Health Care in Central and Eastern Europe: Reform, Privatization and Employment in Four Countries

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Abstract

Health care workers throughout Central and Eastern Europe (CEE) are today experiencing the impact of restructuring and privatization. Focusing on four countries - Czech Republic, Lithuania, Romania and Ukraine - this project attempts to gauge how restructuring has affected the working conditions of individual health care workers. From the 2,215 replies to a questionnaire returned by health care workers, the analysis treats a wide range of issues, including hours worked, overtime work and overtime pay, relative earnings, non-payment of wages, changes in job tasks, job security and the role of unions in defending workers. It identifies a number of threats faced by workers, including the threat of job loss, income insecurity, and poverty and bargaining disenfranchisement.

Following a brief overview of the health care systems of the four countries surveyed in section 1, section 2 briefly describes the method of this study. Section 3 examines in some detail differences and commonalities in the experiences of health care workers across the countries surveyed. Section 4 concludes by highlighting some policy relevant findings.

Although still a draft, the report is of sufficient interest to merit publication in its present form.

1. Health care systems in Central and Eastern Europe (CEE)

The experiences of health care workers were investigated in four countries that differ significantly in terms of the organization, level and extent of health care provision, and in the extent and nature of health problems and outcomes. This section summarizes the characteristics of these systems.

Table 1. Total expenditure on health as a percentage of GDP in the WHO European region (1998)

Germany	10.7
France	9.6
European Union average	8.5
United Kingdom	6.8
Central Eastern Europe average	5.3
Lithuania	5.1
Czech Republic	7.2
Ukraine	3.5
Romania	2.6

Source (WHO, 2000a, p. 30)

1.1 Health care in the Czech Republic

Basic statistics

In 1999, the Czech population totalled 10,278,098 people. The death rate currently exceeds a birth rate that is declining steadily, and the population size has been dropping in recent years. The population is ageing, while demands on the health care system appear to be increasing. Today, an estimated 7.8 per cent of Czech GDP, excluding sickness pay, is spent on health care. Health insurance policy accounts for over 90 per cent of the health care funding. The rest comes from grants and earmarked contributions of the State.

Circulatory diseases, cancer and accidents and injuries are, in descending order, the three major causes of death in the country. Infant mortality is low and dropping with fewer than 5 children dying per 1,000 live births in 1999. Life expectancy at birth increased in 1999 from 71.1 to 71.4 years for men, but remained the same for women at 78.1 years. The trend regarding incapacity for work due to both injuries and diseases has been rising since 1975, and has increased most rapidly since the late 1980s. In 1995, figures for newly notified cases of occupational disease totalled 59 per 100,000 people insured for sickness.

The Czech health insurance system

The General Health Insurance Company covers 7.5 million people and eight other health insurance companies cover the remaining 2.5 million people in the country. A total of 5 million policyholders are paid for by the State: for instance pensioners, mothers, children, and sector workers. Their payments are based on the minimum wage, although these groups contain those patients likely to cost the health service most in care delivery. The other five million people pay directly into insurance companies. All health insurance companies in the country are independent but non-profit-making. Schlanger (2000) has summarized recent developments in Czech health care provision as follows:

> The health insurance system is a means for securing attainability of the health care for all citizens in a social system based on solidarity of the rich with the poor and the

healthy with the ill. Hence, the system was understood from the very beginning as an independent and general means of funding of all the health care institutions. This one-source funding was to become a first stage to full privatization of the health service. In time, two basic drawbacks of that model appeared. Firstly payments, irrespective of being based on average or minimum costs of health care facilities, cannot comprise all the specific features and complexity of every single institution. If average costs are taken as the basis, there will be a group of institutions making a profit and a group with higher than average costs, which will be doomed to losses. In the case of minimum costs application, practically all institutions are destined to lose. Secondly, there arises the question of who is going to make up for the inadequate funding. If the proprietors were to be health care workers themselves, or legal entities formed from them, the privatization would have no chance of succeeding. Nevertheless, health workers primarily submitted privatization projects. Only later did it become clear that without any capital investment background it is impossible to be successful in the privatization process.

Health care provision

There were 23,710 independent legal entities in the Czech health sector in 1999 totalling 24,923 health establishments. A total of 667 were state controlled, 137 controlled directly by the Ministry of Health and 530 by District authorities. Meanwhile, 24,256 were non-state establishments with 247 of these controlled by city or municipal authorities and 24,009 private. Between 1998 and 1999, 411 new health establishments have been added mostly independent specialists and pharmacies.

The health sector workforce

In 1999, there were 228,667 people working in health care, 55 per cent in state health establishments and 45 per cent in the non-state sector. There were 36,854 full-time physician contracts, of which 57 per cent worked in private health establishments. The system employs 104,489 paramedics and of these 37 per cent worked in private health care and 7.4 per cent in non-state establishments controlled by city or municipal authorities. There were 6,161 unskilled personnel (3.6 per cent of the workforce) and 15,401 auxiliary health personnel (8.9 per cent of the workforce). Nurses constituted 75 per cent of the paramedical workforce. Of the total workforce, 49.2 per cent (112,412 employees) were employed in hospitals, including outpatient departments. Independent outpatient establishments employed 55,421 employees, 24.2 per cent of the total workforce. Between 30 per cent and 40 per cent of the health care workforce is unionised.

Patient care delivery

In 1999, there were 203 hospitals with 67,365 beds including 2,395 newborn cots (a decline of 3 per cent on 1998) with 25 per cent of physicians (9,121) and 42 per cent of other health care professionals (43,657) working in this sector. Of these, about 80 per cent worked in state establishments, and 161 in therapeutic institutes (what are these?) with 22,151 beds (an increase in beds of 1.7 per cent on 1998 figures), 53 in balneal institutes with 20,687 beds (an increase in beds of 2.6 per cent on 1998). Acute bed numbers have been declining and hospital doctors who served acute beds have tended to become private specialists.

There were 65.5 hospital beds on average per 10,000 Czech citizens. Overall bed capacity has declined since 1990, but specialized beds - for cardiology, geriatrics, heart surgery, traumatology and burns - have increased in number, while maternity and neonatal beds have decreased. From 1997, surplus acute beds were re-allocated to new departments of nursing aftercare, and institutes for long-term patients were transferred to hospital aftercare departments. Despite the comparably high ratio of hospital beds *per capita*, there are problems with waiting times in the Czech Republic.

Less than 26 per cent of outpatient medical care was provided in state health establishments. The number of adults per general practitioner (GP) was 4,819, and of children, 2,193. Over 96 per cent of GPs worked in private practice.

Pharmacies totalled 1,626 of which the majority (1,549) were private.

Wages and working conditions in the secondary and tertiary sector

There is some sign of migration between hospitals inside the country because of wages and conditions, and evidence - albeit very small - of migration of health care workers out of the Czech Republic. There is also clear evidence of immigration of Slovak and other health workers into the Czech Republic where wages and conditions are better.

The interviews of the survey indicate that all health care staff are working harder now than in the past, sometimes disguised by the euphemism that they are working more "effectively". The Labour Code control on working hours has, according to some managers, restricted "opportunities" for paying staff higher wages. Health care managers argue that employees accepted a working hours directive on health and safety grounds, although this meant a drop in wages. In some hospitals, it would appear that when jobs were lost, vacancies were not filled and the job "tasks" were redistributed to existing employees to give them extra responsibilities and hence extra payments for their work. Overall, there seems to be some concern with the decline in the relative position of health care workers in terms of earnings, which appears to make employment in the publicly owned health care sector increasingly unattractive.

It appears from the interviews that while the Labour Code is a significant achievement, there are nevertheless dangers in over reliance on the code as a protective mechanism. Particularly worrying is that the absence of a developed health and safety committee structure for workers may also be detrimental to employee voice and representational security. In summary, of the four countries surveyed, the Czech Republic is the one where market reforms have taken deepest root. Whether this will be to the long-term benefit of the population remains to be seen.

1.2 Health care in Lithuania

Basic statistics

In 1999 the population totalled 3.7 million. The growth rate has been negative since 1994, due to a decline in birth rate from 15 per 1,000 in 1990 to 10 in 1998. Infant mortality is comparable with other CEE averages. As elsewhere in transitional societies, the most common causes of death are cardiovascular diseases, cancers and accidents (table 2). Death rates increased significantly between 1990 and 1995, although there are signs of a stabilization in recent years (Ministry of Health, no date). Coronary heart disease has increased 1.5 times since 1981 and is three times the European average. Suicide rates reached 46.4 per 100,000 in 1996. There is a significant health status gap between men and women and between urban and rural areas.

Table 2. Most common causes of death, 1990 - 1998

	Most common causes of death (per cent of total deaths)	% increase in age adjusted mortality rate 1990-1995	Standardized mortality rate 1998 (per thousand population)
Cardiovascular disease	50	2.1	5.28
Cancers	17	4.6	1.94

Accidents	14.4	49.1	1.46
All causes	100	12.1	

Source: Ministry of Health (no date), Department of Statistics, 1999

The Lithuanian health care system

Prior to the Second World War, a health system based on the Bismarkian model began to develop in Lithuania, where

> the state determines the conditions that govern the relations between sickness funds, providers and patients, but does not directly integrate the funding and provision of health care. Sickness funds, at arm's length from the government, were responsible for the execution of the plan. The relations between the health care providers and sickness funds were governed by contracts. Only workers with an income below a certain level were insured compulsorily (Marrée and Groenewegen, 1996, p. 6).

Following the incorporation of Lithuania into the USSR, health care was reorganized along *Semashko* lines, as in other Soviet Republics. The *Semashko* system is highly centralized and funded by the state budget, guaranteeing free access to health care for all. To ensure equal access, emphasis is put on geographical distribution of services throughout the country. Facilities are state-owned and managed by district and regional authorities, under the direct control of the central government (Marrée and Groenewegen, 1996, p. 7).

It is this system, with its structure of polyclinics providing outpatient primary health care and physicians salaried by the State, which provides the starting point for examining the impact of health care reforms. In addition, there is an extensive network of primary and secondary occupational medical facilities, mainly for industrial workers. According to the WHO (2000a, p. 1), Lithuanian health care was "relatively well funded and the population's health status was better than in other parts of the USSR". As elsewhere in CEE, the period of transition has been marked by a significant deterioration in the health status of the population as measured by adult morbidity and infant mortality.

Health care provision

The Ministry of Health is responsible for the general supervision of the entire health care system. It shares responsibility for running the two teaching hospitals, in Kaunas and Vilnius. Through the State Public Health Centre, it manages the public health network of ten county public health centres. The counties are responsible for implementing health care policy, while below them; the municipalities provide primary health care to the local population.

In 1998 about 4,650 physicians, including 1,168 dentists, worked in primary health care as well as about 10,500 nurses. There were 187 hospitals with 35,612 beds including 76 general hospitals, 68 nursing inpatient facilities, 38 specialized hospitals and 5 rehabilitation hospitals. Two-thirds of the beds are concentrated in general hospitals. The number of beds per 1,000 of population decreased by 23 per cent between 1990 and 1998, but at 9.6 per 1,000 this is still one of the highest levels of provision in CEE (average 5.8, Czech Republic 6.5 and Ukraine 7.4).

Economic recession has resulted in a sharp cutback in public financing of health care with a corresponding deterioration of facilities. Decreased investment in medical equipment has resulted in much equipment still in use after more than 10 years. Manufacturers to purchase high technology equipment such as CT scanners, angiographs and ultrasound equipment are active in lobbying providers of highly specialized care, such as neurosurgeons and heart specialists. This skews the investment programme away from rational provision. The situation is worsened by unregulated and uncoordinated Western

charitable donations of equipment since 1990. In September 2001, the Lithuanian press reported that investment programmes designed to supply hospitals with needed equipment had been delayed for the second year in a row "due to unknown reasons". Only one third of government assigned allocations of 91 million Litas (US$22.7 million) reached hospitals and medical centres because of lack of transparency when arranging public tenders and delayed signing of agreements. Medical equipment purchasing procedures were reported as having been "hopelessly dragged this year again". The head of health programmes under the Ministry of Health is quoted as saying "Our worries are that part of the investment funds, allocated for the acquisition of medical equipment will get lost again" (*Lietuvos Rytas*, 14 September 2001). As a result, access to cardiac surgery, hip replacement and kidney transplants is restricted by lack of funding. The financial deficit in the hospital sector has resulted in the widespread unofficial practice of asking patients to pay for medicines and disposable goods in under-the-table payments. As many as 40 per cent of hospital inpatients report having paid for services which are officially free of charge (WHO, 2000a, p. 49). The situation is one of declining public funding and poor investment strategy against a background of deteriorating health in the general population. The emergence of a public health strategy to combat preventable disease has been very slow in Lithuania, historically oriented towards infectious disease control and environmental health, but not focusing on the prevention of chronic conditions such as cardio/vascular disease, diabetes, stress-related illness. Introducing anti-smoking legislation is inhibited because of the strong tobacco lobby backed by Philip Morris, one of the largest foreign investors in the country.

According to the World Bank, an inefficient health care delivery system can be characterized by excessive, poorly organized, low quality hospital infrastructure; absence of first level and family care and related over-reliance on inpatient treatment; and poor mix of skills (too many specialist physicians, too few skilled nurses and managers). Besides the "inheritance" of the Soviet system, says the Bank, there is a "low institutional capacity" in the health service, contributing to inefficiencies. The World Bank remedy is the predictable one of recommending a shift in resources to GP based primary health care, patient choice, capitation financing of GPs and the development of their gatekeeper role to minimize referrals to hospital services.

Recent developments

Since the mid 1990s, health care has been moving away from the integrated model of municipal delivery under the supervision of the Ministry of Health, towards a contract model with the emergence of a statutory insurance system, and the possibility of creating private institutions. Although the role of the private sector is still quite small, its political significance outweighs the volume of private activity and can be seen as a test-bed for future, more extensive privatization. Significant in this respect is the separation of primary health care since 1997 into primary health care centres, in contrast to the polyclinics that provided both primary and secondary outpatient services.

In accordance with the 1996 Law on Statutory Health Insurance, a Statutory Health Insurance Fund provides for a separate social insurance scheme covering health care to be administered by the State Sickness Fund (SSF) and its ten regional branches. Lithuania has retained the basic principles of financing out of general taxation, with only 20 per cent of SSF revenues being derived from payroll taxes and the contributions of the self-employed. Contracts between private providers and sickness funds are still not very common, as the private clinics mainly serve wealthier patients.

Zapoliskiene (2001, p. 41-2) suggests that two-thirds of privately owned health enterprises are dental care providers, of which 70 per cent employ just two or three individuals. Private outpatient clinics, where miscellaneous medical services can be obtained, comprise some 5-6 per cent of total provision, being mainly concerned with

cosmetic surgery, psychotherapy and gynaecology, as well as dentistry. Between 1996 and 2000, the number of employees in the private sector increased by 1.7, to around 4,600. Some 79 per cent of dentists are engaged in private practice, in contrast to 26 per cent in other medical specialists. Other diagnostic and specialist personnel working in the private sector include cardiologists, rheumatologists, endocrinologists, obstetricians-gynaecologists, oculists and surgeons. About 70 per cent of therapists and 20 per cent of dentists engaged in private practice also continue to work in the public sector. Many private institutions now conclude contracts with the State Territorial Patients' Fund in order to be paid for certain services rendered from the budget of the Compulsory Health Insurance Fund. More important is the role the private sector plays in the pharmaceutical sector where it controls the entire wholesale trade and about three-quarters of the retail trade (WHO, 2000a, p. 7). No hospitals have been privatized and there are no plans to privatize polyclinics or larger hospitals.

