because of the different degrees of union autonomy of SIGTUR members and different levels of capacity; and there are gender imbalances at conferences, with the majority of attendees being

men, although some delegations are made up solely of women.

Ashman (2004) provides two further perspectives that are useful in looking at the nature of the struggles against health-sector reform. She starts by looking at whether the global social movement is *against* globalisation, and finds that the answer is more complex (see Gill, 2000). Ashman argues that the emergence of a new internationalism can be detected, for example, in solidarity between movements of resistance in the global North and South.

Health Activism

Health activism is a broad term covering a range of resistance efforts that can include isolated protests and the actions of a single organisation, as well as many of the characteristics of social movements (Zoller, 2005: 347). Health social movements and community organising are included within the wider umbrella of health activism.

Geist-Martin, Ray and Sharf (2003, cited in Zoller, 2005: 344) define health activism as 'taking responsibility for individual health, working to improve health conditions for a group, and making efforts to change and improve policies for large groups of people'. They also see health activism as a form of health citizenship. In this sense, health activism attempts to challenge existing order and power relationships. This is in contrast to health advocacy, which focuses on education and works within the existing system and medical model. The literature on social movements has not yet been integrated into health-communication theory, but according to Zoller, the field of health communication would benefit from a study of health activism, looking at 'issues of power and inequality and linkages among multiple social domains that influence health'. More specifically, this would 'encourage attention between activism and socio-political and economic influences on health status at local and global levels' (Zoller: 2005).

Zoller defines three categories of health activism: activism for medical care access and improvement; illness and disability activism; and public health promotion and disease prevention activism, with campaigns against changes in care delivery and trade union campaigns against reductions in health services both being forms of activism for medical care access and improvement (Brown et al., 2004).

The process of the commodification and marketisation of healthcare is a gradual one. It may cover public–private partnerships, corporatisation and the contracting out of services, as well as full-scale privatisation. These changes take place in

different sequences at local and national levels, so that resistance has to be flexible enough to respond to these changes in different ways, and may involve alliances between trade unions and other community organisations or social movements. The marketisation of healthcare is often not immediately apparent to patients, and this can make it difficult to mobilise immediately.

The debates about social-movement unionism and new labour internationalism show how these issues are dynamic, and demonstrate some of the change processes that trade unions are undergoing. Rather than considering social-movement unionism as a new model that will address some of the problems currently facing trade unions throughout the world, seeing it as a way of reasserting the *movement* dimension of trade unionism may be a more realistic way of using the experiences of trade-union–social-movement coalitions (von Holdt, 2002). It can also serve to acknowledge that there is a continuous tension between trade unions' movement dimension and the institutionalisation of collective bargaining.

Much of the research into social-movement unionism has been predominantly focused on trade unions in the manufacturing sector, and has been concerned with the effects of increasingly mobile capital. A few studies involve struggles against the privatisation of public services, but these raise different questions. By their nature, many public services serving local communities, such as healthcare, cannot be relocated to another country. The effects of privatisation on service provision may affect local communities immediately.

The experience of South Africa shows that there can be tensions between trade unions and community groups over the defence of public services (Lier, 2005; Xali, 2006). Trade unions often have to show that they are committed to improving public services as well as to protecting their own jobs. In Colombia, SINTRA-EMCALI had to work with local communities to mend broken infrastructure as well as carrying out occupations that did not directly threaten the delivery of public services (Novelli, 2005). Some of these experiences have helped to build up a body of knowledge about what contributes to successful trade-union–social-movement coalitions. Evidence so far available shows how social-movement unionism has developed in different contexts, but the extent to which it can be applied in other national contexts is unclear. Experiences in South Africa and South Korea show that social-movement unionism cannot automatically be transferred to a changed political context. New strategies may be needed to address some of the schisms that emerge between trade unions and

community groups following significant political change.

Trade unions have a long history of international action. However, since action on different issues at the same time can help a trade union campaign to operate effectively at local, national and international levels (Novelli, 2007), more needs to be done to understand how trade unions can achieve this.

Education played an important role in changing SINTRA-EMCALI. New communications technologies can facilitate the increased exchange of information, but the process of transforming information into knowledge that can be used to inform action is also important. In this world of rapid information exchange, the analysis and interpretation of information and its use in union strategies has also to be refined.

These issues provide a useful framework of analysis for the four case studies.

