

Associations, unions and everything in between: contextualising the role of representative health worker organisations in policy

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To cite: Sriram V, Brophy SA, Sharma K, *et al.* Associations, unions and everything in between: contextualising the role of representative health worker organisations in policy. *BMJ Glob Health* 2023;**8**:e012661. doi:10.1136/bmjgh-2023-012661

Handling editor Seye Abimbola

Received 24 April 2023

Accepted 20 August 2023



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ABSTRACT

Associations, unions and other organised groups representing health workers play a significant role in the development, adoption and implementation of health policy. These representative health worker organisations (RHWOs) are a key interface between employers, governments and their members (both actual and claimed), with varying degrees of influence and authority within and across countries. Existing research in global health often assumes—rather than investigates—the roles played by RHWOs in policy processes and lacks analytical specificity regarding the definitional characteristics of RHWOs. In this article, we seek to expand and complicate conceptualisations of RHWOs as key actors in global health by unpacking the heterogeneity of RHWOs and their roles in policy processes and by situating RHWOs in context. First, we define RHWOs, present a typology of RHO dimensions and discuss perceived legitimacy of RHWOs as policy actors. Next, we unpack the roles of RHWOs in policy processes and distinguish RHO roles in regulation from those of regulatory agencies. The final sections situate RHWOs in political and labour relations contexts, and in sociohistorical contexts, with attention to institutional frameworks, professional hierarchies and intersectional factors such as race, gender, sexuality, class, caste and religion. We conclude by outlining research gaps in the study of RHWOs and policy, and by encouraging global health researchers and practitioners to incorporate an expanded focus on these actors. Taking this approach will generate a wider range of strategies to better engage these organisations in policy processes and will ensure stronger health workforce policies globally.

INTRODUCTION

Associations, unions and other organised groups representing health workers play a significant role in the development, adoption and implementation of health policy.¹ These representative organisations are a key interface between employers, governments and the members they represent. In this article, we refer to such organisations as representative health worker organisations (RHWOs)

SUMMARY BOX

- ⇒ Representative health worker organisations—associations, unions and other organised groups representing various groupings of health workers—are key actors at all stages of health policy processes.
- ⇒ There remains a paucity of research on representative health worker organisations and the ways in which these groups engage in health policy processes, particularly in low and middle-income countries.
- ⇒ Researchers must engage with the heterogeneity of representative health worker organisations, across dimensions such as public or private sectors, levels of specialisation, career stage or systems of medicine.
- ⇒ Power dynamics within and between representative health worker organisations, and the ways in which these organisations are situated in governance processes, are critical to understand.
- ⇒ Further clarity and distinction between interest-oriented roles and regulatory roles of organisations in health workforce governance.

and present an overview of their role in health policy processes. We define RHWOs as organisations of health workers that identify and act on the collective interests of members (both actual and claimed) regarding labour conditions, articulate collective positions on policy issues (pertaining to health systems and beyond) and engage in other activities as determined by their organisational mandates.

RHWOs often focus advocacy efforts on policy that directly impacts the health workforce, such as around training, remuneration, pricing negotiations, job security and working conditions.² RHWOs may also advocate for broader aspects of health reform (ie, availability, financing, quality of care, access)³ and partner with governments to expand access to particular health services and health as a human right.^{4,5} Such advocacy aligns with the interests of RHWOs both insofar as it advances

a vision of health reform that protects the professional status and scope of practice of members and because such actions justify or reinforce the status of RHWOs as important policy actors.¹⁶ Examples of interest-oriented action on the part of RHWOs include well-documented actions on the part of physicians associations, such as the consequential, longstanding opposition of the American Medical Association (AMA) to single-payer financing of healthcare in the USA,⁷ and the influence of the British Medical Association in expanding access to abortion in the United Kingdom on the grounds of protecting clinical autonomy for physicians.⁸ In recent years, a more complex picture regarding RHWOs has begun to emerge with researchers attending to the multifarious policy goals of RHWOs and in a wider array of contexts, particularly low and middle-income countries (LMICs). Examples of actions by RHWOs to actualise principal commitments regarding health systems include RHWOs' roles in shaping access to health services or health rights,³ influencing regulatory policy pertaining to the health sector to protect their financial or professional interests⁹ or advocating for improved remuneration, safety and working conditions.^{10 11} COVID-19 further amplified the role of RHWOs in health policy processes as platforms and channels for health worker discontent and frustrations during the pandemic.¹² Beyond these policy objectives, RHWOs also work to define, build and strengthen capacities within their membership, such as through standard and norm setting and continuous education as well as to provide service to the community and to their membership.^{13 14}