Formally at least, the scope of services provided free of charge is still very generous with little popular support for further increases in co-payments. Under-the-table payments as a result will remain extensive. A major proportion of the national health budget is accounted for by pharmaceutical costs (as Western drugs replace "de-registered" cheaper Soviet versions). Pharmaceutical expenditures comprised 37 per cent of total expenditures on health care in 1995, reducing to 27.6 per cent in 1997 after cost stabilisation measures were introduced. Labour costs are another factor in health expenditure, although average salaries are very low compared to EU levels, and were only 83 per cent of the Lithuanian national average wage in February 1999. The IMF is pressuring the Government to restrain wage increases, and there are ongoing debates on closing surplus facilities, on reducing the number of personnel and medical students and on retiring physicians over the age of 65 years.

1.3 Health care in Romania

Basic statistics

Romania has about 22 million inhabitants, of whom about 55 per cent live in urban areas. Infant mortality (20.5 per 1,000 in 1998) is almost three times that of Western Europe and maternal mortality (40.5 per 100,000 in 1998) is six times the EU average and three times the CEE average, despite a drop since 1990. Communicable diseases remain common with a rising incidence of tuberculosis. AIDS is a problem among children in certain districts. Life expectancy at birth is five times lower than in Western Europe, the lowest in Europe outside the former Soviet Union. For men it is just sixty-six years, less than it was in 1989, and ten years short of the EU average. The standardized death rate for all ages was 1,190 per 100,000 in 1998, almost 70 per cent higher than the EU average and 10 per cent higher than the CEE average. The main listed causes of death are cardiovascular disease and cancer (over 50 per cent of deaths of those from 0-64 years). Lung cancer rates and deaths from chronic liver disease and cirrhosis have been rising for many years. Tuberculosis at 65 per 100,000 is more than 50 per cent higher than the average for CEE countries and is equivalent to the average found in sub-Saharan Africa (UN, 2000).

The percentage of the population living in absolute poverty is among the highest in the European Region (WHO, 1999). It is estimated that two out of five Romanians live on less than US$30 per month (by contrast to e.g., Peru, where the minimum monthly wage today is US$40). According to *The Economist's* survey for the year 2000, the quality of life in Romania ranks somewhere between Libya and Lebanon. The Foreign Affairs Committee of the European Parliament lists Romania as last among the EU-candidate countries.

The Romanian health care system

Like many other transition societies, Romania has had to try to adjust a *Semashko* health system inherited from the pre-transition period, which was publicly funded, providing universal health care, highly regulated and centralized under the Ministry of Health. Over the last decade, public expenditures on health have been below average, even in CEE terms, and this has affected maintenance, investment in new equipment and access to services, especially for low-income groups. The introduction of market forces and competition in health service provision has not been significant. Under-the-table payments still continue, with a strong emphasis on hospital-based curative services. Other characteristics are the inadequate provision of drugs and lack of good equipment, a growing inequity in health care provision between different social groups and regions and a lack of skills development of the workforce.

Since the mid-1990s, a number of laws have sought to create a more pluralistic and decentralized system. The 1997 Law on Social Insurance has attempted to introduce a contractual relationship between health insurance funds as purchasers and health care providers.

Health care provision

The 42 district health directorates in Romania (since 1999 designated District Public Health Directorates) are each comprised of three to six functional areas in which there is at least one hospital, one or more polyclinics and a network of dispensaries. The District Health Insurance Funds are, since 1999, the contractual bodies that pay health care providers rather than direct financing by the State. Thus, doctors as primary health care providers are paid on a contractual basis, mainly according to the number of people on their register. The former polyclinics are also in a process of transformation into independent medical facilities, whose services are paid on a contractual basis by the District Health Insurance Funds. Most hospitals are still under public ownership with very few in private hands. Trade unions still play some role in the health care system through the National Health Insurance Fund. Since 1999, the District Health Insurance Funds are responsible for raising contributions from employers and employees at district level, but this will be phased out by 2002.

As elsewhere in the CEE, illegal, out-of-pocket payments for services that are nominally free are significant, amounting to an estimated 30 per cent of total expenditures, of which 33 per cent is for drugs. According to new health insurance legislation, formal co-payments are required for drugs but contracted providers are also allowed to charge for some other services (WHO, 2000b, p. 23).

Recent developments

Prior to 1998, health care was mainly financed by government revenues received from direct and indirect taxes, but also from local government budgets, from the National Health Insurance Fund and from external sources. The Health Insurance Scheme, introduced in January 1998, is based on a social health insurance fund to which both employers and employees contribute 7 per cent of gross salaries. This is not expected to cover all care in the short run, and the State will still provide for fundamental needs of the system. Romania was one of the last CEE countries to attempt to introduce a health insurance fund. The political objectives of health care reform have been to decentralize the health care system and create competition among providers. However, given the overall limitation of resources, the prospects for extensive privatization are poor.

As elsewhere in CEE, the World Bank is a key player in the reform of health care, providing an initial loan of US$150m in 1992, extended for three years in 1996 and a further five-year loan in June 2000 of US$60m. Estimated expenditure on health care

increased slightly in 1999 to 3.9 per cent of GDP, but still leaving Romania well at the bottom of the league. Regional differences within Romania in *per capita* spending on health care remain significant, ranging from 167 per cent of the average in Bucharest, to as low as 52 per cent elsewhere (WHO, 2000b, p. 29). Despite the low level of drug use (only 8-10 per cent of the expenditure of other East European countries) the proportion of expenditure at around 20 per cent of total health expenditure is high due to the prices determined by the international market.

Wages for health care staff are low, and in the 1980s the status of nurses declined with the abolition of nurse training in 1978. Their role is now that of medical assistant, with much of what is understood as nursing in other countries being undertaken by doctors. The social status and pay of doctors is also very low.

1.4 Health care in Ukraine

Basic statistics

Ukraine has a population of 49 million. Since 1993, it has fallen by 4.4 per cent or over two and a quarter million. This is due mainly to the trend in the birth rate, which is sharply downwards at 7.8 per 1,000 in 1999. The rate of premature mortality due to diseases of the circulatory system and cancer is among the highest in the WHO European Region (WHO, 2000c). The level and trends in mortality due to external causes of injuries and poisonings are in line with similar countries. Tuberculosis is on the increase with about 27,000 new cases registered annually (58.9 per 100,000 in 2000). The syphilis rate remains one of the highest in the WHO region (114 per 100,000 in 1999) with AIDS rates being the highest of all in the NIS. Deaths from smoking-related diseases are among the highest in the European Region. The death rate in 1999 of 14.9 per 1,000 is about 50 per cent higher than the European average and one of the highest in the region coming after Turkey, Uzbekistan, Belarus and Tajikistan, but above Moldova, the Russian Federation and the Central Asian Republics. Male life expectancy is 68.2 years compared with 73.3 for the European Region.

Poverty indicators suggest that Ukraine is feeling the full consequences of its former close integration with the economy of the USSR. GDP per person (US$2,190 per annum) is about one fifth of EU averages. Some 27 per cent of the population are poor (defined as consuming 75 per cent or less of median consumption), based on results of a recent household survey covering the first three quarters of 1999. Some 18 per cent of the households are extremely poor: in that they are spending 80 per cent or more of their total expenditures on food (World Bank Report, 2000, p. 4). Official statistics indicate that, between 1991 and 1999, measured national income declined about 60 per cent. There is massive and popular dissatisfaction with the standard of living, and a deep sense of a sharp decline in real incomes. One reason is a significant shift of the sources of income from the official sector of public enterprises and institutions to the private sector - mostly in the shadow economy. The new structure of incomes is inherently less reliable than the old one, and makes decisions about spending patterns less stable. The size of the informal economy has yet to be calculated, but by all accounts it is reportedly substantial, ranging up to 50 per cent of measured GDP (World Bank Report 2000, p. 5). The business environment in Ukraine - ranked at 58, ahead only of Nigeria and Iran - is expected to remain "very poor" (Economist Intelligence Unit, 2001)[1].

[1] The EIU's global business rankings model measures the quality or attractiveness of the business environment and its key components in 60 countries, generating scores and rankings for the past five years and the next five.

Health care provision

Shrinking budgetary resources and unclear responsibilities have led to a deterioration in social service delivery. In Soviet times, large state enterprises were responsible for the provision of many social facilities, including kindergartens, schools, hospitals, sports and social welfare facilities. With the onset of reforms, many of these functions were passed on to a local government that lacked the necessary resources. In some cases, communities have simply curtailed the provision of such services. In others, providers of health care and education exploit the relatively stable demand and charge "informal fees" for access to these services (World Bank Report 2000, p. 5). A survey carried out under the Khrakiv/Lviv/Donetsk anticorruption initiative showed the highest level of perceived corruption was in medical services (World Bank Report 2000, Attachment 1, p. 4).

The Ukrainian health care sector had a long established tradition of good medical provision and was amongst the best in the USSR. A health care reform plan was promoted in 2000, but throughout the transition period there has been a lack of an overall national strategy for co-ordinated restructuring. As a result, the main features of the health care system have been attempts to preserve pre-existing standards and facilities in the face of a dramatically worsening economic situation that, for example, saw GDP halved in the first five years of the 1990s, while health expenditure as a proportion of GDP remained unchanged. Health care expenditure in 1998 amounted to 3.5 per cent of GDP, less than half the EU average and below that of Czech Republic and Lithuania, but in advance of Romania. The number of physicians per 100,000 is 229 compared to an average of 343.4 for the WHO European Region, in all, some 200,000 doctors. Hospital beds were 903.2 per 100,000 in 1998, much in line with 812.0 per 100,000 in the European Region, following a substantial reduction in beds in the early 1990s. Nevertheless, inpatient care amounted to two-thirds of total health care expenditures.

Recent developments

The initial results of the World Bank reform plans for Ukraine were claimed as "encouraging", particularly in the area of privatisation and legal reforms, such as bankruptcy procedures. Very soon, however, the Government was to display a lack of sustained commitment to the reform agenda. This, coupled with growing paralysis in decision-making in the legislature and the rising encroachment of the patrimonial state and the oligarchs, has increased the power of vested interests over the State. This "crony capitalism" makes a rational strategy of reform difficult to implement, since more often than not it merely creates new space for insider corruption. Today, Ukraine ranks among the highest performers in activities such as business harassment and corruption (World Bank Report 2000, p. 6).

In the sphere of health, in line with reforms elsewhere in Eastern Europe, the Government programme proposes to strengthen primary health care on the basis of family medical practice, to develop a system of health insurance, and to create the conditions for private medical practice. A key feature of the current situation in Ukraine is the low level of remuneration for doctors and other health care staff. In regions outside the capital, non-payment of wages or substantial arrears remains a huge problem. In many cases, trade unions work closely with hospital management but many problems remain: low morale and poor working conditions, lack of equipment, unsatisfactory health and safety for employees, and irregular pay and imposed administrative leave for personnel.

2. Methodology

In each of the four countries the researchers held separate discussions with representatives of the medical trade unions. The objectives of the study were to achieve a

"strategic sample" of two or three institutions in which it would be possible to represent "typical" workplaces for health care staff, which would, in turn, manifest the changes in the sector over the last 5 to 10 years. In each case, a primary polyclinic was selected together with, either a secondary level hospital and or a specialist tertiary institution. Since the impact of health care reforms has been particularly severe on polyclinic staff, greater emphasis was placed on acquiring survey returns from this group in each country.

Where possible the researchers met with the hospital management in order to secure their co-operation the study. Not all of these meetings were productive. However, in each country the trade union representative of Public Services International (PSI) attempted to provide a direct link to on-the-ground health care personnel. Where trade unions had a close relationship with management (Ukraine, Czech Republic and, to a lesser extent, Lithuania) this worked well in terms of ensuring the comprehensive distribution of the questionnaire in the selected facilities. Where management was uncooperative with the project, as in the first locations in Romania and Lithuania, it was necessary to attempt to select alternative sites. The stress on meeting management and securing their co-operation was based on the research team's goal of ensuring that the questionnaires were not completed by trade union members alone, but were distributed to all employees, union and non-union, whether or not they chose to complete them. In Ukraine, where some 90 per cent of medical employees are unionized, distribution through union-only channels might not be a significant distorting factor. In Lithuania, however, with the medical unions perhaps representing at best 20 per cent of the workforce, this was an important consideration. The sample was reasonably representative, at least so far as concerns Ukraine, Lithuania and the Czech sample, with perhaps major caveats regarding the Romanian sample as detailed below.

In total 2,215 self-administered questionnaires were returned, including 466 from the Czech Republic, 834 from Lithuania, 735 from Ukraine and 180 from Romania.

- The Czech sample was mainly drawn from a large teaching hospital in Prague with a link to the Charles University. The teaching hospital produced as many as 374 of the 466 returns and particular efforts were made to sample all sectors of health care personnel, although the final sample yield was approximately 10 per cent of the work force. The remaining two institutions, a regional hospital and a town/community hospital yielded a sample return of only just over 4 per cent.

- The Lithuanian sample was drawn from four institutions: a Red Cross polyclinic employing about 200 workers in Vilnius which caters for police personnel (and therefore might be said to be more insulated from many of the changes and pressures prevalent elsewhere in the system), a city polyclinic employing 350 workers in central Vilnius, and two further smaller institutions. The overall response rate of the Lithuanian sample was 76 per cent of those surveyed.

- The Ukrainian sample was drawn from a polyclinic employing 210 doctors, 400 nurses and 50 support staff, and a district hospital (No. 4), which employs a total of 3,000 employees. The third institution was an Institute of Paediatrics, Midwifery and Gynaecology with some 200 doctor/scientists. The overall response rate of the Ukrainian sample was 68 per cent of those surveyed.

- The 180 returns in Romania proved to be more problematic. Following initial unproductive discussions with the hospital management of the leading Bucharest hospital, about 500 questionnaires were subsequently distributed at the national council meeting of the SANITAS trade union federation. The questionnaires were given to union representatives from 12 health care

facilities, all located in Bucharest. Another trade union, HIPOCRAT, distributed 150 questionnaires to seven health care facilities, again mostly located in Bucharest. Each facility received 20-25 questionnaires. The Romanian sample thus utilized trade union-only channels of distribution, and therefore was completed mainly by union members or activists. While the level of trade union membership in this sector remains high, and therefore the bias of using trade union channels is not necessarily fatal, the results could not be claimed to be representative of the workforce. The very low response rate was in part explained by the difficulty experienced at one key hospital where the director was not prepared to cooperate with either the unions or the research team. While the unions did assist with the distribution of questionnaires, a further complicating factor was the fact that at the time, the unions were involved in protest actions, meetings and negotiations with the Government over pay and working conditions and consequently they were not able to follow-up on the questionnaires.

Nevertheless, although the number of responses differed substantially across the countries surveyed, we are confident that, with the exception of the Romania results which must be treated with caution, the questionnaires returned allow for a valid assessment of the work experiences of health care workers in these countries.

3. Questionnaire analysis

This section focuses on a cross-country analysis of survey responses. Its principal objective is to identify common themes in the work experiences of health care workers in the four countries surveyed, as well as issues which affect workers in one or other of the countries. The overarching *leitmotiv* of this analysis is the issue of how health care reform has affected the status and well being of public sector.

In the following sections we will explore many of the threats and challenges that health care workers in Central and Eastern Europe are facing today. No analysis can do full justice to the multifaceted changes experienced by different groups of employees, nor, especially when conducted by Western researchers, fully gauge the socio-economic upheaval that has accompanied the transition of CEE economies to capitalism. Nonetheless, this study should be seen as an effort to assess at least a part of the range of problems health care employees face today. In this sense, it can be seen as an antidote to those analyses which view transition and its accompanying reforms as a costless enterprise.