- What contributes to success?
- How do actions at local, national and international levels operate?
- What is the role of education and research in informing strategies?
- What is the influence of changing political contexts?

The empirical section that follows uses a comparative case study approach to examine the experience of trade union involvement in four countries. Each case study is discussed using the framework set out above, and the section concludes with a discussion of the similarities and differences between them.

Health reforms and trade union action

El Salvador

In September 2002, 700 doctors went on strike in El Salvador in protest against plans to privatise health services. The strike was led by the Workers' Union of the Salvadorean Social Security Institute (STISSS), and it was the culmination of a longer struggle over healthcare privatisation that had started several years before, when President Flores promised to promote health-sector reform. The government started to privatise different services within the healthcare system so that public hospitals had to contract out food, security and cleaning services, with the contracting-out of medical services under consideration. In 2002, the National Association of Private Business presented its proposals for the modernisation of healthcare services to the president. The ARENA (Alianza

Republicana Nacionalista) government has already privatised several sectors including banking, telecommunications and electricity, resulting in price rises that had been experienced disproportionately by the lower income groups in the population.

The social security system in El Salvador provides healthcare cover for everyone working in the formal economy, with costs covered through employer contributions. There is a separate healthcare system that provides healthcare for people who are not employed in the formal sector. The privatisation proposals would have led to increased costs in healthcare that would have made them inaccessible to the 70 per cent of the population who are not covered by social security schemes. For workers who are part of the formal social security systems, the proposals would have decreased the benefits provided (Centro de Intercambio and Solidaridad, 2002).

There was widespread support for the strike. Over 200,000 people joined a demonstration in October 2002, and this support continued until the end of the strike in May 2003. The demonstrations drew support from student groups, women's organisations, disabled veterans of the armed conflict, trade unions and non-governmental organisations as well as from healthcare workers throughout the country. In what were known as *marchas blancas* (white marches), participants wore white as a sign of peace and solidarity with the white-clad healthcare workers; and as a sign of the marches' anti-liberalisation focus, one of the most widely used slogans was 'health is a right not a commodity' (Zwahlen, 2002).

The widespread support was motivated by a sense that this was part of a struggle against liberalisation policies that would affect the whole country. A second demonstration took place on 23 October 2002. As a representative of the Lutheran Church in El Salvador reported, 'Privatisation has made life impossible for Salvadoreans. If the population doesn't act now to demonstrate that we are not in agreement, the government will privatise health (and education) and we will end up sold to foreign interests' (Creedon & Ney, 2003).

There was also some support within the National Legislative Assembly for maintaining a public healthcare system. On 17 October 2002, the Assembly had approved a decree, Guaranteeing Health and Social Security, that would have stopped the privatisation of what was, at the time, guaranteed state-provided healthcare. However, the limits of this support became clear two months later on 19 December 2002, when, following a deal with President Flores, the Legislative Assembly overturned the earlier decree against privatisation.

The strike ended in June 2003 with an agreement between the government and the STISSS. One element of the agreement helped to extend free medical care to over a million people, and in addition, the government agreed to reinstate the striking workers and those who had been dismissed, as well as paying half of the salaries that had not been paid during the strike. There was no agreement by the government not to introduce privatisation in the future, although due to the extensive popular support for the strike, it had withdrawn three decrees that would have promoted healthcare privatisation. The secretary–general of the ISSS doctors' union said, 'The greatest achievement of this strike is that we reactivated the social movement, and were able to block the privatisation'(Interpress News Services, 2003).

The significance of this example is that health trade unions and civil society groups came together in a struggle against healthcare privatisation. Previous experience of the privatisation of banks and energy utilities had raised awareness of how privatisation frequently leads to price increases, especially for people in low income groups. The strike activated a wider social movement, which one union leader felt was one of the biggest achievements of the strike. There were also effects on wider party politics in El Salvador, specifically the relations between the ARENA party, which has held power since the civil war ended, and the FMLN (Farabundo Martí Liberación Nacional), the left political party that emerged from the guerrilla movement. Since the strike ended, the trade union has experienced intimidation and threats because of its continued criticisms of the government.

The international campaigns set up to support the people of El Salvador during the civil war have continued to provide support for more recent struggles. Information on the doctors' strike was made available through the websites of several solidarity and social justice organisations based in the USA and Canada. This illustrates one of the forms of international solidarity.

