# Failing Health Systems: Failing Health Workers in Eastern Europe

Report on the Basic Security Survey
for the International Labour Office and Public Services International
Affiliates in the Health Sector in Central and Eastern Europe

**By**

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December 2001

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ISBN 92-2-113059-2

First published 2002



Printed by the International Labour Office. Geneva, Switzerland

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# 1. Introduction

## 1.1 Background to the report

Over the past ten years the countries of Central and Eastern Europe (CEE) and Commonwealth of Independent States (CIS) have all embarked upon health sector reforms. Inevitably, these reforms have had an enormous impact on the workforce. The International Labour Organization (ILO) and Public Services International (PSI) have taken a lead in responding and have begun to assess how change, (the process of structural adjustment and privatization), has affected representation, remuneration, working time, career development and occupational health in the health sector.

This work is now being taken forward by the ILO InFocus Programme on Socio-Economic Security (IFP-SES) and PSI who have developed the current project, to address in detail the impact of the decade-long reform process on workers' security.

## 1.2 Rationale for the report

Health sector reforms have, at least in theory, been inspired by the desire to improve the quality of care and to replace a highly centralized (*Semashko*) model of provision with a more responsive and effective approach to service delivery. However, the need to reduce overall costs and to achieve greater efficiency has also been a prime motivating factor. The last ten years of health sector reform have seen:

- expenditure falling in real terms in the context of economic decline;
- governments maintaining low wages, and in some cases introducing long delays in payment, for personnel at least in part as a means of depressing costs;
- reliance on labour-intensive rather than capital-intensive approaches to service delivery, that, while they maintain job numbers, also keep pay low;
- little or no investment in new facilities or equipment, compromising health and safety;
- pressures to substitute primary care and preventive services for more expensive secondary care (Healy and Humphries, 1997).

Steps taken by government have included decentralization, reorganization of primary care, the introduction of insurance-based funding and the emergence of private models of health care provision, which at the very least have created a great deal of uncertainty for the workforce.

This report uses empirical evidence to quantify and assess the impact of reforms on health workers' security as defined by the seven IFP-SES socio-economic components (see below).

## 1.3 Scope of the report

The Basic Security Survey (BSS) was developed around the IFP-SES framework to explore the seven distinct dimensions of socio-economic security (ILO, 1999):

- Labour market security: Adequate employment opportunities, through state-guaranteed full employment, or at least high levels of employment ensured by macro-economic policy;
- Employment security: Protection against arbitrary dismissal, regulations on hiring and firing, imposition of costs on employers, etc.;
- Job security: A niche designated as an occupation of "career", plus tolerance of demarcation practices, barriers to skill dilution, craft boundaries, job qualifications, restrictive practices, craft unions, etc.;
- Skill reproduction security: Widespread opportunities to gain and retain skills, through apprenticeships, employment training, etc.;
- Work security: Protection against accidents and illness at work, through safety and health regulations, limits on working time, unsociable hours, night work for women, etc.;
- Representation security: Protection of a collective voice in the labour market, through independent trade unions and employer associations incorporated economically and politically into the state, with the right to strike, etc;
- Income security: Protection of income through minimum wage, wage indexation, comprehensive social security, progressive taxation, etc.

The questionnaire was sent to 35-PSI trade union affiliates in order to collect country-by-country data for the period 1990 to 1999. Replies were received from Armenia, Belarus, Bulgaria, Croatia, Czech Republic, Kyrgyzstan, Georgia, Latvia, Lithuania, the Republic of Moldova, Poland, Romania, the Russian Federation, Slovakia and Ukraine. The replies are the subject of this report.

The report also provides the background "story". Secondary sources used include the VoiceNet questionnaires of IFP-SES, which examine the overall socio-economic security of the economically active population in selected countries and WHO and European Observatory on Health Care System studies, which provide technical evidence on the thinking behind changes in health policy. This material provides an account of the diversity of health care provision across CEE and CIS as well as of the *raison d'être* of health reform, which set the employment issues discussed in context. The report also explores the correlation between organizational structures and workers security.

In parallel to this report, four in-depth country studies have been conducted in selected health care facilities in the Czech Republic, Lithuania, Romania and Ukraine, based on interviews and surveys of management, government representatives, union officials and worker representatives as well as individual employees (Beck et al., 2002).

The results of the survey work and the in-depth country studies were considered at a Technical Review at the ILO in Geneva, December 2001, where recommendations and future directions were formulated.

## 1.4 Structure of the report

This report is divided into six parts. Chapter 2 addresses the socio-economic conditions across the region while Chapter 3 deals with human resources pressures, as seen through the eyes of health system analysts. Structural reforms are examined in Chapter 4 with special emphasis given to the impact of privatization. In Chapter 5 the report turns to the survey for evidence on the changes taking place as regards the seven security dimensions. The conclusions of Chapter 6 are followed by an annex summarizing the socio-economic conditions in the health sector for each of the countries that participated in the survey.

# 2. The CEE and CIS context

## 2.1 The countries of CEE and CIS

The countries of CEE and CIS are diverse in culture, history and economic strength. They include groups as distinct as the Baltic States and the countries of the Caucasus, the Central Asian Republics and candidate countries for accession to the European Union. Size of GDP, dependency on industrial or agricultural production and the extent of structural adjustment all vary enormously. Patterns of change have differed and many have been embroiled in civil wars or refugee crises. Yet despite their diversity there are common circumstances and challenges that affect their respective workforces.

All have been profoundly marked by their experience of central planning and are experiencing immense upheavals as the transition to market economies takes place. Typically before 1989

- ownership of the means of production was public and agriculture was largely collectivized with only limited experiments in private ownership and trade;
- command economies operated through highly centralized planning and with a degree of inherent inefficiency associated with the model, (although there were variations, notably self-management in Yugoslavia);
- there was a profound reliance on established norms and quotas and little opportunity for innovation;
- there was full employment and centrally determined rates of pay which rewarded "productive", industrial workers more highly than the "unproductive" (including those in the health sector);
- an extensive informal economy existed in parallel to the formal economy, with widespread reliance on under-the-table or gratitude payments.