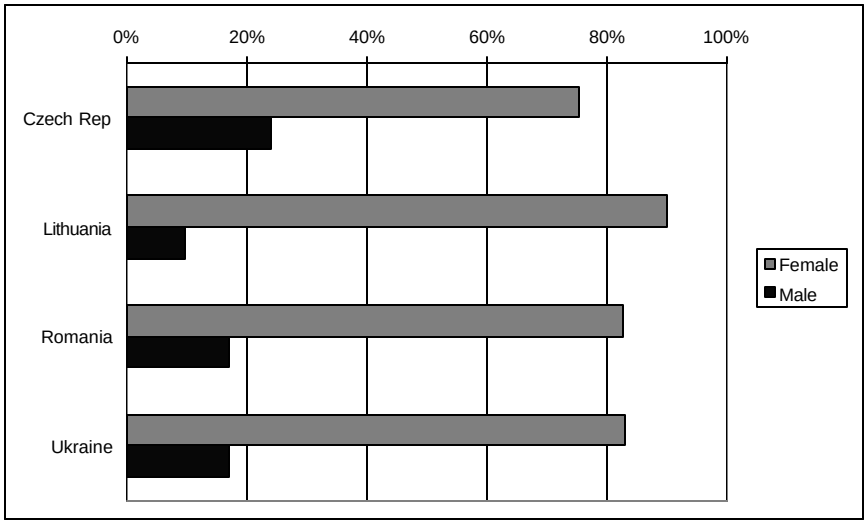
The first section briefly explores the nature of the workforce employed according to employment history or nature of contract. This is followed by an analysis of working hours, overtime, and overtime pay, together with respondents' views on their current pay. The core section focuses on respondents' views on their current working conditions. This is followed by more detailed queries regarding hours, pay, regularity of pay and the impact of restructuring on job tasks. Next, we investigate respondents' views on the job security and the impact of current and future initiatives on their position. The last section investigates respondents' views on the efficacy of their union and the attitudes of management towards the workforce. Again, on this sensitive issue of union efficacy, we suggest caution with respect to the rather positive evaluation revealed in the Romania responses.

3.1 Nature of the workforce

A legacy of the concentration of male employment in manufacturing during the communist period, is that health care provision in CEE nations relies heavily on female

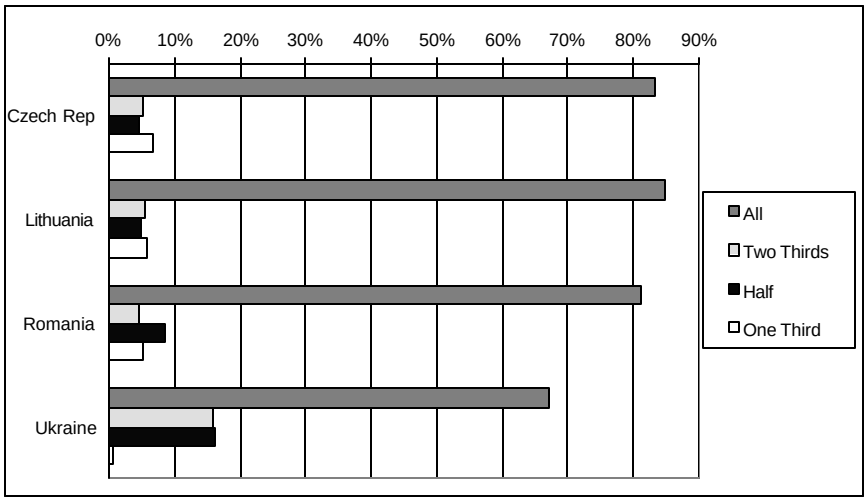
workers. According to the survey (Figure 1), the concentration of female workers was highest in Lithuania with over 90 per cent of respondents being female, followed by Ukraine, Romania and the Czech Republic.

Figure 1. Respondents by gender



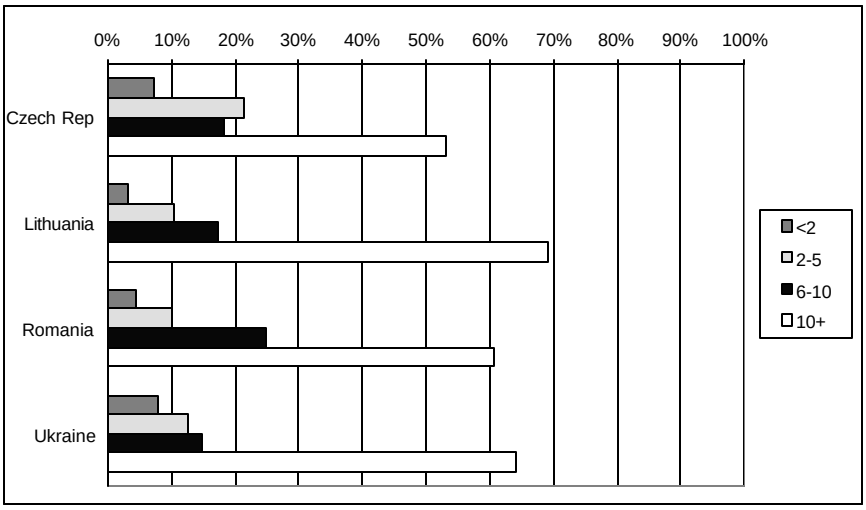
The majority of employees note (Figure 2) that they have been in the public sector throughout their working life, the percentage of respondents in the "all" category being highest in Lithuania (with over 84 per cent), followed by the Czech Republic, Romania and Ukraine.

Figure 2. Respondents by portion of working life in the public sector



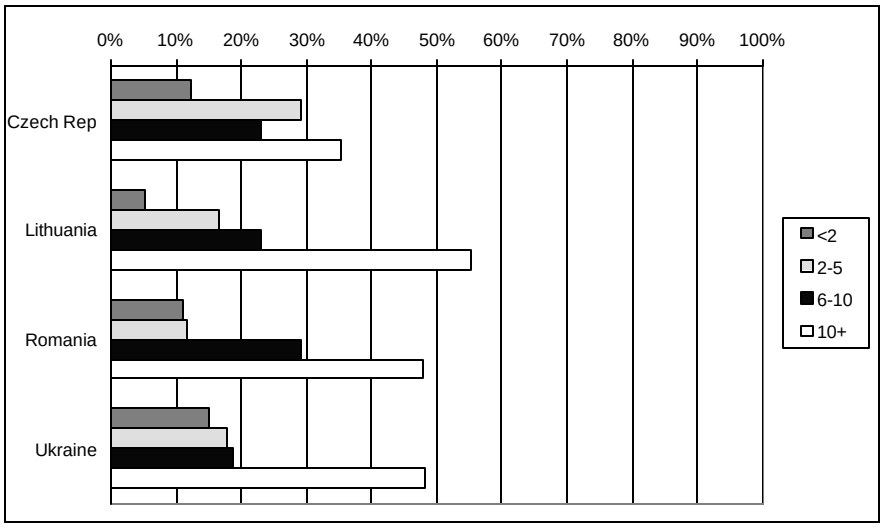
Over half the Lithuanian, Ukrainian and Romanian respondents (in descending order) state that they have worked for more than 10 years in health care (Figure 3). This rate was considerably lower for respondents from the Czech Republic, which indicates that this may be the only health care system that has had substantial recruitment over the past decade.

Figure 3. Respondents by years worked in health care



This pattern is closely matched by responses to the query regarding years spent with the current employer (Figure 4). Thus, in the case of Lithuania, Ukraine and Romania (in descending order), more than 40 per cent of respondents state that they have spent more than 10 years with their current employer. Again, for Czech respondents this rate was significantly smaller, perhaps as a consequence of the comparatively shorter tenure of Czech employees in health care employment in general. Despite the fact that of all categories, respondents who identified themselves as belonging to the 10-year-plus group were the most frequent, there is an indication of some kind of mobility within the health care sector of all three countries. This becomes especially clear if we compare Figure 3, which shows significantly higher tenure rates for employment in the health care sector as compared to employment with the current employer in Figure 4.

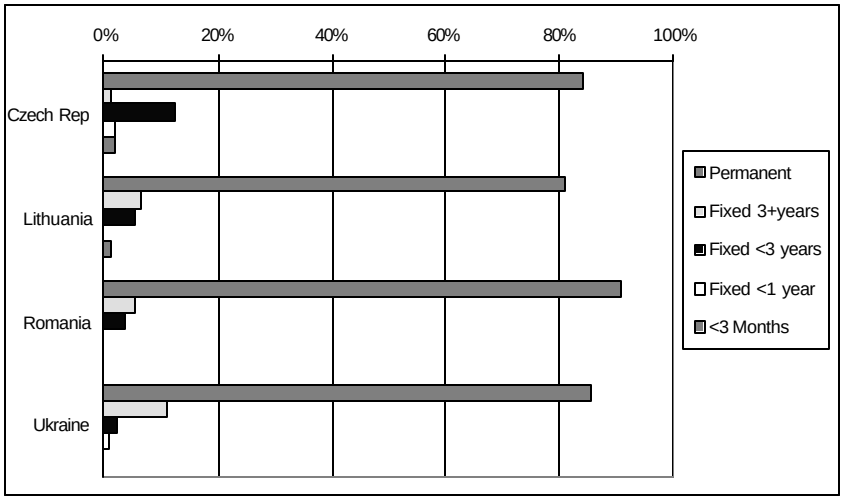
Figure 4. Respondents by years worked with current employer



The overwhelming majority of respondents were employed on a permanent contract, with rates of permanent employees being highest in Romania, followed by the Czech Republic, Ukraine and Lithuania (Figure 5). Interestingly, in two countries, the Czech Republic (for fixed less than 3 year contracts), and Ukraine (for fixed over 3 year contracts), more than 10 per cent of employees noted that they were not permanent. This

could be taken as evidence of a creeping casualization of health care employment. However, the questionnaire did not investigate these arrangements further.

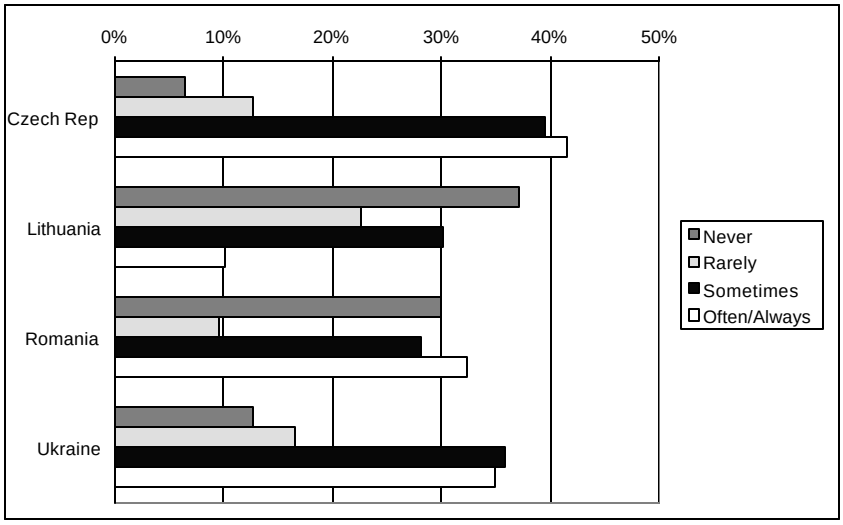
Figure 5. Respondents by contract type



3.2 Working hours and overtime

Respondents reported working hours ranging from an average of 37.7 in Lithuania, to over 46 in the Czech Republic. Figure 6 shows that 41.5 per cent of Czech respondents noted that they worked overtime often or always, followed by 34.9 per cent in Ukraine and 32.4 per cent in Romania, but only 10.1 per cent in Lithuania. The high rate of frequent overtime work in three of the countries surveyed must be taken as evidence of health care workers being over-stretched and/or facilities being understaffed.

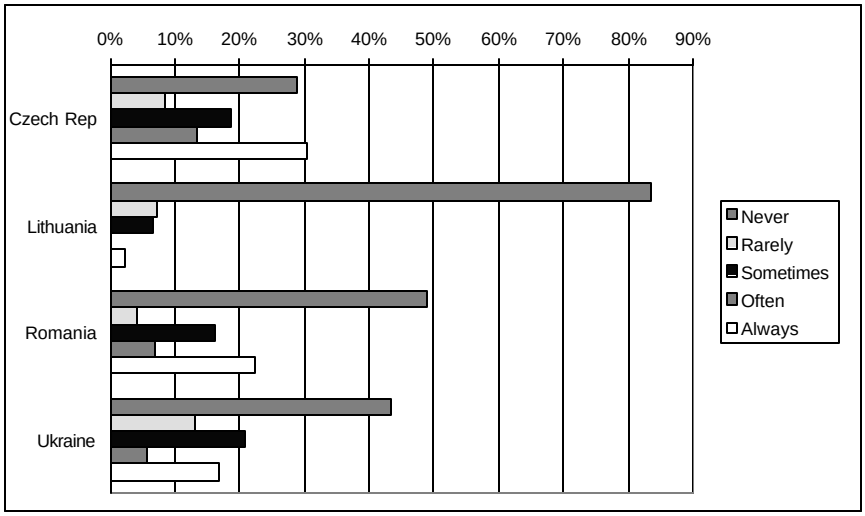
Figure 6. Respondents by incidence of overtime work



These patterns of overtime work were closely linked to the incidence of overtime pay (Figure 7). Thus, 90.8 per cent of Lithuanian respondents noted that they received overtime pay rarely or never. This was followed by Ukraine with 56.5 per cent, Romania with 53.1 per cent and, lastly, the Czech Republic with 37.2 per cent. While it is unclear what factors

allow employees to work overtime without receiving pay, it might be worthwhile to examine this issue further.

Figure 7. Respondents by incidence of overtime pay

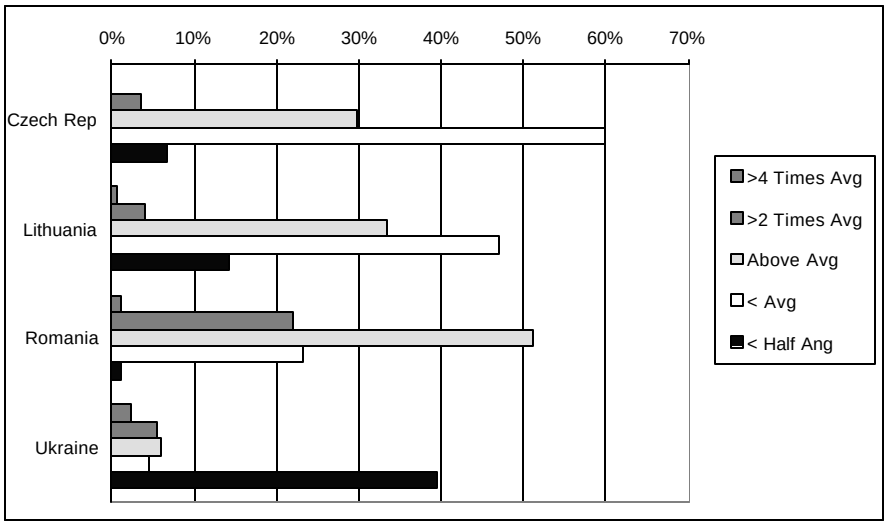


3.3 Relative earnings

Respondents were asked to compare their current earnings with average earnings in the country. The purpose of this question was to allow respondents to gauge their remuneration by reference to their own knowledge of the labour market, rather than by reference to concrete monetary amounts.

According to this analysis, Ukrainian health care workers fared worst, with only 13.7 per cent of respondents stating that their earnings were above the national average. Next worst was the Czech Republic at 33.3 per cent, followed by Lithuania with a figure of 38.1 per cent. Although data on relative earnings during the pre-transition period is scarce, our data is likely to reflect a situation where the earnings of health care sector workers have fallen gradually behind those of other employees. Amongst Romanian respondents, 74.4 per cent stated that they received earnings above the national average, which may be attributable to the fact that average wages in this country are, by comparison to many other CEE nations, exceptionally low. More likely, however, this particular finding is a function of sample bias.