Evaluation

The success of the campaign was rooted in several factors. Popular support was generated partly because of the important role healthcare plays in people's lives, but also because the population has previous experience of privatisation. Electricity privatisation has resulted in higher prices, and this provided a model of what might happen after privatisation. The campaign resulted in the *reactivation* of a social movement, and this is important to understand, because the campaign was led by healthcare trade

unions and can be seen as being part of the *movement* activities of trade unions, rather than as an initial process of developing coalitions with a social movement. In this sense, it does not correspond, at this stage, to social-movement unionism.

There were also elements of political party politics in the campaign. The ARENA government was becoming increasingly unpopular, while the groups involved in the campaign were largely supporters of the FMLN. In this sense, the trade-union–social movement was not outside mainstream politics, but was playing a role within the political system.

The international aspect of the campaign had built on previous international solidarity groups that had been set up to provide support during the civil war. This support had evolved to include anti-privatisation and anti-liberalisation campaigns, in a reflection of the changed issues facing people in El Salvador. The impact of solidarity campaigns has continued after the initial reason for solidarity has passed, suggesting that the creation of international links is significant, and that it can form a basis for future international campaigns. However, these were not solely trade union links, but were built on wider solidarity campaigns that had brought together a range of different groups and organisations more than a decade before.

United Kingdom

The process of challenging the effects of liberalisation has to continue even after policies have been implemented. In the East End of London, a coalition of local community organisations, the East London Communities Organisations (TELCO), has campaigned against low pay in the National Health Service in partnership with UNISON, a public-sector union. The low pay was a direct result of the contracting out of catering and cleaning services. Set up in 1997 as a coalition of 37 local community organisations and local trade union branches, TELCO aims to bring these diverse communities into an effective alliance, in order to 'Press power-holders, in the public and private sectors, to act for the benefit of families and communities in East London. TELCO trains leaders from its member organisations to be skilled and capable citizens, who can act collectively for the common good and take their case wherever it needs to be heard' (TELCO, 2003).

The campaign to increase the pay of health workers started in 2002. TELCO pointed out that low rates of pay impacted on 'Household poverty, the health of staff, the quality of services delivered to the public, the turnover and management of ancillary

services'. It also observed that the majority of contracted-out staff in East London are women from black and minority ethnic groups. 'Their second class pay and conditions are inconsistent with the obligation on public bodies to actively promote racial equality under the Race Relation Amendment Act' (TELCO, 2003). TELCO's main proposal was for the Strategic Health Authority to adopt a policy on contracting out, which would require contractors to agree that 'new employees will receive the same terms and conditions and pay as existing NHS employees and improvement to NHS Whitley terms and conditions will apply to all transferred and new staff' (TELCO, 2003).

More recently, local government has agreed the Code of Practice on Workforce Matters in Local Authority Service Contracts, which states that 'Where service providers recruit new staff to work on a local authority contract alongside staff transferred from a local authority, it will offer employment on fair and reason terms and conditions, which are, overall, no less favourable than those of transferred employees. The service provider will also offer reasonable pension arrangements' (TELCO, 2003).

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

In March 2003, the North East London Strategic Health Authority (SHA) stated that its position remained unchanged from that of 12 November 2002: 'The SHA is encouraging Trusts and Primary Care Trusts to work with local trade unions and independent sector contactors as contacts are negotiated, to discuss improvements to base rate of pay and terms and conditions of employment for staff not covered by NHS terms and conditions' (NE London SHA Press release, March 2003). Recently, new agreements between hospitals, trade unions and companies that deliver cleaning and catering contracts have been agreed. They establish minimum pay as well as sickness pay, holiday pay and pension provisions, which will help to eliminate the 'two tier workforce' (TELCO).

Evaluation

This campaign is significant because it brought together trade unions and local community and faith groups, and was successful in establishing a coalition between health service workers and users. It used arguments based on the reduction of health inequalities – part of central government policy – to provide a rationale for the campaign. In the UK, there has been a growing awareness of the role that the NHS and local government play as major employers in disadvantaged areas. TELCO has also developed a campaign for low-paid workers who are contracted to provide cleaning services to large private companies such as banks. The campaign focuses on locality and does not involve international campaigns or solidarity groups, although the same approach has also been used in the USA as part of the Justice for Janitors campaign. The approach reflects social-movement unionism more than it does the 'new labour internationalism'.