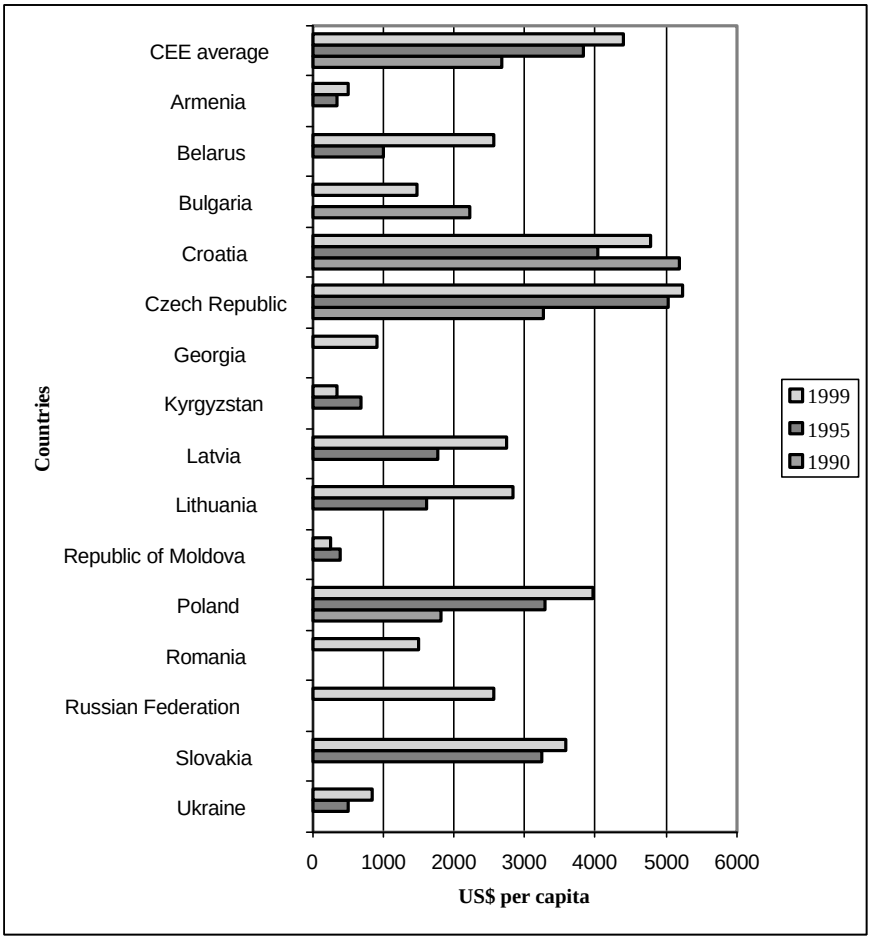
The collapse of communism saw immense economic dislocation and the failure of much of the industrial infrastructure in place. The break up of the Former Soviet Union (FSU) had a particularly profound affect on its constituent Republics where industrial undertakings had often formed part of a USSR-wide chain of production. Agriculture was also profoundly affected with pressures to return collective farms to individual ownership, the fracturing of supply chains and markets and the uncovering of evidence on the environmental degradation caused by Soviet experiments with monoculture.

The early 1990s saw spiralling inflation across the CEE and CIS. Disruption in employment was overwhelming with widespread reliance on administrative leave, which saw staff sent home often without pay yet never able to register as formally unemployed. Many workers were paid late, often as much as 3 months in arrears.

Responses to the disruption varied considerably, depending, amongst other factors, the degree of development achieved by 1989 and the role of Western European and international institutions. Of the countries returning the questionnaire the Czech Republic and Poland have realized the most radical overhaul of their economies and are now well advanced in their negotiations to join the European Union. Lithuania and, to a lesser extent, Croatia, Latvia and Slovakia have also gone a long way towards achieving structural adjustment as promoted by institutions like the World Bank and the IMF. The war in Croatia notwithstanding, these countries typically had considerable infrastructure development and strong geographic or historical access to Western capital. The other countries responding to the questionnaire have seen slower progress in GDP growth and

have tended to adopt incremental approaches to reform. Some economies have still to return to 1989 levels (figure 1).

**Figure 1. Gross Domestic Product by country, 1990-1999 in US$ per capita**




Source (WHO, 2001).

## 2.2 The health context

Despite their economic diversity, CEE and CIS countries had an extraordinary degree of commonality in their health care systems prior to 1989. This was a direct result of the political commitment to providing free health care wi th guaranteed, universal access and comprehensive cover. The changes that have taken place since, and in particular the impact on the health sector workforce, must be seen in the context of the system, as it existed in the 70s and 80s. Provision across countries was along similar lines, and drew heavily on the Soviet *Semashko* model which meant:

- citizens were guaranteed access to a full range of preventive, curative and rehabilitative services free at the point of use, normally through a network of primary care posts, ambulatory clinics offering primary and specialist outpatient care (polyclinics) and hospitals. Primary care featured in the system but was generally under-developed;
- financing of the system was tax-based with funding channelled through central and local government. There were also parallel health systems funded and run by other Ministries and by large enterprises;

- central planning was all but universal and resource allocation was determined in line with detailed norms based on population levels, leaving little decision-making capacity at local level;
- numbers of beds, institutions and staff were set out by the respective national Ministry of Health and implemented by regional/local government;
- considerable over-provision of hospital beds, due to the traditional emphasis on communicable disease and a funding system based on global budgets which were increased through historical incrementalism and favoured large institutions;
- crucially, the health sector was defined as non-productive and workers were remunerated on pay scales significantly lower that those applying in industry. A majority of doctors were female, (although men typically filled the most senior positions), and this may have exacerbated the pay issue as women earned less than men on average;
- labour rather than capital intensive provision with high bed and staff ratios to population because of a lack of incentives for efficiency and low staff costs (Saltman and Figueras, 1997).

Health care systems experienced a huge dislocation on the collapse of the centrally planned economies in line with the wider environment. The early 1990s saw little if any maintenance of health care facilities and very low levels of capital investment in equipment. Heating, cleaning and maintenance services were often inadequate and supplies of pharmaceuticals and other goods erratic. In many cases this pattern of under-investment persists. Health sector staff, particularly in the FSU, were often put on administrative leave or paid in arrears and there was widespread reliance on patients paying out-of-pocket for essential supplies and giving under-the-table gratuities to staff. Health care systems were clearly not coping and this added to the impetus for reform and restructuring that already existed.

These pressures for change were linked to the wider restructuring of CEE and CIS societies and to moves to rationalize public services like health, which made such a huge call on resources. They were also about a desire to decentralize as a conscious rejection of central planning and as a means of responding better to patients' needs and demands for quality and efficiency.