Figure 8. Respondents by relative pay

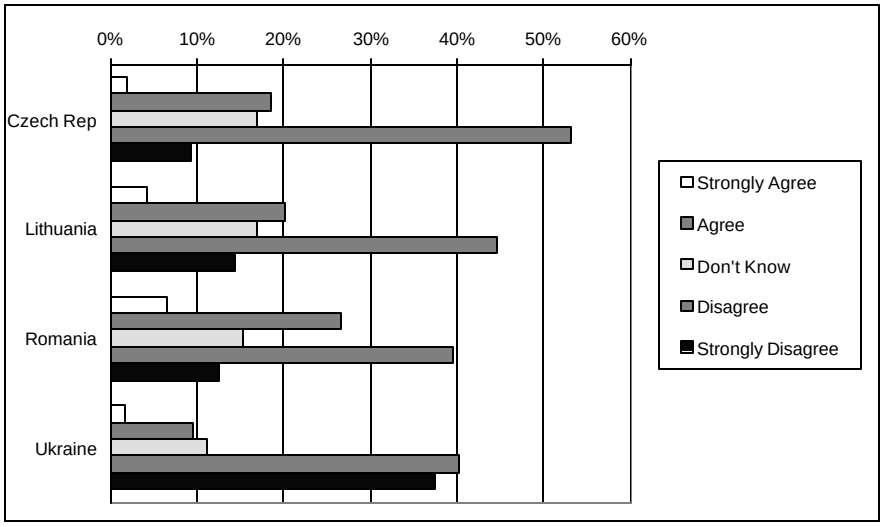


3.4 General working conditions

The core of the survey related to respondents' perceptions of their working conditions, as well as to changes which may have occurred over past years.

The questionnaire asked whether respondents believed their working conditions to be "excellent" by the standards of their country. The majority in all four countries disagreed with this statement (Figure 9). The highest incidence of disagreement was in Ukraine with 77.7 per cent, followed by the Czech Republic with 62.4 per cent, Lithuania with 58.8 per cent and Romania with 51.8 per cent.

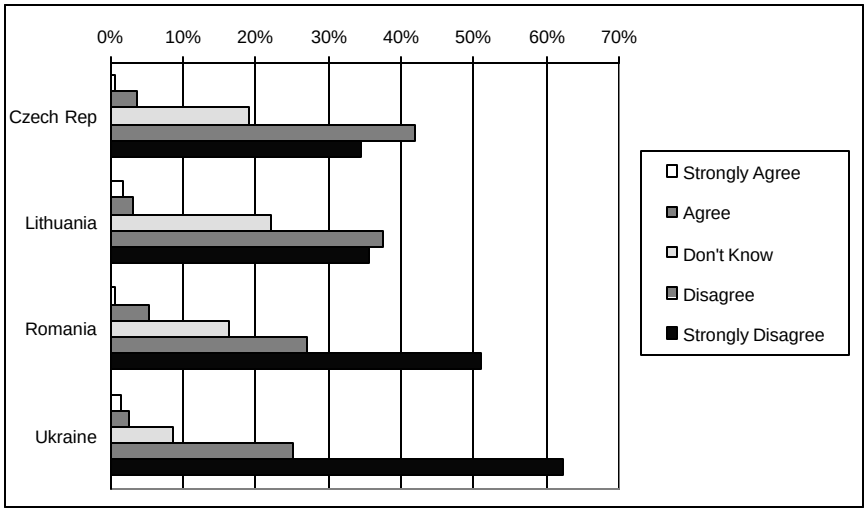
Figure 9. Responses to "By the standards of my country my working conditions are excellent"



When queried whether, by Western standards, their working conditions were excellent, even fewer respondents could agree with this statement, unsurprisingly (Figure 10). Again the percentage of those disagreeing was highest amongst Ukrainians, with 87.4 per cent, this time followed by Romanians, the Czech and Lithuanians. Although most respondents are probably unfamiliar with actual Western working conditions, the

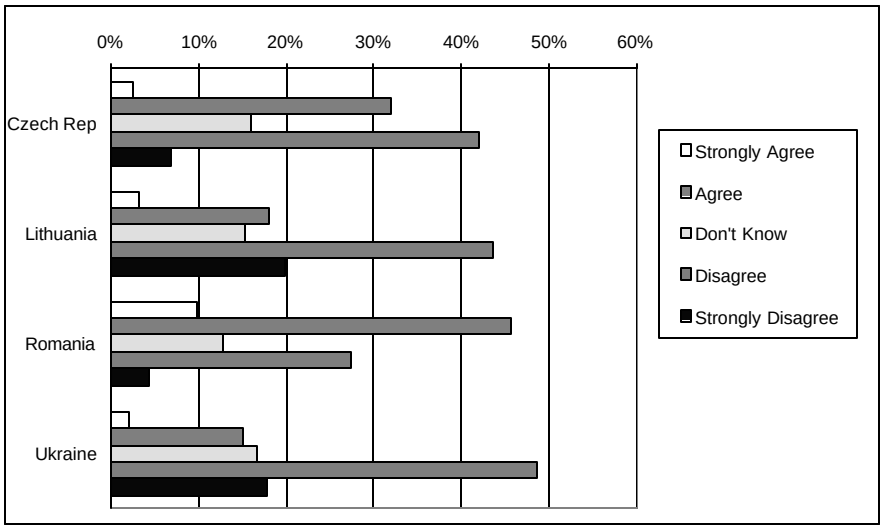
perception of these conditions, mistaken or not, is important to health care personnel in CEE. For many in these countries, the replication of conditions of the West (real or imagined) would represent fulfilment of longstanding aspirations.

Figure 10. Responses to "By western standards my working conditions are excellent"



In order to further investigate how respondents felt about recent developments, they were asked to comment on the statement that their working conditions have been generally improving (Figure 11).

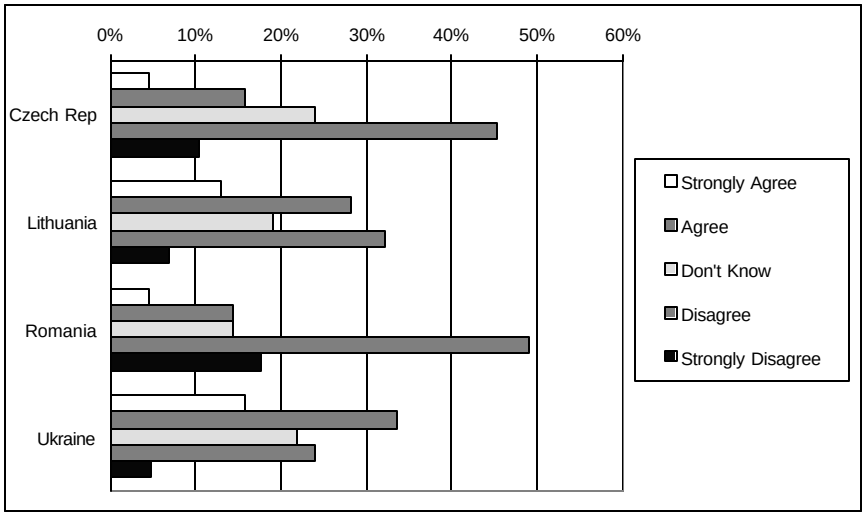
Figure 11. Responses to "My working conditions have been generally improving"



Opinions on the statement that working conditions had worsened in the past 5 years were divided both across and within countries (Figure 12). A high percentage of Romanian respondents (66.6 per cent) disagreed with this statement. One interpretation here is that respondents felt that their working conditions could not get any worse than they were in the past and that by comparison, today's conditions could be seen as an improvement. The Czech Republic data showed 55.7 per cent as disagreeing. In Lithuania and Ukraine opinion was more evenly divided. We may surmise that the Romanian figure may have much to do with the wish of union members to project "union efficacy" so far as defense of

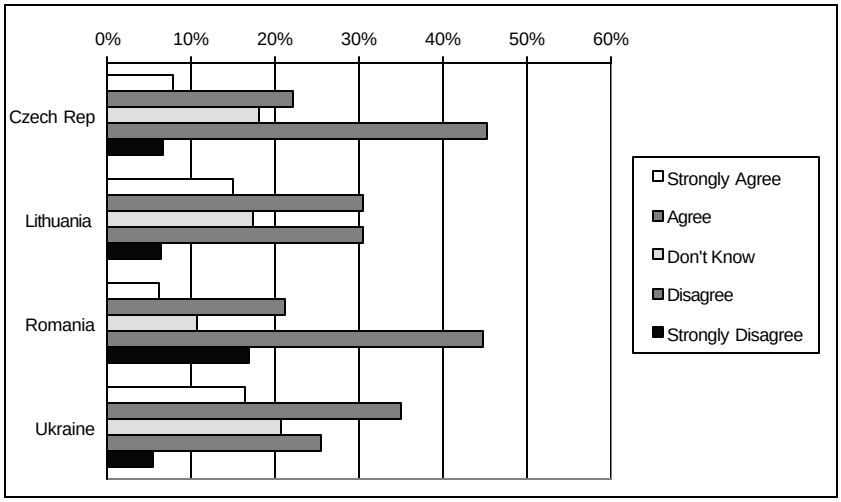
working condition is concerned. By contrast, the Ukrainian figures more likely represent a reflection of the actual situation pertaining in the country over the last five years.

Figure 12. Responses to "My working conditions worsened over the past five years"



This pattern of responses was largely supported by reactions to the statement that working conditions worsened over the past 10 years (Figure 13). The replies in Romania, at 61.5 per cent disagreeing, suggest that viewed from today's stance, conditions are somewhat better than they were at the end of the communist regime. A majority of Czech respondents (51.8 per cent) disagreed with this statement. In Lithuania, respondents were again more evenly divided, 45.6 per cent agreed with this statement while 36.9 per cent disagreed. Responses were similar in Ukraine.

Figure 13. Responses to "My working conditions have worsened over the past 10 years"

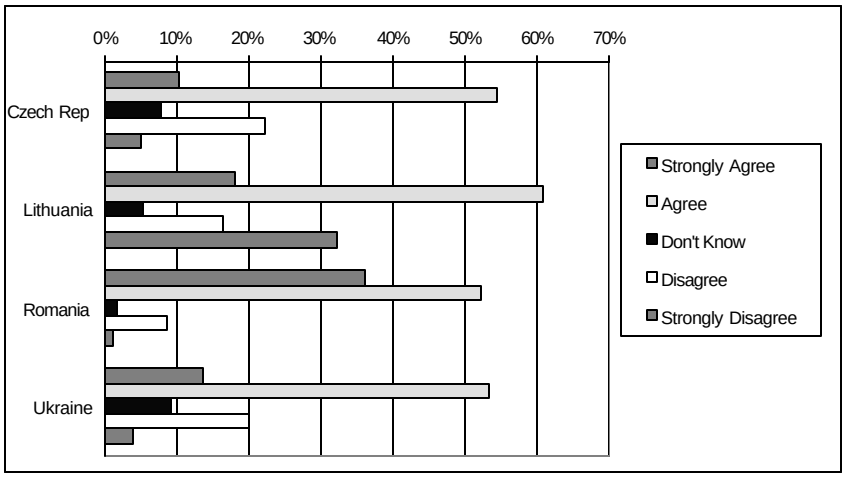


3.5 Working hours

The questions about whether respondents felt that work arrangements in terms of hours met their needs are of particular importance to workers with family obligations, who may have entered health care sector employment in anticipation of some level of flexibility.

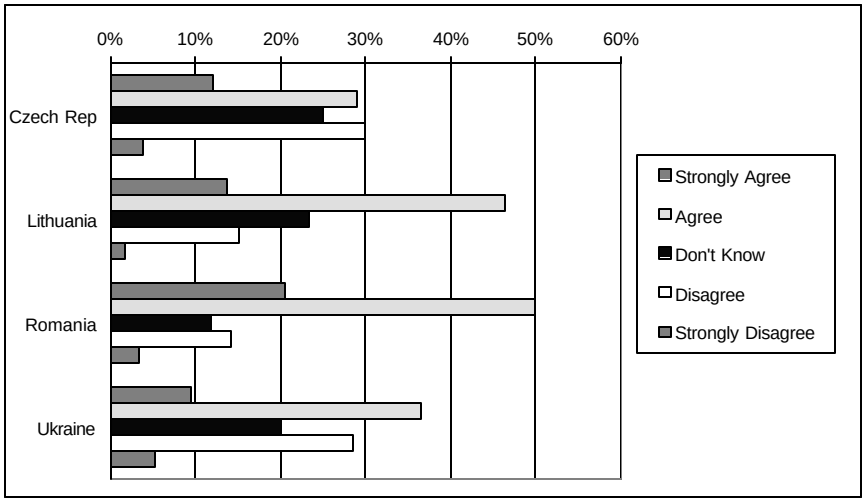
The majority of respondents in all four countries were happy with their current hours (Figure 14). The lowest rates of agreement could be observed in the Czech Republic with 64.6 per cent and Ukraine with 66.9 per cent. The high proportions expressing satisfaction here, Romania 88.3 per cent and Lithuania 78.9 per cent, suggests that working hours are associated with income earning opportunities.

Figure 14. Responses to "I am happy with my current hours"



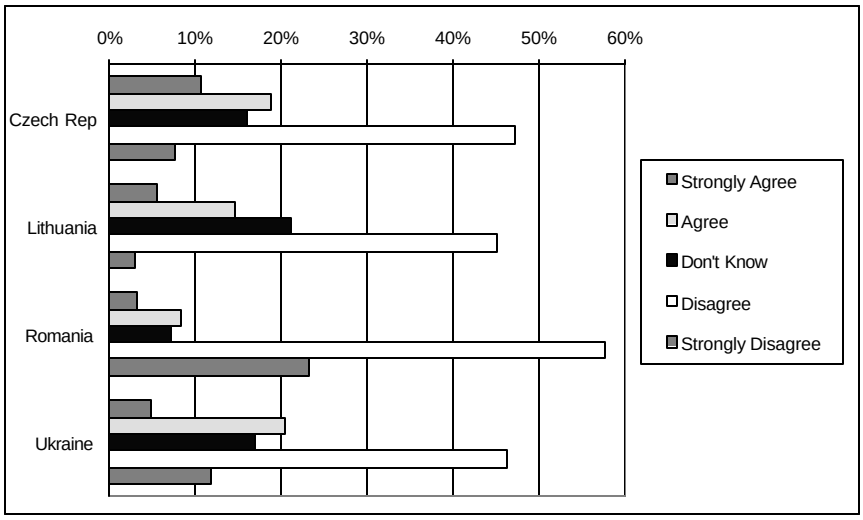
Despite this overall positive attitude towards current working hours, a significant portion of respondents wished for more flexible working hours (Figure 15). This was most pronounced in the case of Romania, where 70.6 per cent of respondents agreed, followed by Lithuania (60.0 per cent), Ukraine (46.1 per cent) and the Czech Republic (41.0 per cent).

Figure 15. Responses to "I wish I could work more flexibly"



Overtime work was not a major concern (Figure 16). Amongst Czech respondents, only 29.4 per cent agreed with that they were concerned with the amount of overtime worked, followed by Ukrainians with 25.2 per cent.