Despite their major role, there remains limited global health research about how RHWOs engage in health policy processes, within countries and transnationally. Much of the existing scholarship on these actors, particularly those organisations representing physicians, have emerged from high-income countries.^{7 15 16} In the context of LMICs, attention to the political economy of health policy processes is growing,¹⁷ with scholars highlighting context-specific dynamics and interactions between governments, domestic actors (eg, business, civil society, labour), international actors (eg, aid agencies, multinational corporations, philanthropy) and other stakeholders in shaping policy processes and outcomes. With some key exceptions,^{3 9 11 18} there is very limited research on groups representing health workers' associations, unions and other organised groups serving as policy actors in LMIC contexts as well as the interactions of RHWOs globally and their influence on national and subnational policy. Existing research in global health often assumes—rather than investigates—the role variously played by RHWOs in policy processes and lacks analytical specificity regarding the definitional characteristics of RHWOs.¹⁹ The high degree of self-regulation involved in health occupations—particularly for doctors—has the potential to conflate organisations representing health workers, non-profit regulatory

agencies and statutory bodies enacted through legislation, but led and/or run by representatives of the professions.¹³

In this article, we seek to expand and complicate conceptualisations of RHWOs as key actors in global health by unpacking the heterogeneity of RHWOs and their roles and responsibilities in policy processes, and by situating RHWOs in political, historical, social and labour relations contexts. Our analysis is drawn from completed and ongoing research on RHWOs by the authors^{19 16 20 21} as well as a review of existing research in LMICs and HICs. Our goal is to contribute to a deeper understanding of these organisations in global health scholarship and to stimulate further research on a largely neglected, yet important, set of actors in health policy analysis regarding LMICs and transnational contexts.

DEFINING AND CATEGORISING RHWOS

RHWOs—which encompass a wide variety of organisation forms—are civil society organisations, rather than official organs of the state apparatus.¹⁴ In the literature, health workers' associations and unions are often discussed using homogenous terms that do not capture the heterogeneity found in most contexts. Research in global health often makes reference to different types of 'advocacy organisations' for health occupations (ie, labour unions, professional associations, etc), but in practice, this grouping lacks precision regarding the distinct interests, membership, constituencies, histories, modes of functioning (ie, organisations professionally managed compared with those managed by members) and sources of power of these organisations.

RHWOs exist on multiple (sometimes overlapping) dimensions—as captured below and in [figure 1](#)—and geographic scales (local, subnational, national and international). Building on a typology of the health workforce in 'mixed health systems',¹⁹ [figure 1](#) presents a non-exhaustive set of dimensions on which RHWOs exist, which includes the following:

- ▶ Occupational group (eg, nurses, physicians, allied health professionals, etc).
- ▶ Sectoral (public sector employment vs private sector employment vs both) and subsectoral (eg, long-term care, acute care, etc) employment.
- ▶ Level of seniority (students, residents, attendings or consultants).
- ▶ Systems of medicine (eg, forms of traditional medicine, biomedical, etc)
- ▶ Level of specialisation (umbrella vs specialist associations)
- ▶ Qualification-specific (eg, medical students trained outside of the country).
- ▶ Type of employment (eg, contractual employee).
- ▶ Demographic characteristics (race, gender, religion, ethnicity, sexuality, country of origin, etc).
- ▶ Geographic scale (international, national and/or local).