Not least among the factors contributing to the desire for change was the dramatic crisis in health status that afflicted CEE and CIS in the early years of transition. Life expectancy in all 15 countries studied fell dramatically although there was some subsequent recovery. In particular, there were extremely high levels of excess and premature mortality in middle-aged men. This has been explained in terms of the stress of dislocation (Chenet et al., 1996), often accompanied by alcohol use and violence. This health crisis placed additional pressure on health sector workforces, creating extra demand and exposing staff to traumatic situations. Health sector workers would also suffer the stress and other factors linked to excess mortality.

There has also been debate about the extent to which health sector failures may have contributed to poor health outcomes. However, it is extremely difficult to attribute outcomes to a single, causal factor because health is the result of so many wide-ranging determinants. It is certainly the case that health expenditure fell at a time of increasing need.

These pressures led to a range of reform initiatives. The extent to which reforms were implemented varies across the countries responding to the questionnaire. Nonetheless, common themes include attempts to downsize the health sector; decentralization; a shift from tax-based to social health insurance systems; privatization of elements of health

services and the introduction of formal out-of-pocket payments, through co-payments and user-fees. These changes have often affected the resource allocation mechanisms in place and might be expected to affect the payment of hospitals and doctors, with consequent effects on the socio-economic security of staff.

## 2.3 Socio-economic security

Reforms in the health sector and their impact on health care staff should be seen in the context of the socio-economic security of all workers in the period of transition, which was accompanied by widespread hardship, typically including spiralling inflation, the closure of heavy industries and an end to old certainties. Workers from all sectors experienced an often-precipitous decline in standards of living, which appears to have undermined their health and their ability to pay for health services (whether through taxes or out-of-pocket payments). Despite the consolidation of the last decade, political instability, slow economic recovery interspersed with periods of downturn, and in some cases changes in national boundaries and population displacement, have limited growth in many of the countries concerned.

Clearly, with the ending of state guarantees of full employment, labour market security could only diminish yet the SES study shows that the degree of security remaining varied considerably at the end of 1999.

The economically active population (EAP) has declined in some of the countries surveyed (Armenia, Georgia, the Republic of Moldova, Ukraine) due to migration, and in some instances, increasing levels of imprisonment, but overall it is changes in the economically inactive population (EIP), which are the most striking. The EIP has increased dramatically in many countries (Armenia, Croatia, Georgia and the Republic of Moldova) and unemployment has spiralled. There are increases in both registered unemployment and in long term unemployment (Armenia, Croatia and particularly, Lithuania) and even more so in recorded unemployment which is higher when workers perceive there being no benefits associated with formal registration (Armenia, Ukraine). Adding to these totals are those workers concealed from official unemployment estimates, but adding to the numbers of unpaid or partially paid employees. This group, those on "administrative" leave, are particularly prevalent in the Republic of Moldova and Ukraine.

The SES questionnaires also suggest a striking decrease in more secure forms of employment. In particular the category "employees" has fallen as has work in the public sector, while overall part-time work, which often provides less socio-economic security has increased (Armenia, Croatia). Changes in labour market security within the health care system are perhaps less striking when seen in the overall socio-economic context of these countries.

Employment security has also been weakened. Non-regular employment has risen steeply (Armenia, Georgia, Lithuania, the Republic of Moldova) and is often associated with service sector work. Voluntary turnover has declined but the employment market is generally more volatile with reductions in tenure common. Protection against arbitrary dismissal continues to exist but the extent to which entitlements can be called on in practice is undermined by the growth in small employers (Ukraine) who are less likely to have the reserves needed to fulfil their obligations. Certainly, at the beginning of the 1990s there was often a gulf between formal protection and the reality so that established work practices were undermined by the sheer pressures on the economy.

Job security or the protection of skill-areas and careers, has maintained many of the safeguards of the previous era. Indications are that professional and technical staff enjoy reasonable job security, although those in elementary work find it harder to maintain their positions. Associations and unions are entitled to protect workers in employment matters.

Discrimination continues to be formally outlawed in almost all instances including gender. Maternity leave is provided in all cases ranging from 16-18 weeks (Armenia, the Republic of Moldova), to 156 weeks (Ukraine) and women continue to have rights to return to the same position after maternity leave.

The picture as regards skill reproduction has shifted. The numbers completing tertiary education and literacy levels remain high but concerns are raised by a fall in those entering post-secondary schooling in some instances (Armenia) and a drop in uptake of vocational training and apprenticeships (Ukraine). As in the health sector, traditional and established training and continuing education programmes may now experience difficulties at a time when demand for new skills is increasing.

Work security trends are complex with daily absenteeism rates and occupational death and injury rates falling on the whole (Lithuania, Slovakia, Ukraine) with some exceptions (Armenia has decreasing absenteeism and occupational deaths but increasing cases of work-related injury and the Republic of Moldova has increasing male death rates). It is unclear whether the overall improvement is due to the decline in industrial production and the closure of hazardous plants, better conditions, or simply fear of taking time off given falling labour market security. Nonetheless, in most cases there are reported improvements in health and safety mechanisms and in the number of labour inspectors (Armenia, Croatia, Lithuania, Slovakia). Legislation to prevent discrimination against workers with disabilities is also widespread.

Working-time legislation remains robust with the maintenance of public holidays and leave entitlements. However there are widespread concerns about the erosion of entitlement to pension benefits and the numbers of pensioners continuing to work suggests that current pension provision is inadequate.

Representation security has also altered over the course of the last decade. There has been a growth in the number of trade unions coupled with an overall fall in membership, although it is difficult to ascertain the full extent of this decline. Coverage by collective agreements also seems to have fallen although again it is unclear to what extent. The Armenian example (a fall from 95 per cent to 41 per cent) is typical. Only the Ukraine reports restrictions in the right to strike and these only apply to essential public services.

Income security must be seen in light of changes in the other dimensions of socio-economic security and in the context of inflation. Workers' wages are often increasing at face value but it is much less clear how far these increases offset rises in living costs. Gender disparities and inequality as measured by the Gini coefficient may highlight areas of concern (Armenia, Ukraine). Even where there is a statutory minimum wage, workers have received wages below this level (Bulgaria, Georgia, Lithuania, the Republic of Moldova) and the contributions based insurance schemes in place do not always guarantee payment of benefits (Armenia, Croatia, Georgia, Slovakia).