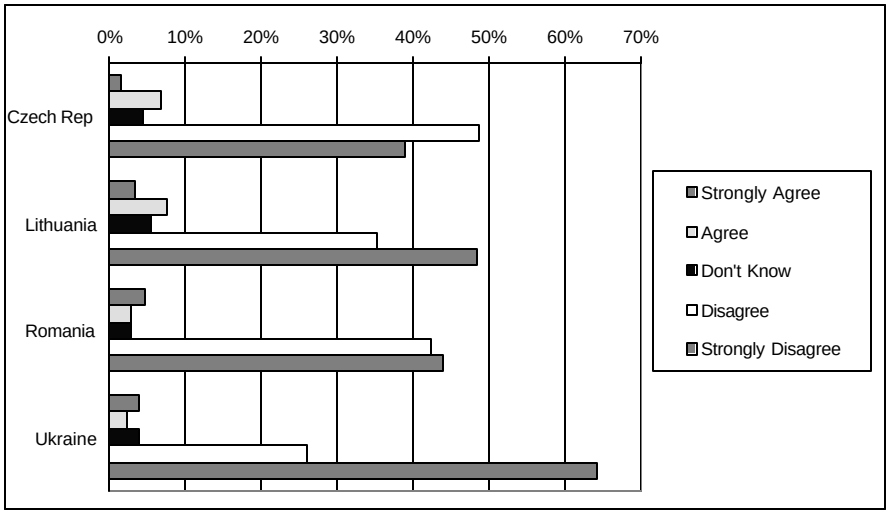
Figure 16. Responses to "I am concerned with the amount of overtime I work"



3.6 Earnings and regularity of pay

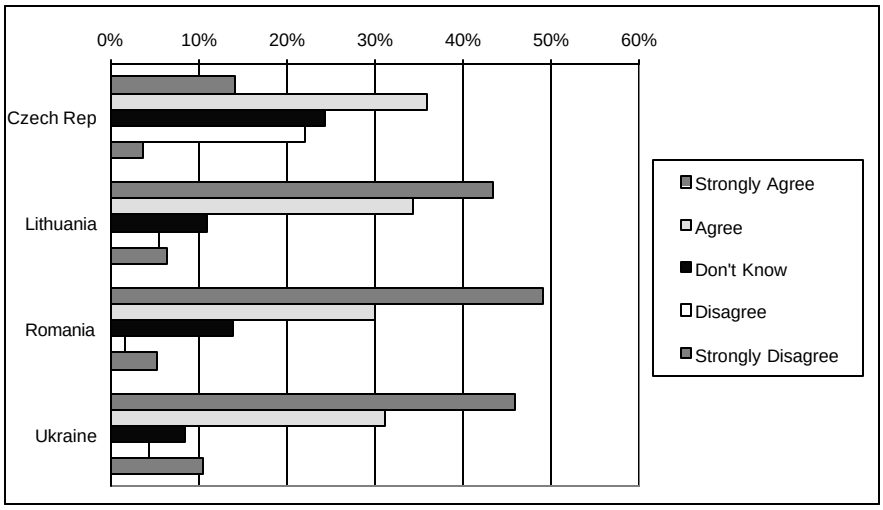
This series of questions sought to identify whether low or irregular pay constituted a major problem for health care workers. Respondents were asked to comment on the statement "I am happy with my current pay" (Figure 17). The vast majority of respondents rejected this statement: 90.2 per cent of Ukrainians disagreed, followed by those from the Czech Republic (87.4 per cent), Romanians (86.3 per cent) and Lithuanians (83.6 per cent).

Figure 17. Responses to "I am happy with my current pay"



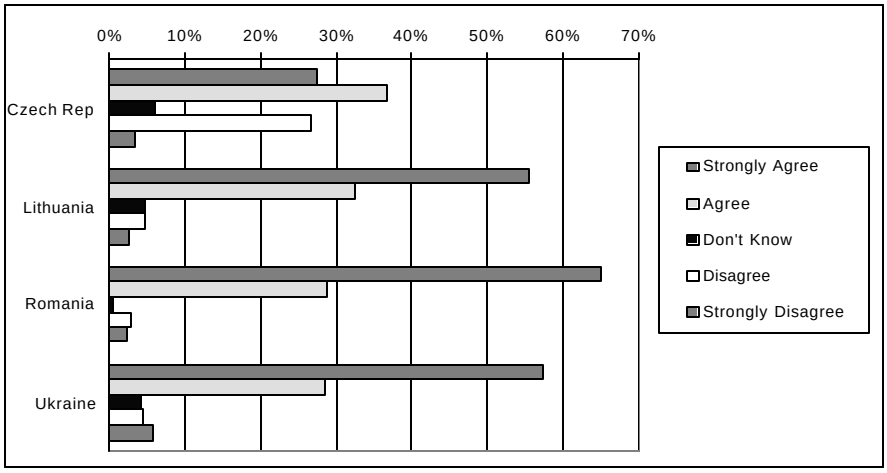
To further explore how respondents were affected by adverse pay conditions over time, they were asked to comment on the statement that, taking into account inflation, they were paid less than 5 years ago (Figure 18). An overwhelming majority of respondents in Romania, Lithuania and Ukraine supported this statement: over 75 per cent. The lower proportion in the Czech Republic agreeing with this statement may well be accounted for by the significant pay rises for health care workers achieved in 2001.

Figure 18. Responses to "Taking into account inflation, I feel that I am paid less than five years ago"



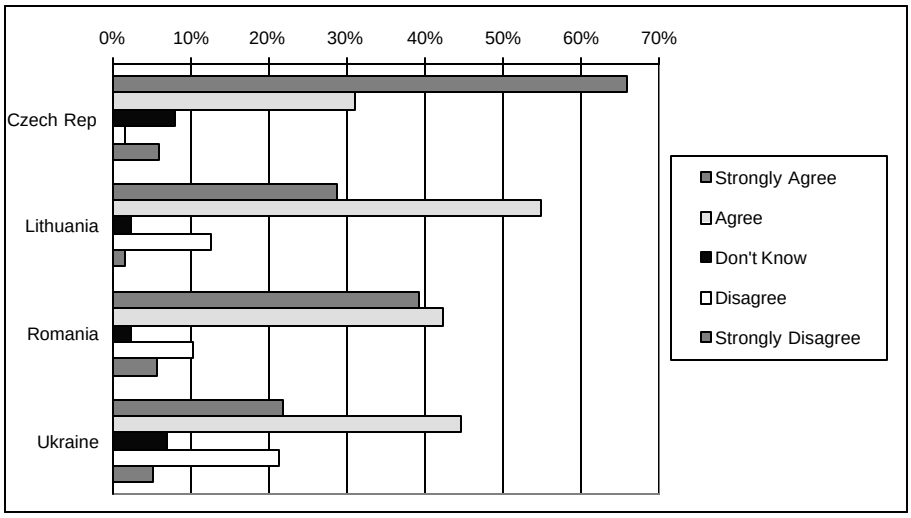
Nearly all those questioned in the four countries agreed that one of their greatest worries was whether they could live on their wage (Figure 19). Approximately 90 per cent of Romanian respondents affirmed this, followed by 87.9 from Lithuania, 85.8 per cent of Ukrainians and 64.3 per cent of Czech respondents.

Figure 19. Responses to "To be able to live on my wage is one of my greatest worries"



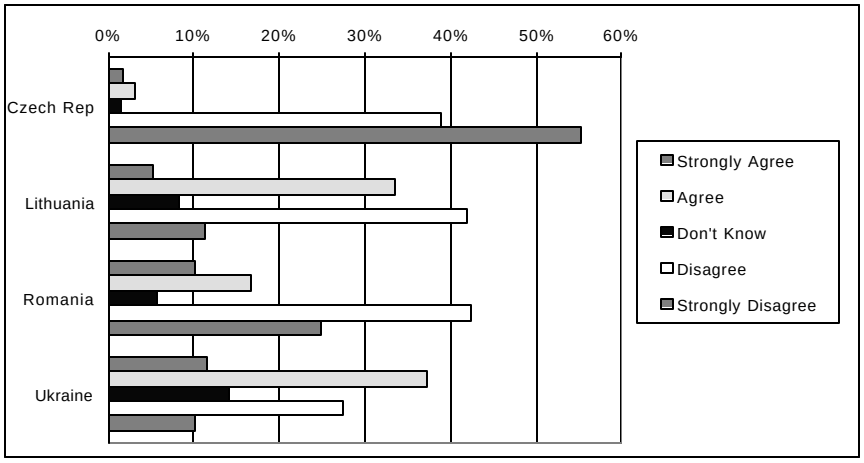
Since there is evidence of non-payment of wages for a number of CEE countries, respondents were asked to comment on the statement that their employer always paid them on time (Figure 20). The highest percentage of respondents disagreeing with this statement was in Ukraine with 26.7 per cent followed by Romania (16.0 per cent), Lithuania (14.1 per cent) and, lastly, the Czech Republic (7.7 per cent).

Figure 20. Responses to "My employer always pays my wage promptly"



This pattern was mirrored by responses to the statement that they had experience of not receiving their full pay on time (Figure 21). The percentage of those agreeing was again highest in the case of Ukrainian respondents with 48.5 per cent, followed by respondents from Lithuania with 38.7 per cent and Romania 26.7 per cent. For the Czech Republic, the figure was much lower at 4.7 per cent.

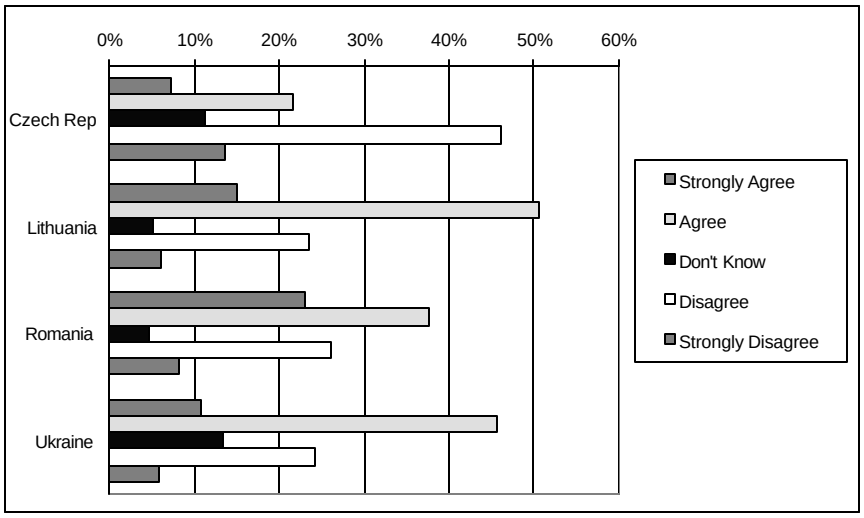
Figure 21. Responses to "I had experience with not receiving my full pay on time"



3.7 Job tasks

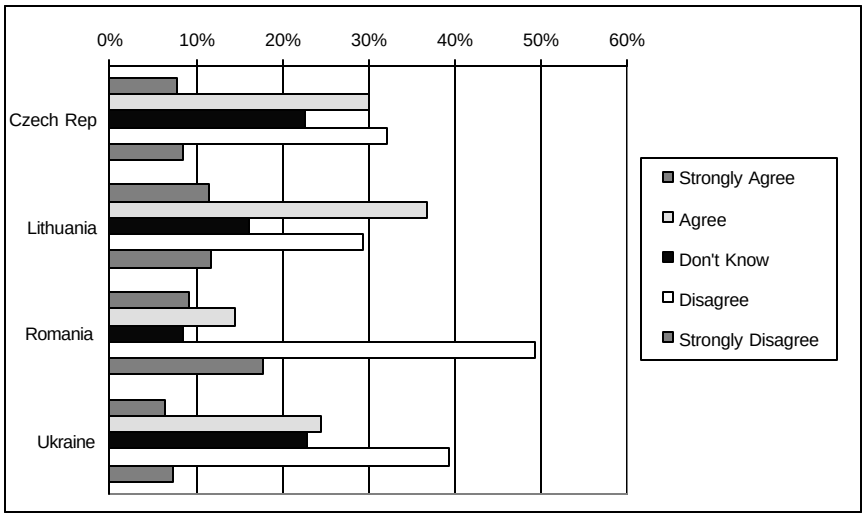
The next series of questions investigated the impact of restructuring on individual respondents. Respondents were first asked whether their job tasks had changed over the past 5 years (Figure 22). The highest percentage of those feeling that they had changed was found in the Czech Republic with 59.9 per cent, followed by Romania with 34.0 per cent, Ukraine with 30.1 per cent and Lithuania with 29.4 per cent.

Figure 22. Responses to "My job tasks have not changed over the past five years"



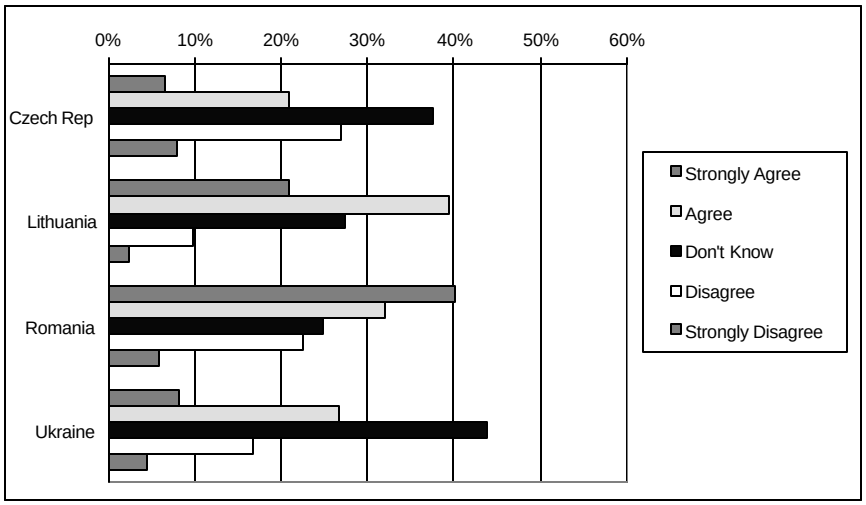
To further clarify the extent of restructuring their workplace had undergone, respondents were asked to comment on the statement that their workplace had undergone massive restructuring, which had affected their job (Figure 23). Opinions regarding this statement diverged. In Lithuania, 48.3 per cent of respondents agreed, followed by 37.8 per cent of Czech respondents, 30.7 per cent of Ukrainians and 23.7 per cent of Romanians.

Figure 23. Responses to "My work organization has undergone massive restructuring which has affected my job"



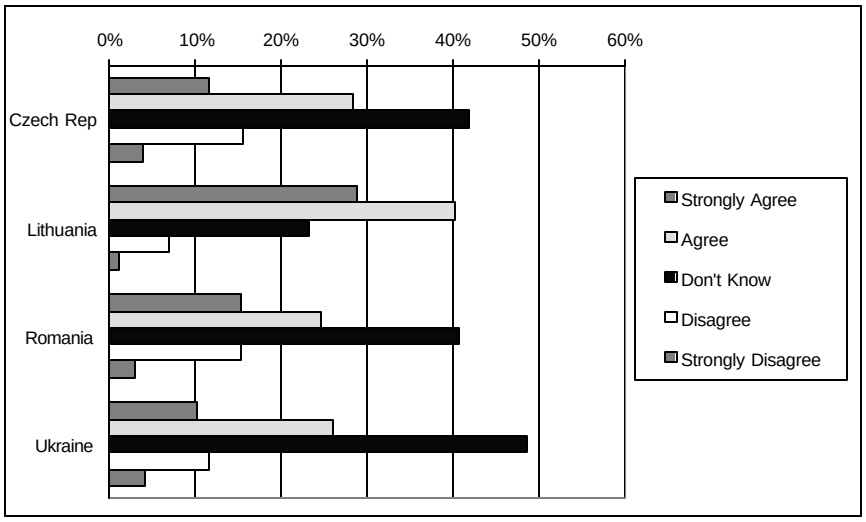
When asked to comment on the statement that they expected future restructuring to further erode their working conditions, (Figure 24) the overwhelming majority of Romanian (72.2 per cent) and Lithuanian (60.4 per cent) respondents agreed. The corresponding percentages for Czech and Ukrainian respondents were much lower at 27.5 per cent and 35.0 per cent respectively.

Figure 24. Responses to "I expect that future restructuring could further erode my working conditions'



In order to gauge expectations about government plans, respondents were asked to comment on whether they expected that existing government plans would make their job worse (Figure 25). While for all countries more respondents think so, this was most pronounced in the case of Lithuanian respondents (69.0 per cent agree), followed by those from Romania (40.0 per cent), the Czech Republic (39.8 per cent) and Ukraine (36.1 per cent).