The work of TELCO is informed by research into working conditions in the East End of London; and in recognition of the fact that effective campaigning needs people with different skills who are prepared to adopt multiple approaches to campaigning, TELCO also plays an important role in providing training for members of the coalition. This means that campaigns supported by TELCO can make use of its research and training capabilities to inform their strategies and actions and to prepare activists.

Spain

The Federación de Asociaciones para la Defensa de la Sanidad Pública (FADSP) is a federation of associations of health professionals, who include doctors, nurses, auxiliaries, administrators, psychologists, social workers, managers, economists and others. It supports a universal and redistributive public health system that guarantees equal access to healthcare in Spain. Members of FADSP are drawn from different political parties, ideologies and trade unions, but share a common view that the public health system is in danger (FADSP, 2006).

Although FADSP is a Spain-wide federation, it has been most active in the region of Galicia. The focus of its campaign in the period 2000-2005 was to challenge the establishment of *foundation hospitals*, which are public hospitals that have to operate under business principles, which is often considered a first step towards privatisation. The campaign had two key elements: public debates and demonstrations. It also led to groups of health professionals' working together in different ways to provide improved services. It

worked closely with local trade unions involved in the health system.

The struggle for improved healthcare services has been going on for at least a decade, according to local newspaper reports, but it intensified after 2000. In June 2000, both the Galician branch of the FADSP and the Comisiones Obreros (CCOO), the Spanish trade union that organises health workers in the public sector, called a meeting in Pontevedra, Galicia. The president of the FADSP spoke to the meeting about the threat privatisation posed to the public health system (*Voz de Galicia*, 22 June 2000). On 29 May 2001, a round-table meeting bringing different healthcare professionals together was called by the FADSP in order to debate the issue of waiting lists. Waiting lists had been getting longer and longer, with some gynaecology patients having to wait five years. The Spanish government has used waiting lists to justify the introduction of private-sector providers and management approaches to the national health service (*Voz de Galicia*, 29 May 2001).

On 3 June 2002, the five local health trade unions called a demonstration to protest at the closure of beds in the public healthcare sector, as well as at waiting lists, labour conflicts and problems in primary care. Fifty-seven beds were earmarked for closure over the summer in the Pontevedra Hospital Centre, and in addition, savings were being made through not providing cover for health professionals when they were on leave. The trade unions felt that there was justification for calling a large demonstration because conditions had deteriorated since December 2000, when the first large demonstration had taken place (ibid.).

There had been attempts by the health department of the regional government health department to meet some of the demands of the campaigners, and some degree of 'social peace' – a term used in the local newspaper – had been reached after changes had been made to organisational structures in the hospital in the Pontevedra Hospital Centre and new projects were proposed for a hospital in Montecelo (*Voz de Galicia*, 2 June 2002)

Apart from the continued threats to the delivery of health services, the protests were also focused on a proposed new health-service law: the Anteproyecto de Ley de Ordenación Sanitaria de Galicia (LOSGA). Both health-service users and health professionals were united in their criticism of this proposed law, since they felt that it would benefit private companies to the detriment of the public hospitals as well as threatening the care of chronic patients. Private providers and public providers would be linked into a network in which private providers would be able to

treat patients in the public healthcare system and would be paid directly for providing care (*Voz de Galicia*, 21 December 2002).

Five local health unions organised a debate on the new law. Miguel Martín, chair of the Galician branch of FADSP, reported that hospitals that were becoming foundation hospitals had 32 per cent fewer doctors and 45 per cent fewer nurses than did the public hospitals, and that the number of beds had been halved (ibid.). More than a year later, on 4 December 2003, a meeting took place between the major trade unions, an association of housewives and consumers, the Federación Castelao (Federación de Asociaciones de Vecinos Castelao de Pontevedra, a federation of neighbourhood associations), the FADSP and professionals from the Pontevedra Hospital Centre. They were defending basic hospital services. SERGAS, the health department of the regional government, had abandoned the expansion of the Montecelo hospital because of a lack of funds (*Voz de Galicia*, 4 December 2003).

Again, six months later on 13 May 2004, the Federación Castelao, the major trade unions and the FADSP, with the help of an organisation of housewives and consumers in Rias Baixas, organised a public debate on the hospital situation in Pontevedra. Speakers argued that little had changed over the past ten years; that money had been wasted on new schemes and that the health services had not improved (*Voz de Galicia*, 13 May 2004). As can be seen from this example, struggles to protect or improve health services take place over long periods of time, with more intense activities at certain times, and with regular meetings and demonstrations. The involvement of a range of local organisations and trade unions, which characterised the period 2000–2004, shows that a strong coalition had been developed, informed by earlier struggles, that effectively involved many local organisations and health services users as well as health workers. The group of five local trade unions was active from the beginning of the campaign in 2000, and worked closely with other local organisations.