Socio-economic security across the region can be typified as bleak. In particular, the early 1990s witnessed large numbers of lay-offs and extensive use of administrative leave. Wages were not indexed to inflation and were frequently paid two to three months in arrears. While the worst insecurities may have diminished in some countries over recent years, significant socio-economic difficulties for the majority of workers still persist.

# 3. Human resource pressures in the health sector

## 3.1 Health – a distinctive sector

The evidence of a general erosion of workers' socio-economic security across CEE and CIS is compelling, and inevitably workers in the health sector face many of the insecurities felt in the wider workforce. Health systems and health sector staff have experienced additional consequences of reform imperatives as public sector service providers at a time of structural adjustment and as part of a unique and peculiar market for health care. The rationalization of health care has therefore included pressures on human resources, which stem from the atypical nature of health care provision.

Human resource issues examined from the perspective of health system analysts have a particular slant and the definition of terms and issues has not always been harmonious with labour economics literature. This section of the Report explores human resource issues, as seen through the eyes of health analysts, and identifies points which touch on socio-economic security.

Unsurprisingly, the reform of health care systems in CEE and CIS countries has not been driven by the socio-economic needs of the workforce (German Foundation for International Development, 2000). Rather reforms have tended to focus on cost containment, decentralization or quality of care and this is perhaps understandable given the pressing need to improve the overall performance of health care systems in terms of outputs to patients. Nevertheless, the World Health Organization's (WHO) World Health Report 2000 emphasizes that,

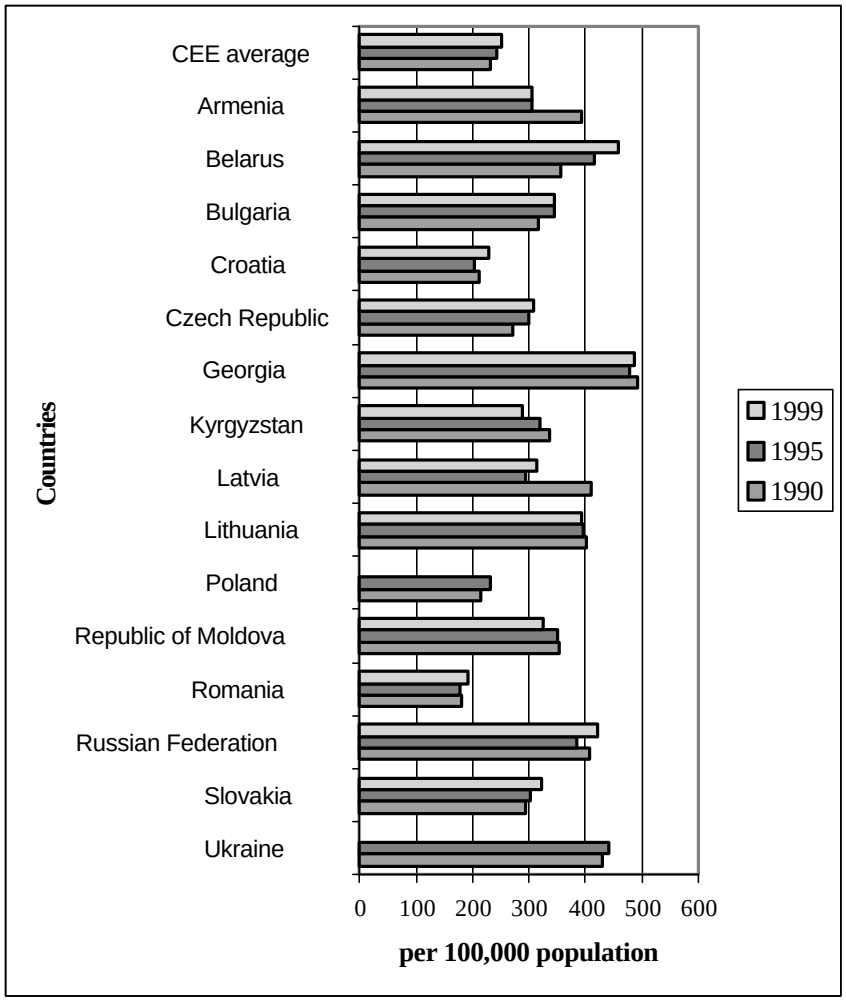
> "Human resources, the different kinds of clinical and non-clinical staff who make each individual and public health intervention happen, are the most important of the health system's inputs. The performance of health care systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering services". (WHO, 2001).

Health system analysts, in recognizing the role of motivation, tacitly acknowledge the importance of the socio-economic security of staff. It follows then that the security of workers will have profound implications for improving care for patients and the efficiency of health care systems.

## 3.2 Staff numbers

It was a fundamental tenet of much of the advice provided to those restructuring the health care systems of CEE and CIS that they had an over provision of beds and crucially, of staff, particularly physicians. This was seen as important not because of salaries alone but because physicians contribute significantly to rising costs (through tests ordered and procedures undertaken). Certainly the levels of doctors to population were significantly higher in CEE than those regarded as appropriate in Western Europe. In 1992, for example the number of physicians per 1,000 population in Latvia, Lithuania and Ukraine was 4.3, 4.3 and 4.5, respectively, higher than in any EU Member State, while even in 1999 after successive waves of reform Belarus, Georgia, and the Russian Federation had over 4 physicians per 1,000 population (figure 2), compared to levels of 3.1, 2.5 and 2.3 in Finland, Luxembourg and Ireland.

**Figure 2. Number of physicians per 100,000 of the population by country, 1990-1999**




Source (WHO, 2001).

The high number of physicians in CEE and CIS is explained by the norms established in the 1970s and a conception of health care that allowed for higher levels of hospitalization and longer lengths of stay than are now regarded as desirable. Furthermore, doctors as "non-productive" labour were an affordable substitute for more capital-intensive approaches to care. Nursing was under-developed and physicians carried out relatively low-tech interventions. In certain hospitals in Tbilisi for example, the ratio of doctors to nurses was virtually one to one (Gamkrelidze et al., 2002). The situation was exacerbated by poor medical resource planning, and the late introduction of limits on medical school places.

Reforming policy-makers were therefore inclined to reduce the numbers of physicians and cut the training places available with obvious implications for labour market security and to a lesser extent for skill reproduction security. The trade-off for reducing physician numbers was expected to be cost containment, a cap on supplier induced demand and opportunities for substitution policies replacing doctors with more cost effective nursing staff. It is unclear to what extent these aims have been achieved but certainly the data suggest that attempts to reduce physician numbers have had limited success (Kanavos and McKee, 1998).