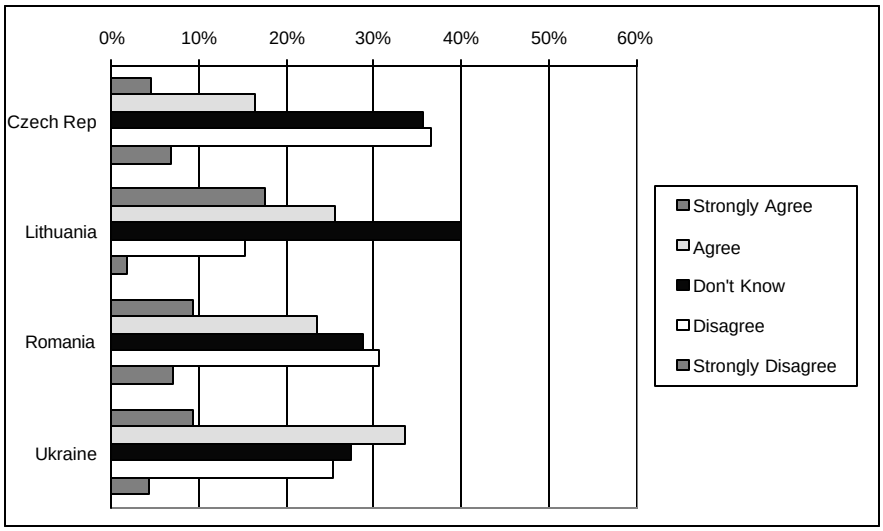
Figure 25. Responses to "I expect that existing government plans will make my job worse"



3.8 Job insecurity

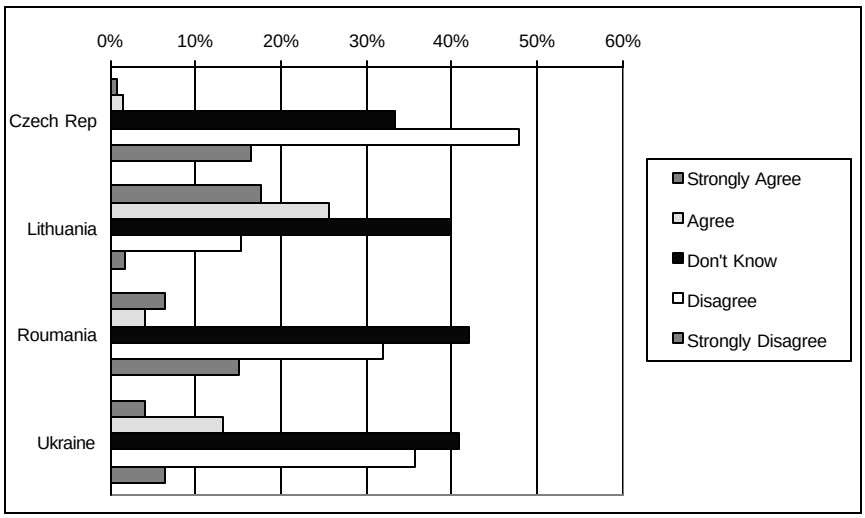
Questions on the nature and extent of job insecurity commenced by asking respondents to comment on the statement that they were afraid of losing their job (Figure 26). The fear of job loss was greatest amongst Lithuanian respondents, where 43.2 per cent agreed with the statement, followed by Ukrainians (42.9 per cent), Romanians (32.9 per cent) and respondents in the Czech Republic (20.4 per cent).

Figure 26. Responses to "I am afraid I could lose my job"



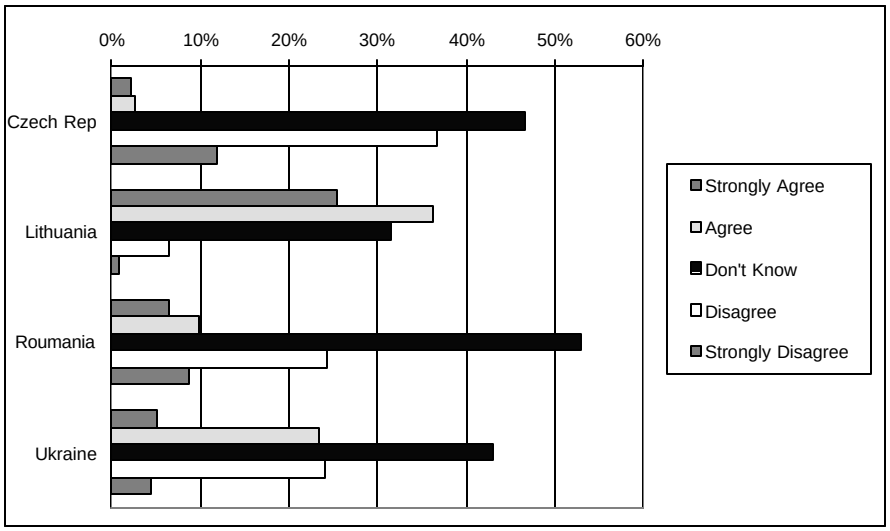
This issue was further investigated by asking respondents to comment on the statement that they could lose their job within one year (Figure 27). The immediate fear of job loss was greatest amongst Lithuanian respondents, where 43.2 per cent of respondents either agreed or strongly agreed with this statement, followed by respondents from Ukraine (17.1 per cent), Romania (10.5 per cent) and the Czech Republic (2.1 per cent).

Figure 27. Responses to " expect that I will lose my job within one year"



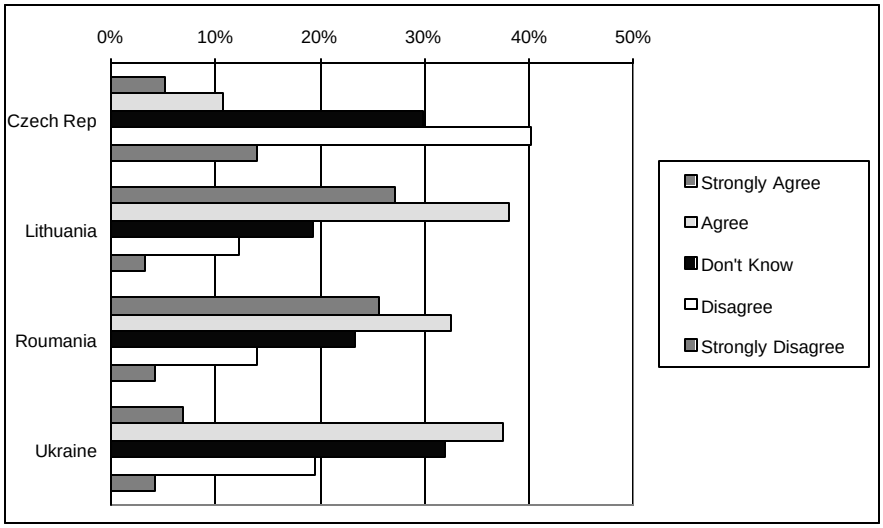
When asked about whether they expected to lose their job within the next 5 years, (Figure 28) Lithuanian respondents again appeared the most concerned (61.4 per cent), followed by lower percentages for Ukraine (28.4 per cent), Romania (16.2 per cent) and the Czech Republic (4.6 per cent).

Figure 28. Responses to "I expect that I will lose my job within the next five years"



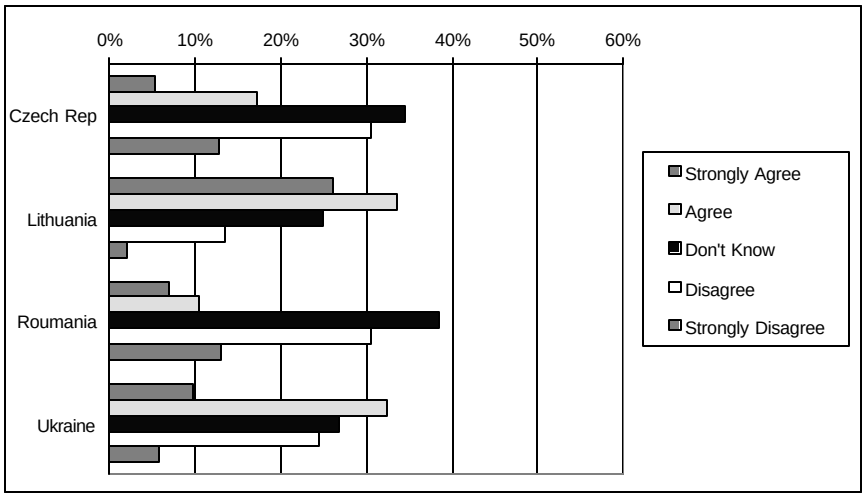
Job insecurity not only results from the direct fear of job loss, but also from uncertainty about finding alternative employment. Respondents were asked to comment on the statement that there was very little possibility for them of finding another job (Figure 29). The highest percentage agreeing with this statement was amongst Lithuanian respondents with 65.2 per cent, followed by those from Romania (58.2 per cent) and Ukraine (44.3 per cent). Czech respondents were the most confident, with only 15.9 per cent agreeing.

Figure 29. Responses to "There is very little possibility for me to find another job"



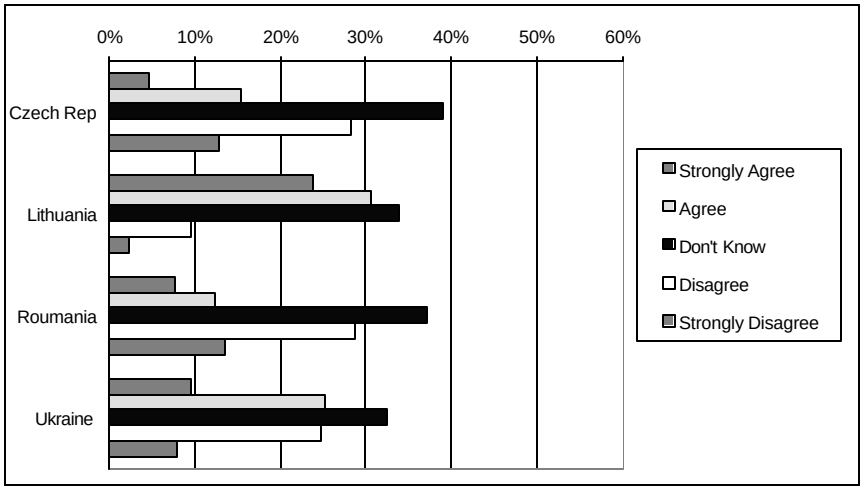
Respondents were next asked to comment on the statement that if they were dismissed, they would have to work in a less qualified job where they could not use their qualification (Figure 30). In Lithuania, 59.4 per cent of respondents agreed with this statement, followed by 42.0 per cent in the Ukraine. The corresponding figures for Romania and the Czech Republic were much lower at 17.5 per cent and 22.3 per cent respectively.

Figure 30. Responses to "I expect that if I am dismissed, I will have to work in a less qualified job where I cannot use my qualifications"



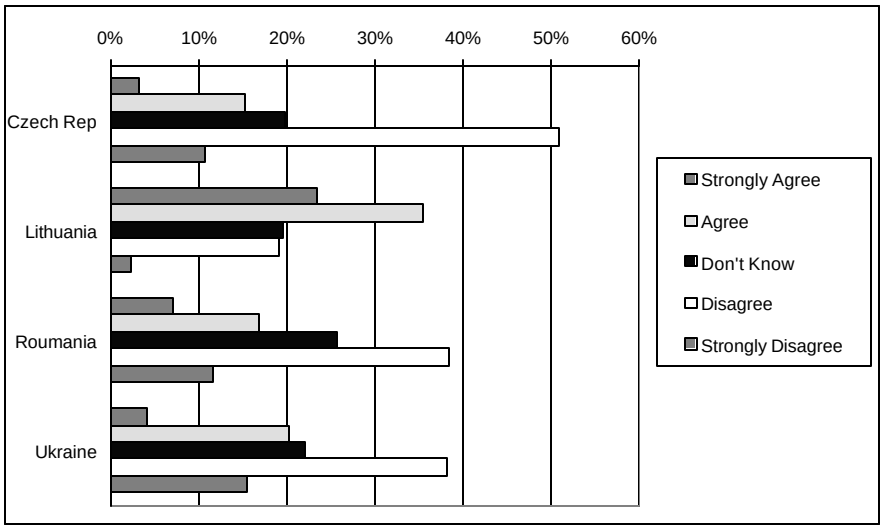
Along similar lines, respondents commented on the statement that, if they were dismissed, they would have to work in a lower paying job (Figure 31). Again, the most pronounced agreement with this statement came from Lithuania (54.4 per cent), followed by the Ukraine (34.8 per cent), Romania (20.0 per cent) and the Czech Republic (19.8 per cent).

Figure 31. Responses to "I expect that if I am dismissed, I will have to work in a lower paying job"



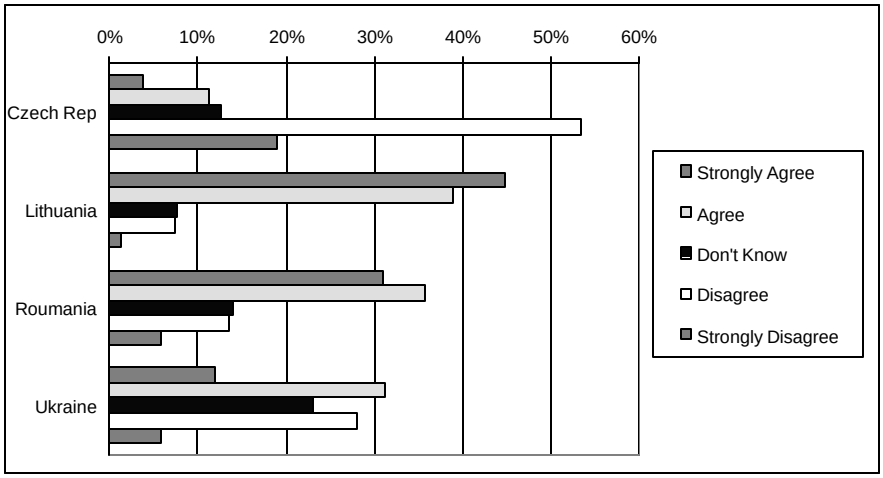
Responses to the question as to whether jobs were felt to have become less secure over the past 5 years (Figure 32) differed widely across countries, with 58.9 per cent of Lithuanian respondents agreeing, followed by 24.4 per cent of Ukrainian, 23.9 per cent of Romanian and 18.5 per cent of Czech respondents.

Figure 32. Responses to "I believe my job became less secure over the last five years"



Finally in this series, respondents were asked to comment on the statement that losing their job was their greatest fear (Figure 33). A total of 83.7 per cent of Lithuanian respondents agreed with this statement, followed by 66.7 per cent from Romania, 43.1 per cent from the Ukraine and 14.4 per cent from the Czech Republic.