Evaluation

FADSP activism encompassed different forms of mobilisation, with actions focusing on specific issues within the proposed reforms of Galician health services. The trade unions worked together with local community groups in specific locales, and the overall campaign was not trade-union driven, although trade unions were part of the coalition and took individual initiatives.

The role of education, training and research seems to have increased as the campaign evolved. The FADSP published

commentaries on many new developments in the health service, including new management models, foundation hospitals, and the effects of the reforms on health workers. The campaign also made health professionals consider new and different ways of working to improve services. In 2004, the Galician section of the Family Planning association, the Galician Society of Family and Community Medicine and the FADSP met with the Galician Confederation of Neighbourhood Associations, and made an agreement to work together more closely in future. They felt that it would help them to intervene more effectively and to be more aware of local public health issues in general, and those of women in particular (*Voz de Galicia*, 28 October 2004). These groups went on to make a unified protest at the introduction of a new system of care, which threatened the existing primary care system by its blurring of the boundaries between primary and secondary care (*Voz de Galicia*, 5 April 2005). These unified protests about how care was delivered can be interpreted as signs that the campaign was evolving into a form of *health activism*, because it was beginning to focus on the promotion of health, and a form of *health citizenship*, which was beginning to challenge existing power relationship within the health services.

The FADSP has also written on international health issues, including on the foundation trusts set up in the UK. There was also some international solidarity through FADSP's participation in an international network, but it was less focused on support for a long-term strike than on giving legitimacy to the range of protests taking place. It was also the initiator of the Balearics Statement, a statement drawn up at a conference of the International Association of Health Policy (IAHP), held in Palma in May 2002. This called for the strengthening of public healthcare services and was signed by activists and health policymakers attending the conference. Thus the regional campaign in Galicia, while specific to that locality, also drew on information and support at national and international levels. Its views were also informed by these other experiences, which were broad-based campaigns, and drew only indirectly on specific international trade union links.

South Africa

Social-movement unionism has been developing in South Africa since the 1980s. The case of the South African trade union movement COSATU and its alliance with the Treatment Action Campaign will be used to show how relations between trade unions and civil society groups can change.

In South Africa, the trade union movement has become involved in campaigning for healthcare, and particularly for access to HIV/AIDS treatment. The high prevalence of HIV/AIDS in South Africa – up to 30 per cent of the adult population is HIV positive – and the lack of effective treatment are impacting on the social and economic system, which will affect South Africa for decades. HIV/AIDS affects trade unions in several ways, in that it is a major health and safety issue that features in collective bargaining agreements, and in that members need to secure rights to treatment for HIV/AIDS. COSATU and other trade unions provide health education programmes for their members (Lethbridge, 2004).

The development of an alliance between COSATU and the main campaign for AIDS treatment, the Treatment Access Campaign (TAC), has been triggered by the lack of government action on HIV/AIDS. TAC is a non-governmental organisation that campaigns for better treatment for people with HIV/AIDS. In this sense, this campaign has great political significance. When the alliance was first set up between COSATU and the Treatment Action Campaign in 2002, it was described as the 'Alternative alliance, with the potential to split the trade union federation away from the Communist Party and the ANC' (*Africa News*, 28 June 2002). This shows that when COSATU campaigns against the ANC government, it threatens its relationship with the ANC party.

Relations between COSATU and NGOs have not always been so cooperative. In 1999, when the government proposed to make notification of HIV status to the government mandatory, the trade unions and NGOs reacted in different ways. NGOs felt that notification would increase the stigma, and often violence, experienced by people with HIV/AIDS. Trade unions felt that if high-profile individuals made public statements about their HIV status, this would help to change attitudes and encourage people to seek treatment and education. There have also been tensions between trade unions and civil society groups about the balance of resources going into the treatment and prevention of HIV/AIDS (Lethbridge, 2004).