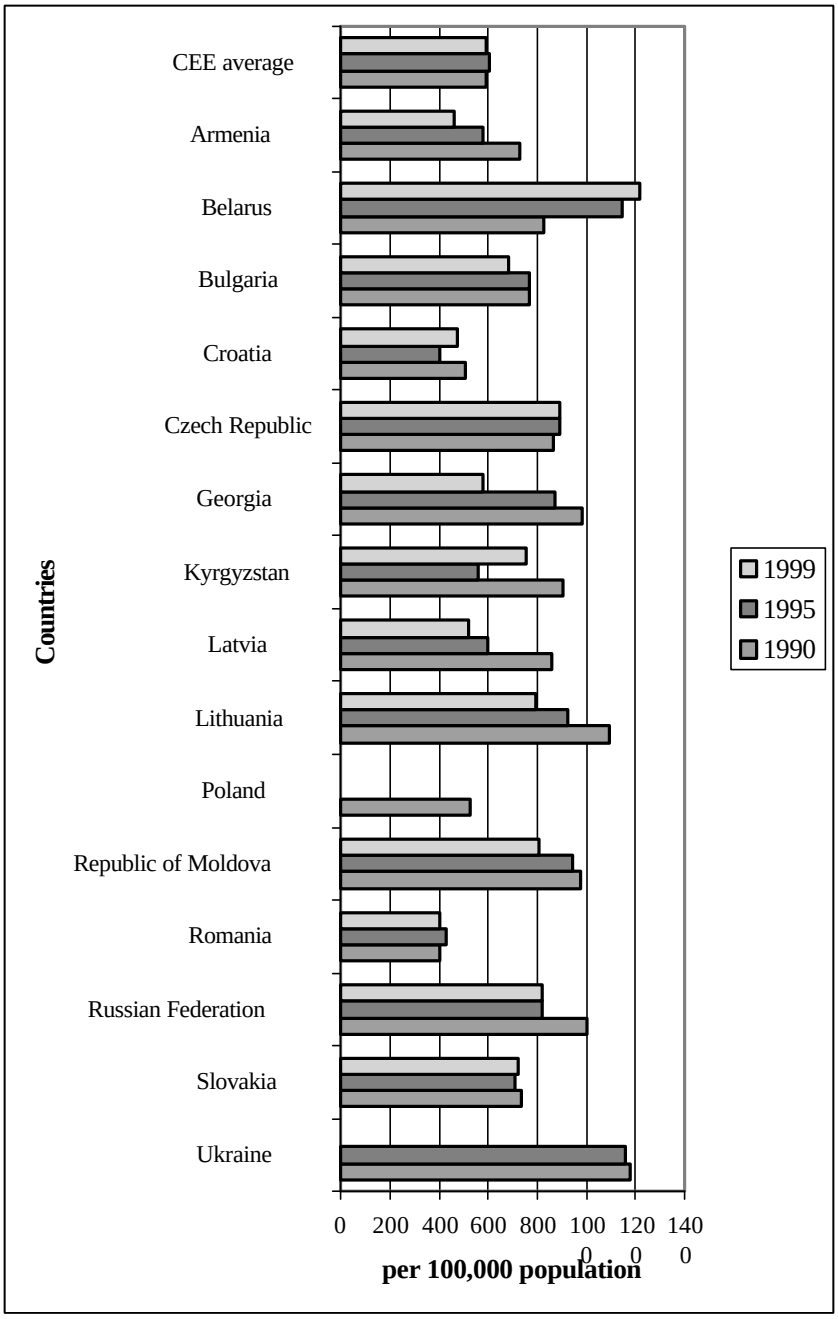
Notwithstanding the focus on physicians, nurses were and continue to be the single most numerous group of health care professionals in the region (figure 3), and they play a significant role as the first and often most consistent point of contact for patients. They do not however, play an important part in determining levels of health system expenditure in the way that doctors do. Nursing in CEE and CIS tended to be a relatively underdeveloped role with nurses rarely approaching the levels of skill or autonomy seen in Western Europe. Most commonly nurses before transition served as relatively unskilled assistants (Armenia, Belarus, Poland, Romania, the Russian Federation) and little distinction was made in the data between fully qualified nurses and nursing auxiliaries. Typically too, they earned significantly less than physicians. However, nursing is seen by international agencies as a cost-effective resource for delivering health care, public health and primary health care services. Increased attention has therefore been given to developing nurses as a professional group (Czech Republic, Hungary, Slovakia) and policy-makers have begun to address the potential to substitute nurses for physicians. This has major implications for job security, in particular for increases in tasks and skill reproduction security as it affects existing staff wishing or obliged to acquire new skills. It also has some impact on labour market security as again, numbers overall are felt to be excessive (Salvage and Heijnen, 1997).

The implications of reform for a sub-set of nurses, called *feldshers*, are less clear. *Feldshers* filled a particular niche in many of the countries of the FSU. They had a standard nursing education plus one year's additional training that allowed them to work as nurse practitioners and perform preventive, diagnostic and therapeutic tasks and carry out midwifery duties with considerable independence. They often took on the bulk of primary health care responsibilities in rural areas. However, changing skill profiles, the redefinition of nurse and physician roles and reforms in nursing education appear to be ruling out the model in favour of increasingly hospital-based technical skills. The job and general socio-economic security of this particular group of nurses must therefore, be severely compromised.

Interestingly, the health systems literature contains little reference to professions allied to medicine. This may be in part because there has been a generalized move of dentists and pharmacists into the private sector meaning they have a diminishing impact on public sector budgets. It may also reflect the fact that physiotherapists, speech therapists and others are seen as playing little role in shaping the costs of the system overall. It is also notable that there is almost no discussion of the numbers or role of administrative or support staff or their impact on health care system performance.

Numbers of doctors however, are regarded as important in terms of health expenditure and performance, and reforms have often attempted to achieve a reduction in staffing levels regardless of the socio-economic security implications. However, evidence of significant decreases in personnel is patchy and in some areas there have been increases, perhaps because freer access to training has raised numbers qualifying (see below) and perhaps because data are complicated by retired staff remaining on professional registers and in work (Georgia, Kyrgyzstan, the Russian Federation).

**Figure 3. Number of nurses per 100,000 of the population by country, 1990-1999**




Source (WHO, 2001).

## 3.3 Skills

The lengthy training involved constitutes a significant barrier for new entrants to the health sector. This affects the market for skills and skill reproduction security. It is also seen by policy-makers as an opportunity to limit staff numbers and to address issues of quality and the mix of specialities provided, with implications for labour market and job security.