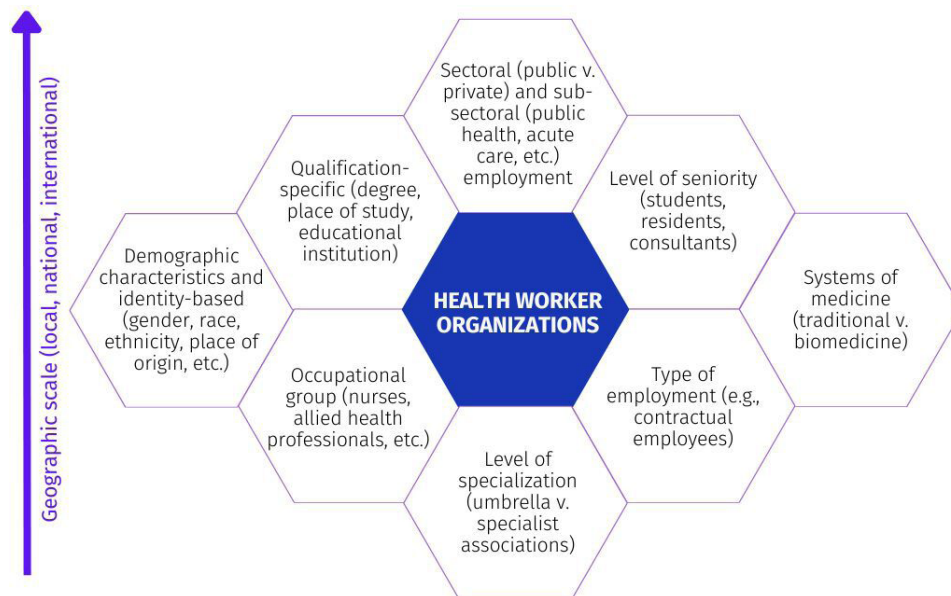


Figure 1 Types of representative health worker organisations.

Engaging with a diverse set of representative groups that cut across some of the dimensions addressed in [figure 1](#) will provide a richer, more nuanced set of perspectives that are often missed in current research and analysis. Many research projects currently engage ‘umbrella’ representative groups in order to provide perspectives of health workers (eg, national medical associations or nursing unions). These groups undoubtedly provide important perspectives given that their large constituencies often include smaller organisations (such as state and local chapters) or overlapping memberships with other organisations (such as specialist associations). However, our experience suggests that primarily relying on umbrella organisations as respondents results in a limited understanding of health worker challenges and policy priorities. For example, the national umbrella association in a mixed health system context might have greater representation of members working in the private sector rather than the public sector; engaging with public sector doctors’ association might, therefore, provide an additional and arguably more nuanced understanding of issues experienced by those doctors.²² In another example, umbrella organisations might not speak to the demands of cadres organised around particular employment terms, such as contract work, and organisations founded to address these concerns (eg, the National Health Mission In-source Employees’ Association in India) would provide specific insights into the grievances and demands of those cadres.

Taking a critical eye to RHWOs is also important because organisation titles may not accurately convey the scope of the organisation’s membership, mandate or advocacy strategies. For example, National Nurses United, the largest representative organisation of registered nurses in the USA, refers to itself as both a union and a professional association. Many of its affiliates (eg,

California Nurses Association, Minnesota Nurses Association and the New York State Nurses Association) use the word ‘association’ in their titles but describe themselves as labour unions. Similarly, the Indian Medical Association occasionally makes use of tactics typically associated with labour unions, calling for nationwide strikes or days of protest.²³ It is also useful to recognise that the diversity of organisations beyond those with titles of associations or unions that engage in collective action; for example, numerous health worker organisations in India use the title *sangathan*, a term referring to organised groups, but often taking the connotation of grassroots organisations or networks. It is, therefore, more pertinent to look at the type of collective action that the organisation engages in to achieve its policy goals.

Finally, analyses of RHWOs require a deeper understanding of the legitimacy of RHWOs (both with the groups that they claim to represent as well as policy audiences) and of the engagement of ‘members’ with RHWOs. Junk makes a distinction between two types of representation in membership-based organisations: individual *membership* and a broader ‘*claimed constituency*’, wherein organisations speak on behalf of constituents who may not have volunteered to be members and who may not otherwise participate in the organisation (eg, by paying dues or voting).²⁴ This is often the case with umbrella organisations, which claim to speak on behalf of all professionals of a cadre regardless of whether those individuals have chosen to participate. In doing so, umbrella organisations are often able to play an outsized role in health policy processes. This may occur in part because of the significant cost on the part of policymakers in soliciting the perspective of a wide number of stakeholders; instead, these organisations can be assumed to aggregate preferences of all the professionals they claim to represent.^{15 25} Laugesen has shown the ways in which

the AMA has secured its position through its role advising the US government on pricing and through its ability to act as a coalition leader; this has enabled the association to retain power in spite of a drastic decline in membership.²⁶ However, reliance on claimed constituencies rather than active members can also hinder certain type of actions. For instance, RHWOs that call for strikes rely on individual members' buy-in to their agenda in order to get them to join picket lines. RHWOs are typically quite reliant on volunteer labour and also need members to serve on boards and committees, to petition lawmakers, to mentor younger professionals.²⁷ Health workers may also hold multiple memberships, further complicating RHWO claims of representation for particular health occupations.⁹

ROLES OF RHWOS IN HEALTH POLICY PROCESSES

It is important to recognise the linkages between health workforce policy and health sector reform and to note that RHWOs' support or opposition of health reform packages are shaped by their impact on health workers (ie, opposing an expansion of health services due to potential negative impacts on remuneration). RHWOs for the same occupational group might also hold diverse viewpoints on health system structure and reform, and health workers have formed cause-focused organisation in response to specific aspects of health reform (eg, Indian Doctors for Ethical Practice, Doctors for America). Finally, RHWOs might engage in matters of public policy, such as the climate crisis, gender-based violence and prejudicial actions and behaviours from state authorities. The role of RHWOs in these aforementioned policy domains is highly dependent on political context and labour relations in a particular jurisdiction.