Over the last few years, a growing number of joint conferences has been organised by COSATU and the Treatment Action Campaign. Even after the South African government had won an international case against 39 pharmaceutical companies in 2001, which should have facilitated opportunities for producing generic drugs for HIV/AIDS, it was still not providing access to HIV/AIDS treatment. This motivated COSATU and the Treatment Action campaign to continue to work together. A major

conference in 2002 showed how this joint working relationship was beginning to influence mutual understanding between trade unions and NGOs, which was leading in turn to a better understanding of health workers. Two-hundred trade union delegates and three-hundred NGO representatives were present. The conference set out to discuss strategies for better HIV prevention and improved management of the care and distribution of antiretroviral drugs in public hospitals (COSATU/TAC, 2002). Some of the working groups looked at the experiences both of people providing healthcare, and of those receiving it. It emerged that although healthcare professionals were committed to providing care, it was becoming increasing difficult to deliver. This was because of a shortage of nurses, an inadequate supply of medicines, lack of support and a lack of capacity to implement new policies from regional and national governments (COSATU/TAC, 2002). One conference working group concluded that 'providing quality care in the public health services depends on rebuilding relationships' at different levels of the health services, and between different groups in and outside the health system. It also supported increases in wages and improvements in working conditions and terms and conditions for health workers, in order to prevent the exit of health workers from the public sector (COSATU/TAC, 2002).

Perhaps most interesting, in terms of the relationships between health workers and service users, was the conference's recognition of the concept of 'treatment literacy', which was needed for both health workers and other individuals. This suggests a move towards the demystification of treatment, which has been traditionally seen as part of professional power, and a willingness for a wide range of groups to be educated in the same issues (COSATU/TAC, 2002).

As a further indication of a strengthening alliance, COSATU, TAC and the South Africa Council of Churches (SACC) announced, on 22 November 2005, that they were joining together to campaign for HIV/AIDS treatment because of the continuing lack of action by the South African government. COSATU was to focus on HIV/AIDS at the 2006 May Day demonstrations and national congress. In the alliance's joint statement, the participants were critical of the government on several counts, including that the minister of health had failed to ensure that the 30 million rand in the government's AIDS Trust had been spent. The main aim of the AIDS Trust is to support the South African National AIDS Council, and the failure to spend the AIDS Trust budget means that South African National AIDS Council is not functioning. It meets irregularly and fails to meet its targets, and it also fails to consult with civil society and trade union interests (COSATU

Weekly, 25 November 2005). COSATU, the TAC and the SACC were in agreement on the need for three crucial actions: the devising of a national HIV prevention plan to challenge the stigma around HIV; encouraging voluntary testing and changes in behaviour; and increasing the number of people accessing anti-retroviral treatment (Alternative Information and Development Centre, 2005).

The reasons for joint trade union and civil society actions are rooted in the failure of the government to provide adequate services. The struggles are part of a wider struggle for development policies and their implementation to address major problems in South Africa, and in this sense, campaigns for the improved treatment for people with HIV/AIDS have grown into a broader social health movement.

Evaluation

In South Africa, trade union action in relation to HIV/AIDS has been influenced by a high-profile NGO campaign. Some of the tensions that arise between trade unions and NGOs were present at the beginning of their collaboration, but they have been dissipated as shared issues became stronger, in an example of how trade unions and NGOs can work together. This case study can contribute further insights into the social-movement unionism that has already been influenced by South African trade-union–social-movement experiences, although it can also be seen as a form of health activism since it was triggered by demands for better healthcare services for people with HIV/AIDS. One of the factors contributing to the success of the partnership was the recognition by COSATU that access to HIV/AIDS treatments was a crucial issue for its membership both now and in the future. It had become a collective bargaining and health and safety issue, and in this sense, it had become a core trade union issue.

Education played an important role in bringing the trade union and NGOs together. The process of coming together to discuss problems and future strategies has been a powerful force for raising their mutual awareness. Most interesting and significant has been the identification of the issue of 'treatment literacy', in which both health professionals and service users recognise that they need training in order to deliver effective treatment. This campaign for access to treatment has been supported by international campaigns, for example by the International Treatment Preparedness Coalition, and international solidarity networks linking NGOs, health workers and researchers (Cullinam, 2005). International

conferences brought together practitioners, activists, service users and other groups to share experiences and develop future strategies, and helped to pressurise the South African government to recognise the seriousness of the situation. The campaign also benefited from other campaigns for access to HIV retroviral drugs globally.