Control over access to training has been used successfully to restrict physician (and nurse) numbers in many countries, but in CEE and CIS these controls are relatively weak

and have diminished rather than increased over recent years. A poorly regulated private sector has emerged and has contributed to a proliferation of graduates. Student nurses and doctors continue to enter training in excess of numbers designated by planners in parts of CEE and CIS through private medical and nursing schools. It is unclear what the implications of this will be for skill reproduction and socio-economic security in the longer term as many countries have yet to resolve how they will treat private sector graduates, and if they will allow them to practice at all (Armenia, the Republic of Moldova). It is noteworthy however, that students appear willing to enter training at their own expense despite the fact that reported levels of pay are low and income insecurity high.

This lack of control over student numbers is worrying not only because of the impact on total staff numbers but also because an oversupply of professionals may serve to depress the market for existing staff.

There also appear to be changes in in-service, continuing education. Most of CEE and CIS had a standardized approach to continuing medical education and mandated attendance at periodic, post-qualification courses. Increments in pay that came with increased seniority (i.e. length of service) could only be triggered if the requisite training had been completed. Compliance (in the form of attendance) was apparently high, even where the value of training was questioned. The system initially fell into misuse but a new emphasis on decreasing numbers of specialities, meeting EU standards (particularly for Czech Republic, Lithuania, Poland and Slovakia) and shifting the emphasis from tertiary to primary care have made post-qualification development of real importance. Health sector reforms increasingly address the role and content of training programmes. This enhances skill-reproduction security in that it creates opportunities for gaining and retaining skills, whilst undermining it in that it implies that certain specialities are no longer needed and that certain skills will play a less prominent role in future service provision.

Both the merger of separate sub-specialities (Czech Republic, Poland, Romania) and the erosion of the boundaries between doctors' and nurses' roles have implications for the protection of occupation, skill area and job qualifications. Countries seeking to accede to the European Union will increasingly seek to reduce the number of categories of specialists and demand upgraded skills and qualification levels in the remaining specialities in order to meet EU requirements. This will improve job security for some physicians while decreasing it for others.

Similarly the focus on a more cost-effective use of nursing staff may see job security affected as general physicians and primary care doctors lose areas of responsibility while the responsibilities and tasks of nurses increase. Certainly, policy-makers looking to save costs will want to review more traditional divisions of responsibility and to delegate more medical (if clinically less demanding tasks) to nursing staff. This not only raises issues of job security as regards the relationship between nurses and doctors (with scope for substitution) but also of the role of the different generations of nurses now in practice. Many CEE and CIS countries had two streams of entrants to the nursing professions, depending on how many years of high school had been completed. This calls into question the future role of sub-groups of nurses (or indeed *feldshers*) with different levels of education.

As health system reforms continue to tackle performance they are likely to address imbalances in the division of responsibilities, skill shortages (particularly in management and primary health care) and redundancies in terms of established specialities. These will inevitably impact on socio-economic security. It will be essential therefore, to involve both trade unions and professional associations in negotiations, as any significant reform will need staff backing, if motivation - and therefore capacity - is to be enhanced (Scrivens, 1997).

The need to involve staff representatives and to consolidate job and voice representation security is particularly important as Europe's borders become increasingly porous for health sector staff. The World Health Report 2000 draws attention to issues around movement of staff and notes, "globalization has led to greater mobility of staff and the opportunity for overseas training, and students who qualify abroad may wish to stay in the country where they were trained" (WHO, 2001).

It is clearly the case that difficulties in recruiting staff in Western Europe combined with the economic constraints in CEE and CIS and the population displacement caused by conflict, create the potential for a skills drain to the west. The nursing workforce is already affected with nurses moving to richer CEE and Western European countries in search of better wages and working conditions. Some Western European hospitals (especially in Austria, Germany, Italy and Norway) are reported to be actively recruiting nurses from Eastern Europe, even in some cases when there are unemployed local staff. This can only exacerbate existing difficulties in recruiting and retaining nursing staff within the CEE and CIS where there are already marked problems in rural areas due to low status and pay, bad conditions and perhaps, some migration to the private sector. As training standards and job categories become increasingly standardized across Western and Eastern Europe and as accession to the EU increases the free movement of staff, the possibility of a major brain drain must loom large. Concerns have already been expressed in the Czech Republic and the issue is surely something policy-makers must take into account in addressing the socio-economic security of health sector staff.

## 3.4 Payment systems

Changes to the structure of health care workers' remuneration in CEE and CIS, especially in physician's pay, have come about as part of reforms attempting to address efficiency in health care provision, and the amount and quality of the services delivered. Such changes clearly have implications for income security. However, some of the terminology used to describe thinking differs from conventional labour economists' literature on remuneration because of the unique position of health sector staff. A standard economic analysis of payment systems would see firms manipulating wage levels and structures to induce workers to supply the desired quantity and quality of labour. The two main payment modes then are time rates and payment by results. Time, the simplest and traditional form of pay, bases remuneration on hours of labour on the assumption that each is equally productive and measurable so that checks can establish that the contracted hours are delivered. Payment by results relates pay to output and typically would revolve around a uniform price for each piece of output (Elliot, 1998).

It is possible to apply these concepts directly to the health care field, particularly where staff are based in hospitals or working in a support capacity where hours of input can be measured or procedures undertaken can be clearly defined. However, the patterns of care and services provided add a degree of complexity, as does the nature of health care services themselves. It has been suggested therefore, that what is paid for, who it is that determines the level of remuneration, and who pays are all key factors. Health sector literature assumes that it matters whether individuals pay out-of-pocket, the institution employing the physician pays, or third-party payers remunerate staff directly. It also gives weight to whether fee fixing is free or negotiated by physicians' representatives and the third-party payer or whether income-level is defined by a central agency. It looks at how best to combine a range of different types of payment to providers and to mix the two basic systems: piece rates (fee-for-service) and time rates (salary-based payment) so as to create incentives for desirable outcomes, avoid moral hazard and further the objectives of the given reform in payment systems (Contandriopoulos et al., 1990). It also introduces the concept of capitation (remuneration for responsibility), that is the payment of doctors for

taking on a role as carer in regard to their patients regardless of the amount of time involved or the number of service items delivered.