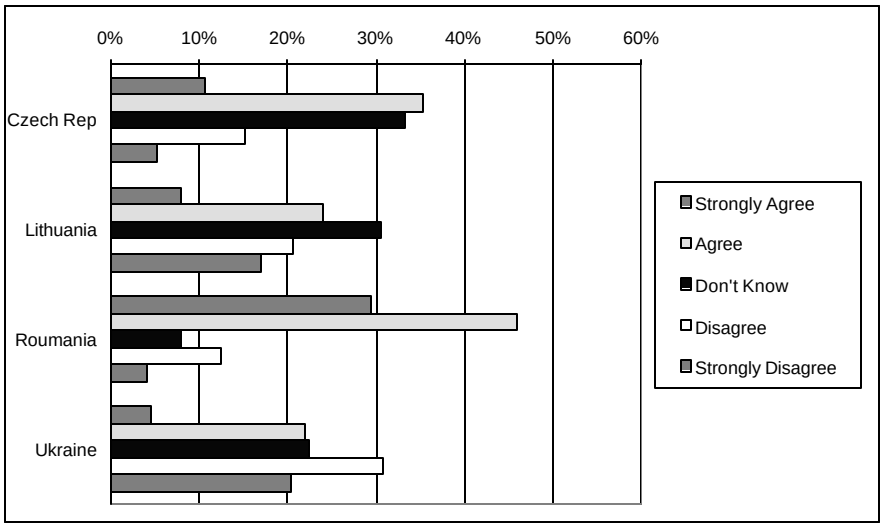
Figure 33. Responses to "Losing my job is my greatest fear"



3.9 The role of unions

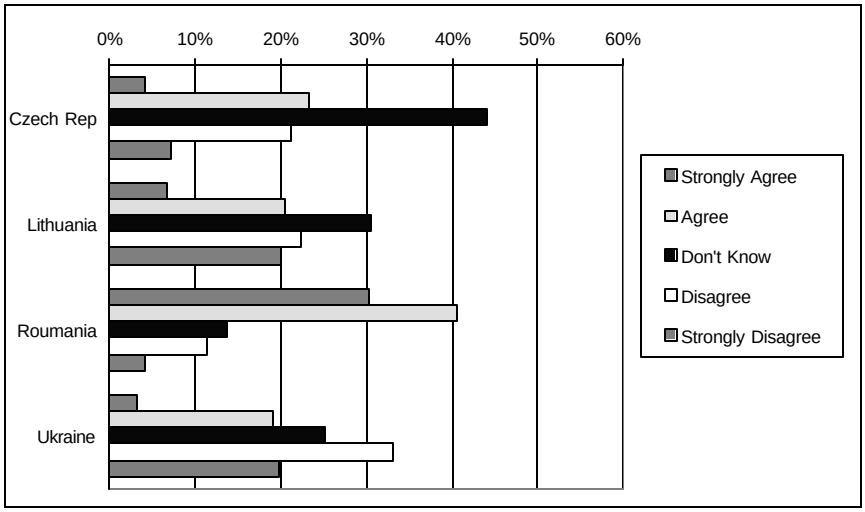
This series of questions focused on respondents' views on the nature and extent of union representation in the workplace. Respondents were first asked to comment on the statement that their organization had an active union (Figure 34). A total of 75.5 per cent of Romanians agreed with this statement, followed by 46.0 per cent of Czech and 31.9 per cent of Lithuanian respondents. Amongst Ukrainian respondents, the corresponding figure was only 26.4 per cent, with over half (51.1 per cent) disagreeing. If the Romanian data are excluded, the picture that emerges is one which is far from reassuring for trade unions. The Ukrainian figure in particular is disconcerting given the high levels of union membership.

Figure 34. Responses to "My organization has an active union"



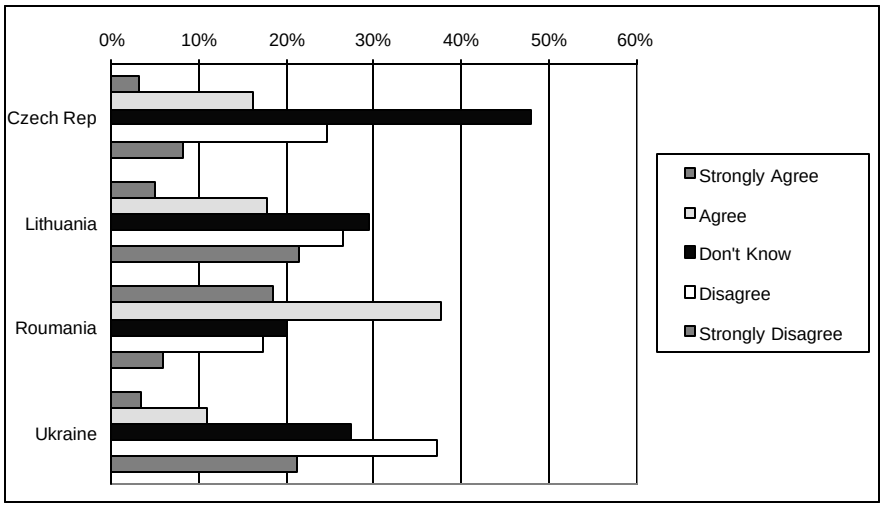
Respondents were then asked to comment on the statement that their union has fought for their working conditions (Figure 35). In the case of Romanian respondents, a large majority (70.9 per cent) agreed, predictably, with this statement. This, however, was not the case for the other three countries, where the corresponding percentages amounted to only 27.4 per cent for Czech, 27.1 per cent for Ukrainian and 22.1 per cent for Lithuanian respondents.

Figure 35. Responses to "My union has fought for my working conditions"



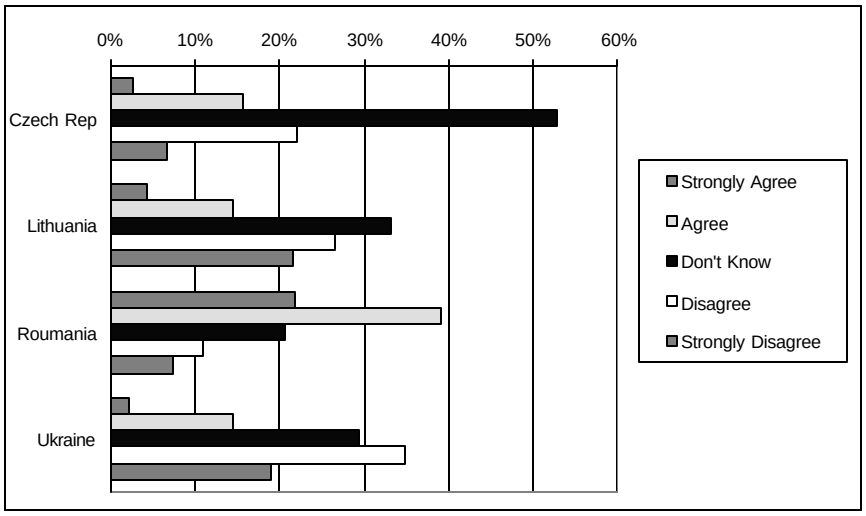
This pattern was closely mirrored by responses to the statement that the union has been successful in defending working conditions (Figure 36). Again, only among Romanian respondents did a majority (56.1 per cent) agree with this statement. The corresponding figure for Lithuania was 22.7 per cent, for Czech respondents 19.3 per cent and for Ukraine 14.2 per cent.

Figure 36. Responses to "My union was successful in defending working conditions"



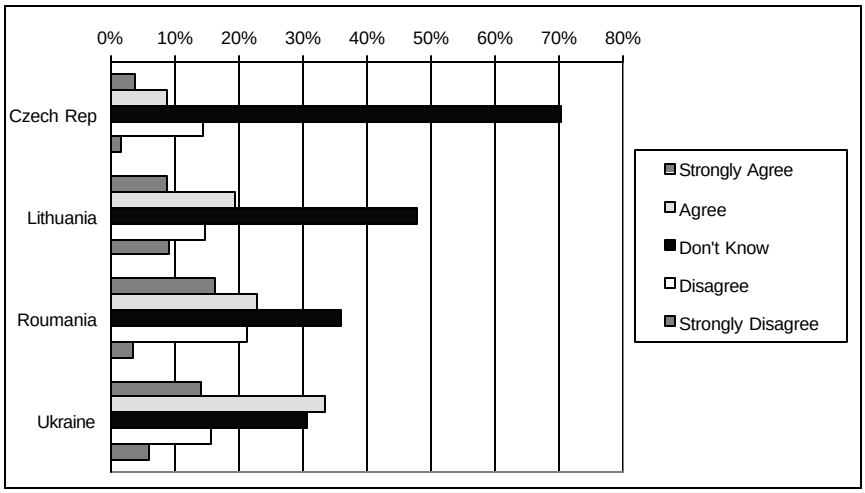
These responses were broadly similar to those drawn from the next question which asked respondents to comment on the statement that their union helped to keep their job safe (Figure 37). Again, only amongst Romanian respondents did a majority (60.9 per cent) agree. The corresponding figures were much lower for Lithuanian (18.9 per cent), Czech (18.2 per cent) and Ukrainian (16.6 per cent) respondents.

Figure 37. Responses to "My union has helped keep my job safe"



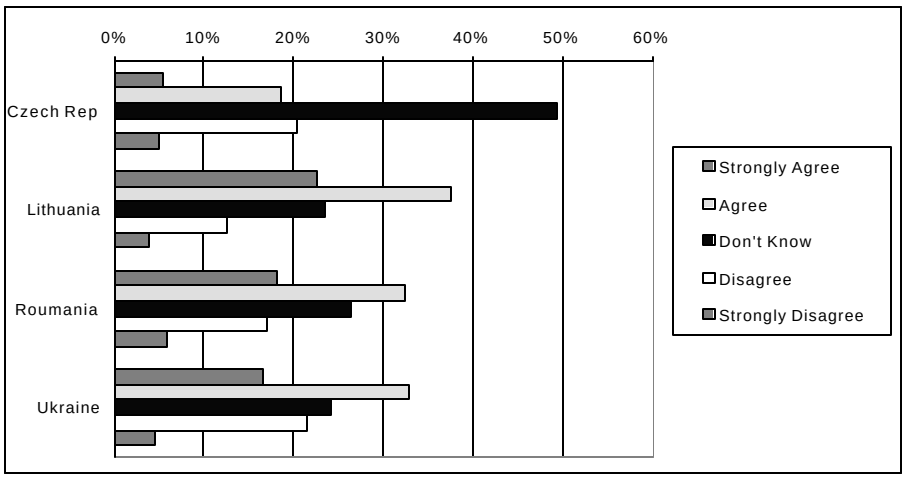
Respondents were also asked to comment on the statement that their union had become less powerful over the past 5 years (Figure 38). Opinions on this were divided. Amongst Ukrainian respondents, 47.7 per cent agreed, followed by 39.4 per cent of Romanian, 28.1 per cent of Lithuanian and 12.6 per cent of Czech respondents.

Figure 38. Responses to "Over the past 5 years my union has become less powerful"



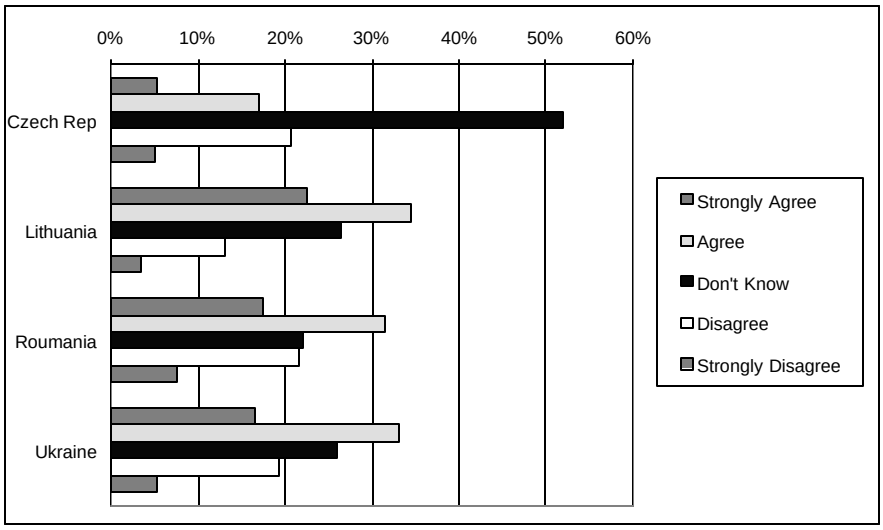
In an attempt to gauge perceptions of management, respondents were asked to comment on the statement that management was less concerned with the needs of workers than it was 5 years ago (Figure 39). With the exception of Czech respondents (only 24.1 per cent approval), this statement found broad approval ratings.

Figure 39. Responses to "Management is less concerned with the needs of workers than it was 5 years ago"



These responses were closely mirrored by reactions to the statement that management was less concerned with the rights of workers than 5 years ago (Figure 40). Here, a total of 56.9 per cent of Lithuanian respondents agreed, followed by 48.8 per cent in Romanian, 45.5 per cent in Ukrainian and 22.2 per cent in the Czech Republic.

Figure 40. Responses to "Management is less concerned with the rights of workers than it was 5 years ago"



4. Conclusion

This analysis set out to include employees from all levels of health care provision, including non-technical and non-specialist support staff as well as medical specialists. For technical reasons, the analysis focused on larger urban hospitals where access could be arranged more easily than in more dispersed health care providers. Despite this focus on large-scale medical providers, the authors believe that the findings give a representative picture of the experiences of the health care labour force in the respective countries.

Various methods were used to explore the position of employees including questionnaires and interviews: these methods offered the opportunity to test the findings from a variety of sources. The benefits, disadvantages and logistical problems with the various methods selected have been discussed earlier. Within the limits of the various methods used, the interview results produced a very different picture to the questionnaire results. The former method – drawing on a maximum of 20 institutional interviews - tends to gloss over problems and often revealed that working practices and conditions were satisfactory; the latter drawing on many hundreds of returns identified far more concerns and provided the most significant findings cited in this study. It is not uncommon for interviews to yield an overly optimistic picture compared with results obtained by anonymous questionnaires. In face-to-face interviews, workers may fear reprisals or job loss for information provided where they can be identified. Conversely, top management on the one hand and government spokespersons on the other, may often be concerned to present an acceptable "official version" of reality to outside inquirers which does not correspond to the views of the workforce.

The perceptions of full-time trade union officials, their lay officers and the membership about working conditions, wages and job security may vary considerably from health unit to health unit, health speciality to health speciality and country to country. The use of questionnaires across a health sector workforce, across managers as well as trade union employees therefore provides a more complete and accurately documented picture of health care problems in transition than would be otherwise the case.

4.1 Outstanding findings

Amongst the most outstanding findings, we note the following:

- The majority of respondents in all four countries either disagreed or strongly disagreed with the statement that, by the standards of their country their working conditions were excellent. This is most pronounced among Ukrainian respondents where 77.7 per cent disagreed, followed by respondents from the Czech Republic with 62.4 per cent, Lithuania with 58.8 per cent and Romania with 51.8 per cent (Figure 9).

- When asked to comment on the statement that taking into account inflation, they were paid less than they were five years ago, more than 75.0 per cent of Romanian, Lithuanian and Ukrainian respondents agreed (Figure 18).

- Many respondents noted that they had experienced not receiving their full pay in time (Figure 21) and a high proportion felt that not being able to rely on their wage was one of their greatest worries (Figure 19).

- A total of 72.2 per cent of Romanian and 60.4 per cent of Lithuanian respondents expected that future restructuring could further erode their working conditions. The corresponding figures for Czech and Ukrainian respondents were around 30 per cent (Figure 24).

- A total of 69.0 per cent of Lithuanian, 40.0 per cent of Romanian, 39.8 per cent of Czech and 36.1 per cent of Ukrainian respondents, felt that future government plans would make their situation worse (Figure 25).

- As many as 43.2 per cent of Lithuanian respondents feared that they could lose their job within one year. The corresponding rates were, 17.1 per cent for Ukrainian, 10.5 per cent for Romanian and 2.1 per cent for Czech respondents (Figure 27).

- A total of 65.2 per cent of Lithuanian, 58.2 per cent of Romanian and 44.3 per cent of Ukrainian respondents noted that they would have difficulty in finding another job if they were dismissed (Figure 29).

- As many as 58.9 per cent of Lithuanian respondents stated that their job had become less secure than it was five years ago. The corresponding rate for Ukrainian respondents was 24.4 per cent, for Romanian respondents 23.9 per cent and 18.5 per cent for Czech respondents (Figure 32).

- A total of 60.1 per cent of Lithuanian, 56.6 per cent of Romanian and 49.6 per cent of Ukrainian respondents felt that management was less concerned with the needs of workers than it was five years ago. The corresponding figure for Czech respondents was lower with 24.1 per cent (Figure 39).

The survey provided a complex picture of the health care system and its impact on employees in the four countries of Romania, Ukraine, Lithuania and the Czech Republic. Health care employees experience common threats, as well as threats unique to the health care system.

Emerging out of the analysis is a complex and differentiated picture of the challenges and problems facing health care workers, which must, for many reasons, be seen as a workforce under threat. The nature of these threats ranges from gross under-payment or non-payment of wages to the fear of job loss without, or with only limited, opportunities for re-employment. Some of these threats are common to the experiences of workers from

all four countries, whilst workers from only one or two of the countries surveyed experience others. Thus, a significant percentage of workers from all four countries identify the ability to live on their current pay and the possibility of losing their job as their greatest concerns, but only in Lithuania and Ukraine do workers attribute a similar importance to not receiving their full pay on time.