Depending on the context and occupation, RHWOs are also involved in the regulation of health occupations.²⁸ Diverse regulatory mechanisms for the health workforce exist across the world, involving combinations of self-regulation, coregulation, direct government regulation or voluntary regulation and variously engaging with RHWOs in these models.²⁸ The role of regulatory bodies, such as professional councils, and RHWOs are conceptually distinct and governed by different institutional frameworks.^{13 29 30} That said, in practice, the membership of regulatory organisations and representative organisations might overlap and result in considerable collaboration between the two, for example, by working together to establish professional regulation and standards³¹ as well in the form of regulatory capture.³²

Professional councils or commissions, particularly in many LMICs, are statutory organisations that exist via legislation but involve self-regulation as their decision-making bodies are comprised of membership from the professional group.³³ The National Medical Commission of India exists via an Act of Parliament, the National Medical Commission Act 2019, but consists primarily of doctors in leadership and decision-making positions.³⁴

These councils are mandated with setting standards of 'entry' into the profession (ie, education, licensing), maintaining quality and standards and overseeing ethical practices. In some contexts, such as the USA, the regulatory bodies overseeing health worker education are non-governmental (eg, the Accreditation Council for Graduate Medical Education is an independent, non-profit organisation).

While councils, commissions and other regulatory bodies are often distinct from representative organisations on paper, there are numerous ways in which representative organisations play a role in regulation, both formally and informally. Formally, representative organisations might have a 'seat at the table' in committees or policy processes, such as price setting or grievance redressal. For example, the Indian Medical Association has a formal seat on grievance redressal committees in Karnataka, India,³⁵ while in the USA, the AMA is the dominant player in the Specialty Society Relative Value Update Committee, a price setting committee that recommends health service prices for the Centers for Medicare and Medicaid, a standard-setter in the country for prices more broadly.¹⁵ Similarly, the Accreditation Council for Graduate Medical Education (ACGME) mentioned above is made up of member organisations including the AMA and other umbrella RHWOs and has been critiqued for its entanglements with these organisations.³⁶ There are also myriad informal ways in which representative organisations shape policy, often through networks. For example, the head of the erstwhile Medical Council of India was also the leader of the Indian Medical Association for a period of time³⁷ and was accused of numerous acts of corruption while serving in both those positions.

Situating RHWOs in political and labour relations contexts

Reich has argued that research on the role of factors in health policy processes should be contextualised within the historical, political and social context in which they operate.³⁸ Building on this scholarship, and recent calls to apply political economy analyses to health labour markets,³⁹ we extend this argument to research on RHWOs. The role of RHWOs varies considerably across political systems (democracy, monarchy, authoritarianism, etc) and labour markets (decentralised liberal, coordinated or dualist),⁴⁰ as the ability for health workers to influence policy is mediated by political institutions, labour or industrial relations and the extent to which civil society organisations are able to exercise power in formal policy processes.^{14 40–42} The institutional framework guiding interactions between the state and interest groups within a particular jurisdiction in turn impacts the organisation, functioning and influence of RHWOs. The importance of these factors is illustrated by a study of the Chinese Medical Doctors Association (CMDA).⁴³ Cao highlights how the CMDA's ties to the Chinese party-state limit its ability to represent its members' interest and influence their working conditions.

Depending on the political, societal and labour relations context of a jurisdiction, RHWOs may draw on a range of strategies to pursue their policy goals. For example, in some contexts, the use of strike action might be sanctioned under institutional frameworks around lawful and unlawful strike action, while in other contexts, strike action occurs without any formal sanction.^{39 44} Such strategies are also strongly mediated by the positioning of a particular occupational group within the landscape and hierarchy of health occupations and the overall societal context (eg, the positioning of doctors as elites in a particular society might facilitate greater informal access to policymakers). The following approaches and strategies might be undertaken:

- ▶ Participation in formal bargaining mechanisms (ie, collective agreement negotiations between employers and workers).
- ▶ Direct access to employers, politicians, bureaucrats and other decision-makers.
- ▶ Use of protests (sit-ins, rallies, marches) or strike action (work stoppage).
- ▶ Social media campaigns.
- ▶ Print, television, radio or other media campaigns.
- ▶ Legal action.
- ▶ Legal financial contributions.
- ▶ Illegal and/or corrupt financial contributions (ie, bribes, favours, etc).
- ▶ Coalition or network building.