The "health sector perspective" means very specific approaches to reforms. They may seek to limit product delivery by physicians in an attempt to cap the overall wage bill (perhaps through points based reimbursement), or alternatively, they may attempt to boost performance and patient turnover (by diagnosis related group case payments). Certainly, payment systems will consistently attempt to address the quantity and quality of care provided and to link these to the remuneration package, taking into account public health objectives. They will not however, despite concerns about the motivation of staff, tend to regard income security (or any other component of socio-economic security) as of particular importance. Trade unions or associations attempting to intervene to negotiate appropriate remuneration or security related packages must be conscious of the potential conflict between elements that favour the employee and those which are in the interests of the health care system as a whole.

Remuneration for physicians may combine salary, fee-for-service, and capitation. Salary relates to time and allows physicians to combine different duties (medical, administrative, research), with the security of knowing what their earnings will be. It does not create incentives for them to treat unnecessarily or for longer than needed but neither does it create incentives for efficiency or differentiate between productive and unproductive staff. It is typical of hospital or health centre employment. Fee-for-service remunerates the services that the resource (physician time) produces. The system revolves around well-defined fee schedules and is closely linked with moral hazard, over provision and cost escalation (Normand, 1998). It works against doctors delegating to other care providers like nurses. Capitation remunerates the responsibility taken for the health of the population covered over a period of time by means of a fixed payment per beneficiary to cover a range of services. It commonly includes funds for purchasing care on behalf of the patient and so can create incentives for prevention and cost-control since these will benefit the provider (Rochaix, 1998). However, it may also prompt under-treatment.

The introduction of capitation in primary health care has sometimes included the assumption that the capitation payment to fund-holding doctors will include the cost of nursing care needs and that physicians as budget holders will then buy in services, employing practice nurses directly (Latvia, Slovakia). This makes the smallest provider unit, the family or general practice, the holder of the nurse's employment contract, tending to call into question representation security, access to collective bargaining rights and other forms of socio-economic security. It would represent the ultimate form of fragmentation of employment and is a clear instance of incentives aimed at improving performance potentially undermining the position of health sector workers. In Slovakia private sector doctors delivering primary health care or specialist outpatient services are believed to earn more than doctors working in the public hospital system while the nurses whom they employ earn less than their public sector counterparts.

Despite the reforms, nurses and allied professionals are still normally paid a salary although elements of fee-for-service may be included. This ought to suggest income security but the erosion of wages by inflation in CEE and CIS negates this. Administrative and support staff are invariably salaried.

Large amounts of health care expenditure in CEE and CIS are out-of-pocket and informal. While in the case of formal co-payments there is some protection for staff (in that the fee and the occasion on which it should be paid is regulated) under-the-table payments appear to be particularly widespread and are not, by definition, subject to scrutiny. The World Bank calculated that only 22 per cent of all health care expenditure in Georgia came from government sources or insurance funds in 1997 with the balance being provided by users. Anecdotal reports from Armenia, Belarus, Kyrgyzstan and the Republic

of Moldova and household surveys of Bulgaria and the Russian Federation confirm this picture.

This compounds the difficulties of addressing income security not least because of the instability and inequity that stem from reliance on undeclared, unregulated income sources. It must also impact on salary negotiations with employers since they will inevitably be aware of the magnitude of informal payments when making pay offers. It may undermine union efforts to address pay differentials consistently, giving an advantage to staff in direct contact with more affluent service users.

No single payment mechanism can deliver all possible performance objectives. Nonetheless, efforts to reformulate payment systems have been a key part of reforms. Health system literature tends not to address socio-economic security or to deal explicitly with labour market, job or skill reproduction security despite its focus on staff numbers, skills and pay and its stated concerns for staff motivation. Nor does it seem to regard employment, work or representation security as instrumental in the structuring of health care systems (or in maintaining staff motivation). As such, evidence from the BSS represents an important step forward.

# 4. Health system restructuring and the impact of privatization

The speed, scope and consistency of the reforms strongly suggest that they have not been genuinely evidence-based. Rather, policy-makers seem to have been prompted by ideological commitments to particular approaches not least decentralization, the shift from tax-based to insurance models, the introduction of market and quasi-market elements and more specifically, privatization. There have also been certain issues addressed with the encouragement of agencies like WHO, notably primary health care reform, a priority that is also high on the World Bank's agenda.

## 4.1 Decentralization

Decentralization has been seen as an important part of the rejection of central planning and as a means of asserting local versus central control. It was a major thrust of health sector reform in the early 1990s affecting all the countries surveyed except Belarus and Ukraine (although they have a notional commitment to it). The extent and form of decentralization has varied with differing degrees of control and responsibility (devolution, delegation, deconcentration) passed to local authorities, although typically it has included an increased role in funding and provision. It has often overlapped with the introduction of insurance schemes that are seen as key areas of delegation of authority (Bulgaria, Czech Republic, Lithuania, Romania) and with privatization, the ultimate model of decentralization (Czech Republic, Slovakia). However, decentralization was not matched by a growth in capacity to generate or manage resources at a local level and several countries have seen some re-centralization/re-concentration of authority[1] (Latvia, Lithuania and Poland). There are also suggestions that reforms have led to regional inequities as wealthier regions offer better services (the Russian Federation).

[1] Croatia is exceptional in having moved from self-managed socialism to a system with more concentrated authority at county and state level and a single main third-party payer. Nonetheless, local management control is considerable and providers are often semi-autonomous or private.

Decentralization is associated with the delegation of rights to hire, fire and set wages to the level of the institution, which calls employment and representation security into question. Can trade unions hope to negotiate with individual institutions with equal success in rich and poor regions? Armenia is the most pronounced example of decentralization with highly autonomous hospitals and polyclinics managing their own finances, setting prices for services paid out-of-pocket (under government regulation), determining staffing levels and negotiating contracts with staff, including pay and terms and conditions of service, but there are also suggestions that hospital directors are or will become increasingly powerful elsewhere (Georgia, the Republic of Moldova, Poland). Professional bodies, too, have often taken responsibility for professional standards and exercise some regulatory powers (Czech Republic, Romania, Slovakia) and this may have implications in the longer-term for skill reproduction security. There are also suggestions that decentralization, and in particular the regionalization of training may introduce inequalities of access (Kyrgyzstan).