Contrary to conventional wisdom, the level to which health care workers experience these threats does not correspond to the level of economic development or prosperity of their respective country. Thus, a higher percentage of respondents from the Czech Republic (by far the most prosperous of the four countries surveyed) note that their working conditions have worsened over the past 5 years (51.8 per cent) or in the past 10 years (55.7 per cent), than do respondents from Romania and Ukraine. Similarly, fewer respondents from the Czech Republic (33.3 per cent) describe their relative annual earnings as above average than respondents from the far less prosperous countries of, Romania (74.4 per cent) and Lithuania (38.1 per cent).

4.2 Threats and challenges

The threats and challenges to the health care workers in each country have been influenced in some respects by the state of the economy, the ideological commitment of politicians to the introduction of market principles in the health care sector and the trade union organizations. Those countries in the study with the stronger economies produced results that tended to show health workers to be less insecure about their jobs and having fewer pay problems. In some countries, the funding and managerial skills necessary to change hospital systems into private concerns were lacking. In other countries, serious early failures with attempts to privatize hospitals led to public opposition. In most countries, the privatization of primary care through the break-up of the polyclinics occurred and the health professionals gaining most from the "transformed" health care systems were general practitioners, dentists, pharmacists and specialists in gynaecology, obstetrics and paediatrics who worked in this sector. Anecdotal evidence indicates that other health professionals and support staff working in this sector now have the worst conditions and operate, even where there are labour codes, in unregulated or minimally regulated settings with long hours and poor pay.

The value, operation and enforcement of labour codes in the health sector merits more detailed study to identify what protection to employees is available and working. Similar work needs to be done to explore the impact of particular trade union organizations on working conditions and wages. Examples of both good and bad practice and effective and ineffective interventions emerged during the study, and it would be valuable to explore these in some detail. For instance, trade union organization of primary care workers has been achieved in some Central and Eastern European countries and not others.

There would also be some merit in a rigorous analysis being carried out that looks not only at the ideological underpinning of state versus private health care provision but also the global and regional performance of privatized and hybrid health care systems and their impacts on health service workers. All too often such systems are presented as unproblematic, successful and of benefit to their workforces, when much evidence exists to the contrary.

It is worth making some preliminary observations on the perspectives and strategies of the international trade union movement for future health care reforms and privatisation. In the West, the word "privatization" has become synonymous with attacks on workers' living standards and security. It has proved impossible to imbue the word with anything other than the most odious connotations. In the newly emerging market economies of Central and Eastern Europe, the picture has been more complex. Like the word "reform"

which it was difficult for any group of workers to be seen to resist openly, privatization had at first been a positive token of the radical separation from the previous system of social planning. However, the smooth rhetoric of the free market produced the harsher reality of catastrophic declines in the health of the population. Here the impact of unbridled market forces in Eastern Europe has caused many to re-examine earlier enthusiasms for all that was new and all that was Western.

In the sphere of health care, the illusion that market forces by themselves can cater for the needs of society in a just and equitable manner has been shattered, if indeed it ever really held sway. What exists today among the health care workers in former socialist countries is a kind of grim heroism in which, against all the odds, they somehow manage to cater for the needs of an increasingly impoverished, desperate and ill population. They do so with less and less resources at their disposal. This is no small achievement. It is a daily-determined and unrecognized sacrifice, physically, emotionally and even financially. It is health care workers, in defending the core value system of their occupation - the basic respect for human dignity and life – who, more than any others, have come face to face with the human consequences of the engulfing tide of legitimized greed and state-sponsored corruption. Those health professionals, who have sought to ride the tide of market forces for their own enhancement, have done so not only at the expense of their fellow workers, but also at the expense of the social polity which funded, trained and educated them to serve their fellow human beings. Whether they will be called to account remains to be seen.

What is clear, tangible but largely immeasurable, is that in most of the countries surveyed, there is already a rising barely suppressed resentment about inadequate funding and equipment, poor working conditions, lack of job security and low pay. All the essential elements that make health care professionals proud to fulfil their vocation have been devalued and casually discarded by a system of values that looks to the dollar for its agenda of priorities. Too many promises have been given to secure social peace and compliant workforces in the health sector, cynically trading on a sense of commitment. The promises have not been delivered. Once again, ordinary health care workers, against their inclinations and even prejudices, are looking to collective forms of action to reassert their right to decent conditions and pay and to basic work security. The opportunity is there for trade unions to take up this challenge and renew their credibility as organizations which defend both the rights of working people and a wider agenda of social equity. The responsibility of the international trade union movement to find new ways to arm and equip trade unions in Central and Eastern Europe for the difficult struggles ahead has never been greater.

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Appendices

Appendix 1. ILO/PSI Health sector employee questionnaire

International Labour Office
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Socio-Economic Security
CH-1211 Geneva 22, Switzerland
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Joint PSI/ILO Health Sector Employee Survey

This questionnaire is part of a research project conducted by the International Labour Organisation and Public Services International into the impact on the workforce of health care reforms in four countries, Lithuania, Ukraine, Czech Republic and Romania. The results of this questionnaire are intended to assist in strengthening the capacity of the trade union movement and employees in the health care industry to influence actively the process of health care reform.

We thank you for your co-operation in answering these questions.

1.) Your Personal Details

a) *Are you*: Female ☐ Male ☐

b) Which of the following **age group** do you belong to:

Below 25 ☐ 45 to 55 ☐ 25-35 ☐ Over 55 ☐

c) How much of your working life have you spent working for the public sector:

All ☐ About two thirds ☐ About Half ☐ About one third ☐

d) How long have you worked in health care?

Less than 2 Years ☐ 6-10 years ☐
2 – 5 years ☐ More than 10 Years ☐

e) If different, how long have you worked with your current employer:

Less than 2 Years ☐ 6-10 years ☐
2 – 5 years ☐ More than 10 Years ☐

f) Do you hold a health professional qualification in any of these fields?

Other than Medicine ☐ A Medical Discipline ☐ A Discipline related to Medicine ☐

g) Do you hold a science degree?

Yes ☐ No ☐

h) How would you describe your highest educational qualification?

School Attendance up to age 16 ☐
School Attendance up to age 18 ☐
Completion of a non-university technical/vocational or apprenticeship of:
- Less than 2 years ☐
- Between 2-3 years ☐
- Between 3-4 years ☐
- More than 4 years ☐

Other _____

University Course of:
- Less than 2 years ☐
- Between 2-3 years ☐
- Between 3-4 years ☐
- More than 4 years ☐
- First degree other than Physician ☐
- Second degree other than Physician ☐
- Qualification as Physician ☐
- Qualification as Specialist/Consultant Physician ☐

Please give details (e.g. I attended a 2 year diploma course as radiographer following school attendance up to age 18)

_____

i) Which category most accurately describes your current position?

MEDICAL		NONMEDICAL	
Orderly/Nursing Assistant	☐	Junior Cleaning/Janitorial and related Support Staff	☐
General Nurse	☐	Senior Cleaning/Janitorial and related Support Staff	☐
Specialist Nurse	☐	Manager Cleaning/Janitorial & related Support Staff	☐
Specialist other than Nurse (radiographer, therapist):		Junior Technician	☐
Specialist with rank below Nurse	☐	Senior Technician	☐
Specialist with rank equal to Nurse	☐	Technician with Managerial Functions	☐
Specialist with rank above Nurse	☐	Junior Administrator	☐
General/Unspecialized Junior Physician	☐	Senior Administrator	☐
General/Unspecialized Senior Physician	☐	Administrator with Managerial Functions	☐
Junior Specialist Physician/Consultant	☐	Junior Driving/Transport	☐
Senior Specialist Physician/Consultant	☐	Senior Driving/Transport	☐
Senior Physician acting as Unit Head	☐	Manager Driving/Transport	☐
Trainee/Apprentice in _____		Trainee/Apprentice In _____	
Other _____		Other	

Please give details (e.g. I am a senior radiographer with supervisory function for two assistants)

_____

2.) Your Job

a) Is your Job:

Permanent (for life) ☐ For a fixed period of over 3 years ☐ For a fixed period of less than 3 years ☐

For a fixed period of less than 1 year ☐ Subject to notice at intervals of less than 3 months ☐

b) How many hours do you work approximately per week? _____

c) Do you work overtime?

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐

d) Do you receive pay for overtime work:

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐

e) How many days contractual holidays do you have (including public holidays):

_____

f) How would you describe your annual earnings?

More than 4 times the recorded national average ☐
More than 2 times the national average ☐
Slightly above average ☐
Less than the recorded national average ☐
Less than half the national average ☐
Other _____

Please give your opinion about the following statements:

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
By the standards of my country my working conditions are excellent	☐	☐	☐	☐	☐
By West European standards my working conditions are excellent	☐	☐	☐	☐	☐
Given my country's economic situation, I would not want to risk my employment security by changing my job	☐	☐	☐	☐	☐
I do not think I could find any another job easily	☐	☐	☐	☐	☐
My working conditions have been generally improving	☐	☐	☐	☐	☐
My working conditions worsened over the past 5 years	☐	☐	☐	☐	☐
My working conditions worsened over the past 10 years	☐	☐	☐	☐	☐
I am happy with my current hours	☐	☐	☐	☐	☐
I wish I could work more flexibly	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
I am very concerned with the amount of overtime I work	☐	☐	☐	☐	☐
I am happy with my current pay	☐	☐	☐	☐	☐
Taking into account inflation, I feel that I am paid less than 5 years ago	☐	☐	☐	☐	☐
To be able to live from my wage is one of my greatest worries	☐	☐	☐	☐	☐
My employer always pays my full wage promptly	☐	☐	☐	☐	☐
I had experience of not receiving my full pay on time	☐	☐	☐	☐	☐
I had frequent experience of not receiving my full pay on time	☐	☐	☐	☐	☐
Not receiving my full pay on time is one of my greatest worries	☐	☐	☐	☐	☐
My work conditions have not changed over the past 5 years	☐	☐	☐	☐	☐
My job tasks have not changed over the past 5 years	☐	☐	☐	☐	☐
My work organisation has undergone massive restructuring which has affected my job	☐	☐	☐	☐	☐
Restructuring has already had a negative impact on my working conditions	☐	☐	☐	☐	☐
I expect that future restructuring could further erode my working conditions	☐	☐	☐	☐	☐
I expect existing government plans will make my job worse	☐	☐	☐	☐	☐
I am afraid that I could lose my job	☐	☐	☐	☐	☐
I expect that I will lose my job within one year	☐	☐	☐	☐	☐
I expect that I will lose my job within the next five years	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
There is very little possibility for me to find another job	☐	☐	☐	☐	☐
I expect that if I am dismissed, I will have to work in a less qualified job where I cannot use my qualification	☐	☐	☐	☐	☐
I expect that if I am dismissed, I will have to work in a lower paying job	☐	☐	☐	☐	☐
I believe that my job has become less secure over the last year	☐	☐	☐	☐	☐
I believe that my job has become less secure over the last 5 years	☐	☐	☐	☐	☐
Losing my job is my greatest fear	☐	☐	☐	☐	☐
My organisation has an active union	☐	☐	☐	☐	☐
My union has fought for my working conditions	☐	☐	☐	☐	☐
My union has been successful in defending my working conditions	☐	☐	☐	☐	☐
My union has helped keep my job safe	☐	☐	☐	☐	☐
My employer listens to my union	☐	☐	☐	☐	☐
Over the past 5 years my union has become less powerful	☐	☐	☐	☐	☐
Management is less concerned with the needs of workers than it was 5 years ago	☐	☐	☐	☐	☐
Management is less concerned with the rights of workers than it was 5 years ago	☐	☐	☐	☐	☐

We would like to thank you sincerely for your assistance in filling out this questionnaire. If you would like to know the results of this study please you can contact your trade union representative or the ILO/PSI representative who will receive our report in due course.

Charles Woolfson, Andrew Watterson and Matthias Beck (ECOHSE)

Appendix 2. Interview schedule

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Trade Unionism and Health Care Privatization

Interview Schedule

This interview is part of a research project conducted by the International Labour Organisation and Public Services International into the impact on the workforce of health care reforms in four countries, Lithuania, Ukraine, Czech Republic and Romania. The results of this study are intended to assist in strengthening the capacity of the trade union movement and employees in the health care industry to influence actively the process of health care reform.

We thank you for your co-operation in answering these questions.

Matthias Beck, Andrew Watterson, Charles Woolfson

Health Care Facilities

In your experience can you identify any noticeable changes – for better or worse – in health care facilities that have taken place in your country as part of a process of health care restructuring?

a) In the primary health care sector (i.e., what would be known as 'frontline' services). For example, this includes regional or district hospitals/community clinics and/or local doctors

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b) In the secondary health care sector (i.e. with reference to services that require a doctor's referral). For example, this would refer to the services provided in general hospitals.

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c) In the tertiary health care sector. For example, this sector would be where you looked for specialist medical care that would be provided at a separate institution from any of the above.

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Are management sufficiently skilled in administration and finance to cope with the new changes?

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Has there been?

a) Change in the use management functions regarding financial and administration duties

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b) Reduction of staff

- Medical
- Nursing
- Lab
- Admin and clerical
- Support staff

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c) Budget cuts

- Unit
- Ward
- Hospital
- Area
- Region
- Other place

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d) Closing of facilities (this includes facilities that are underused and also facilities that are being used regularly)

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e) Reduction of beds or facilities (ask respondent to specify - acute/long-term/ long stay)

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f) Reduction of services (ask respondent to specify clinical/ medical/ nursing/ lab/ admin/ catering/ cleaning/ building maintenance/ porters/)

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g) Introduction of new payment for services

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h) Changes in insurance arrangements

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Is there a difference between in the impact of health care reforms when you compare urban and rural areas? Consider, for example, the relative impact of the closure of hospitals, polyclinics and health posts?

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Do you think it is important if your location in this regard is, for example, the capital city, or a major city? For example, would you believe that proximity to capital as a better base for funding?

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Privatization of ownership

What is the private share of health expenditure?

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Has there been privatization in the following:
a) Drug sector

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b) Facilities (ask respondent to specify, e.g. Clinical/lab/acute/A&E/chronic - young and old? Mental health services and learning disabilities)

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c) Private payments (co-payments) based on ability to pay [an increase in private payments? Eg patients and their families often paying surgeons and physicians for treatment and staff for food or brought in own food, etc.]

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Trade union responses and social dialogue

What has the general trade union strategy towards health service reform been?

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How far has there been social dialogue in implementing changes? With whom and how effective do you assess it has been?'

a) at national governmental level do unions participate in legislation and system design specifically with regard to health?

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b) at health sector level do unions participate in the implementation of legislation
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c) at facility level do unions participate in day-to-day decision making
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Have trade unions responded to changes in health care in a united or fragmented way?
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Has there been the job losses in terms of union members?
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How far has the role of workplace union representatives altered? And in what ways?
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Have new structures of consultation with the workforce been imposed or emerged?
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Are workers representatives involved in managerial bodies? If so, which?
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Are some groups e.g. doctors, much better represented than others?
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Employment and working conditions

How do salary levels of health care workers compare to other sectors?
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Is there a 'brain drain' of qualified staff? And have qualified medical staff 'migrated' into other sectors of the economy to get by?
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Are there other groups of workers in the sector who seek employment abroad?

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Are wages and salaries paid on time?

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Are there areas of over-employment and 'hidden unemployment'?

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Are there areas where there are shortages as a result of the reforms? E.g. too many doctors but not enough nurses/ doctors doing nurses work

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Is occupational health and safety of the workforce adequate?

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Are staff being asked to work harder in their posts? Could you give an example in comparison to the past?

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Are vacant posts being filled or left empty?

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Are staff being required to take on new roles and functions?

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Are training facilities provided for staff?

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Are there programmes for skill upgrading and professional development?

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Have there been changes in contractual arrangements?

a) growth in part-time work
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b) growth in temporary contracts
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c) growth in flexible working arrangements
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d) reduction in pay rates
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e) imposition of new shift arrangements
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f) extension of working hours
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h) imposition of unpaid leave
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