This perspective supports Zoller's argument that health 'as a modifier of "activism" required some theorising not found in general social movement research' (Zoller, 2004: 358). It is also helpful, according to Zoller, when campaigns work to broaden and engage in the global 'interconnectedness of health', which relates to national policies, international agency policies and corporate policies. (Zoller, 2004:359) – this is particularly important in relation to the challenging of neoliberal policies. In this way, health activism moves towards a strong collective approach to change, and also links to wider struggles for 'socioeconomic status and cultural power' and social-movement unionism.

Conclusion

All four case studies show trade unions and community organisations working together in different health campaigns. Some of these have focused on national-level campaigns, for example, those in El Salvador and South Africa. The TELCO campaign was a local campaign, but received national trade union support. In Spain, the focus was on local- and regional-level activities, which involved trade unions working with community organisations, but trade unions were not always in the lead. These case studies show that although trade unions are working with community and social movements, the ways in which they do so vary, and it is difficult to define a way of working that might be described as a model of social-movement unionism within healthcare systems. Three of the campaigns used education, training and research to some degree. The experiences in Spain, the UK and South Africa show how important research can be in raising awareness of issues that a campaign can start to focus on. Education and training can also increase the skills available to activists so that they can campaign more effectively.

The extent of international, national and local alliance interaction varied across the four case studies. Although three of the four benefited from international action and support, the ways in which international links were made differed. In El Salvador, international solidarity networks were already in place from the civil war period. In South Africa, international networks have

developed between AIDS activists, researchers and clinicians, and the TAC-COSATU alliance was able to benefit from these existing links. In Spain, the FADSP built its international links through individual access to international networks and professional associations. The 'new labour internationalism' must be seen in the context of much wider international links being made between campaigns, NGOs and researchers in many fields. Links between trade unions can form an important basis for future trade union action, but they also interact and coexist with a growing number of global networks. The nature of these global networks will also influence the development of 'new labour internationalism', as much as specific trade union activities.

There is also some evidence to show that relationships between trade unions, community groups and political parties can influence the process of campaigning. In El Salvador, the anti-privatisation campaign was influenced by the conflicts between the ARENA party and the left wing FMLN. In South Africa, the alliance between COSATU and the TAC was seen as a potential threat to the relationship between COSATU and the ANC. There has been extensive criticism of the extent to which social-movement unionism has been weakened by trade union links with political parties. Two of these case studies show that trade unions, as political players, are still influenced directly and indirectly by political parties, even if existing political parties did not support all their demands. The transformation of many political parties whose origins lay in trade union movements does not mean that trade unions or social movements must avoid political parties in future as a means of influencing the political process.

The effectiveness of joint campaigns between trade unions and community organisations depends on the defining of shared goals in the short term. These might change in the longer term, and may need to be renegotiated; and at the same time, a long period is necessary in order to understand how these structures work and how shared goals and strategies – and, perhaps most importantly, trust – might be developed. There is growing evidence that trade unions and civil society groups are collaborating more frequently, and this will provide important experience for future mobilisations.

These case studies show that trade union and civil society organisations collaborate in many different ways to challenge the increased 'commodification' of health services, which can be seen in both the global North and South. One important lesson is that the nature of trade union and civil society involvement can vary according to the type of campaign. Sometimes trade unions play a

strong leading role, but in other circumstances, NGOs take the lead role.

All four campaigns, in El Salvador, Spain, South Africa and the UK, can also be placed in a continuum of 'health activism', wherein collective struggles for health may evolve into struggles against other social and political issues, and for new and improved ways of delivering healthcare services. More research is needed to explore whether 'health activism' is becoming more meaningful in wider trade union agendas. There is also evidence that these campaigns had links with national and international networks which enabled them to exchange information and to network, although the nature of the international solidarity seems to differ from case to case. It may provide resources or information, but it can also contribute a voice to a wider advocacy movements. This is an important point for global union activism to take on board so that support can be refined and targeted across the international, national and local levels.

The search for a new model of trade union organisation to counter neoliberal policies, as seen in the development of social-movement unionism and new labour internationalism, may not provide the answer for future trade union strategies. The range of alliances and partnerships that trade unions are making in their actions to fight neoliberalism do not fit neatly into one model, but rather give some valuable insights into the movement elements of trade unionism. It is this dimension that must be strengthened, but which should also be understood as being, at times, in tension with collective bargaining and other institutional processes. How to reconcile these constantly changing positions is the future challenge for trade unions.

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