Situating RHWOs in historical and social context

Historical trajectories also help explain the ideas espoused by certain representative organisations, and as such, are useful in understanding their role in policy processes. For example, the history of the Kenyan Medical Association, from its origins as an East African chapter of the British Medical Association to its post-colonial role, provides important context for understanding its leadership, membership base and policy stances.¹¹ Historical context may also provide a sense of shared ‘traits’ across associations, such as the evolution of profession-specific associations in former colonies. Citing case studies of professions in the British Commonwealth, Johnson⁴⁵ argues that professionals (and professional associations) in former colonies operated under frameworks that emerged during colonialism, where colonial administrations dictated and regulated the terms under which professionals (including health professionals) operate. Notably, colonial occupational control resisted movements towards the independent self-regulation of professions in favour of a system of corporate patronage in which the client (the empire) defines how its needs for professional services will be met. This form of centralised control differs from the norm of colleague authority that is observed in many colonising states, and that we tend to associate with medical regulatory bodies in high-income countries today.

RHWOs do not operate in isolation; they tend to be members of networks that shape their priorities and

approaches to the policy process in complex ways. Health worker organisations collaborate domestically and internationally to advance shared priorities. For example, Public Services International (a global union of workers in public services) develops and organises transnational campaigns that address issues facing health workers and systems globally, such as healthcare privatisation, and represents health workers’ interests when interfacing with multilateral organisations, such as the WHO. Similarly, Mattison and Bourret have described how collaborative transnational relationships involving midwifery associations have enabled these associations to advance sexual and reproductive health and rights.⁵ For instance, the Canadian Association of Midwives (with the support of development funders) partners with midwifery associations in the global south to engage in shared learning that advances the practice of and policy regarding midwifery in both nations. Another example comes from the International Federation of Gynecology and Obstetrics Leadership in Obstetrics and Gynecology for Impact and Change Initiative in Maternal and Newborn Health. This initiative provided a capacity building network that enabled professional associations in eight LMICs to better influence policy and practice regarding maternal and newborn health.⁴⁶ These examples of health worker organisations collaborating as part of networks show how networks influence both the policy outcomes that associations advocate for as well as their methods of advocacy.

An intersectional approach to the politics of health worker representative organisations is crucial to a nuanced analysis of their role in health policy processes. The health workforce has long struggled with a lack of representation in terms of gender in policy spaces, despite women comprising 70% of the workforce.⁴⁷ In addition to gender imbalances, race, class, caste, religion, sexuality and other characteristics—combined with professional hierarchies—also shape health worker voice and representation. One of the clearest examples of this is the organising undertaken by community health workers in India, Pakistan and other contexts.^{10 48 49} These cadres are largely made up of women of low socioeconomic status, living on low salaries and unstable employment, and providing an ever-expanding set of services.²⁰

CONCLUSION

In this article, we have provided an overview regarding a key set of actors in health policy processes, RHWOs and highlighted the reasons for further investigation into their role in these processes. We conclude with a brief overview of knowledge gaps regarding the role of RHWOs as policy actors. Some of the areas requiring further research and analysis include:

- ▶ The internal dynamics of RHWOs’ organisation and representation;
- ▶ The impact of political systems and health labour markets on RHWO policy influence;

- ▶ The usage of advocacy strategies (such as strikes, lobbying and informal networking) to influence policy processes;
- ▶ How power dynamics and hierarchies between occupations shape RHWO policy engagement (eg, how community health worker associations' participation compares with physician associations);
- ▶ The relationship of RHWOs across different levels (local, subnational, national and international) and how these dynamics shape policy preferences;
- ▶ How policy engagement processes are shaped by intersectional factors such as race, gender, sexuality, class, caste and religion.

Health workers are essential to ensuring improvements in access and quality to health services and to achieving targets in health-related global goals. Research on the role of RHWOs in health policy processes is an emerging domain within health policy and systems research. Critical analyses of these organisations will deepen the knowledge base and also stimulate a wider range of strategies to better engage these organisations in policy processes globally.

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Contributors VS conceptualised the article and wrote the first draft. VS, SAB and KS synthesised evidence for inclusion in the draft. VS, SAB, KS, MAE and AM revised the draft critically for important intellectual content. All authors approved of the final version that was submitted.

Funding This study was funded by Social Sciences and Humanities Research Council of Canada (GR024379).

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

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