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## 4.2 Moving from tax to social insurance and quasi-markets

The shift from tax-based to social health insurance systems was often seen as a way of protecting funds for health care, introducing quasi-market mechanisms (contracting) that would enhance quality, and demonstrating independence from Soviet models (and affiliation with German, Bismarkian policy approaches). A significant number of the countries responding have introduced insurance or sickness funds and those that have not, have often taken steps to pave the way for future insurance-led development. Armenia and Latvia have created an agency as third-party payer, and the Republic of Moldova has passed preparatory legislation. Only Belarus has no plans to introduce social health insurance. The models vary with different treatment of employee and employer contributions. The most basic system uses insurance to top-up state health budgets (Kyrgyzstan), whilst many still draw heavily on tax revenues as well as payroll deductions (Bulgaria, Lithuania, the Russian Federation). In countries with a number of funds (Czech Republic, Poland) competition has proved problematic, with evidence of adverse selection and tensions over risk redistribution (Slovakia). Voluntary insurance is still at its earliest stages and is used mostly for non-essential, supplementary services (Croatia) and by foreign companies (Latvia) and citizens travelling abroad (Lithuania).

The implications of this shift of responsibility for financing as regards socio-economic security is not wholly clear. It is certainly the case that insurance approaches separate the purchaser and provider functions and implies that the third-party payer (the insurance fund) will negotiate explicit contracts with health care institutions or professionals. This separation of provider and purchasing role is not unique to insurance

systems but it does suggest that resource allocation will be linked more closely to quantity and quality of care, or to responsibility (capitation). This in turn, will tend to change the way in which staff are paid and managed, with consequences for their socio-economic security (Croatia, Czech Republic, Lithuania). Certainly hospitals and clinics reimbursed for volume of service will seek to maximize the productivity of staff as measured by services delivered, while those paid per case will want to pass on to staff the imperative to treat within the cost limits agreed for reimbursement. Income security may be affected by a shift away from salaries and employment and work security may be undermined as new contractual arrangements are introduced.

## 4.3 Out-of-pocket payments

The introduction of payments by service users or rather the formalization of user-fees has been a significant change and is cited by the responding unions as such (Armenia, Croatia, the Republic of Moldova). Charges take various forms but typically include out-of-pocket and co-payments for pharmaceuticals, and out-of-pocket, private charges for dentistry (Lithuania, Poland). In some instances they include co-payments for a wider range of standard health care services (Kyrgyzstan, Latvia) and in Armenia all users other than those deemed vulnerable or with certain defined conditions, pay out-of-pocket for all care. The introduction of charges was fundamentally about securing extra resources for health, particularly in countries with significant informal economies and a low tax base. It was also seen as a way of reducing under-the-table, or gratitude payments, which have a long tradition in the region. The formalization of such payments may be desirable in this respect and may help to monitor barriers to access. However, there are widespread reports of under-the-table payments continuing and forming an important component of salaries (the Republic of Moldova, the Russian Federation), although they are notoriously difficult to quantify. The impact of formal and informal payments on staff is complex. There is evidence that patients are not always able to make the co-payment expected but are treated nonetheless (Latvia) thus reducing expected income and undermining income security. Staff relying on informal payments clearly have less security than those with a formal entitlement, and any benefits received or pension contributions made will be based on an artificially low income.

## 4.4 Privatization

Privatization, whether by transferring government functions to a profit-making company or to a non-profit voluntary agency, is the ultimate form of decentralization (Saltman and Figueras, 1997) and has been introduced in varying degrees across much of the region (Croatia, Czech Republic, Latvia, Lithuania, the Republic of Moldova, Poland, Romania and Slovakia). Despite some variations there is a striking degree of consistency with significant privatization of pharmacies and dental practices (which often pass into private ownership) and limited introduction of private mechanisms in primary health care. However, hospitals which occupy a dominant position within CEE and CIS health systems remain, to a large extent, in the public sector not least because they do not lend themselves to private, for-profit management and are often debt laden. Privatization and its impact on socio-economic security can be considered from the following perspectives:

- privatization of funding (through private health insurance or reliance on out-of-pocket payments);
- private ownership of facilities (including pharmacies, spas and hospitals or leasing of hospitals to private management companies);
- privatization of service delivery, in the form of profit-making and charitable enterprises (Scheil-Adlung, 2001);

- privatization of employment (with contracts passing from the state to individual institutions and employees becoming self-employed contractors);
- contracting-out or sale of functions like cleaning, catering or computer services (Hall, 1998).

Privatization of pharmaceutical manufacturing and drug market liberalization, which are also part of the overall move towards privatisation, are not discussed here as those involved in manufacture were not normally regarded as health sector staff, nor are private nursing or medical education considered.

### Privatization of financing mechanisms

Many countries in CEE and CIS have passed responsibility for fund raising, pooling and allocation to mandatory insurance funds. These are however, mostly governmental rather than voluntary agencies and so cannot be seen as privatisation of funding. Some have designated state funds to act as third party payers although they carry out no other insurance functions (Armenia, Latvia) and some have more fully developed insurance schemes, which nonetheless depend on, statutory, publicly held funds (Croatia, Georgia, Kyrgyzstan, Poland, Romania). Very few have allowed independent agencies significant control of public financing and these are not-for-profit (Czech Republic). Private insurance is not a major feature of CEE and CIS.

Nonetheless, private out-of-pocket expenditures are important both as formal co-payments or fees and as informal, under-the-table payments. It is difficult to quantify the extent of private expenditure on health but its most immediate affect on the workforce is that of income insecurity.

### Private ownership of facilities

There has been extensive privatization of certain facilities across the region, most notably pharmacies (even Belarus and Kyrgyzstan have allowed some pharmacists to operate as small, private businesses) and dental clinics (with some 79 per cent of Lithuanian, 90 per cent of Polish and 100 per cent of Czech dentists work privately). A number of spas and rehabilitative facilities (Czech Republic) and specialist diagnostic clinics (Armenia) have also been privatized however, these represent only a tiny fraction of the health care system as a whole. The picture with regard to primary care is more complex with many buildings still publicly owned; some owned by state or county but leased to private practices (Croatia, Czech Republic) and some centres with private owners (Croatia, Latvia). Hospitals overwhelmingly remain in the public sector although small numbers are privately operated (6 per cent of the total in Bulgaria accounting for 0.5 per cent of all beds) or belong to church or community or non-governmental organizations (Czech Republic). There is little evidence of private companies leasing hospitals in this sample.

The implications of changes in the ownership of institutions for staff depend very much on whether or not employment contracts change hands too. In the case of pharmacies there has been a shift to self-employment for pharmacists with all that this implies. Dentists have either set up single-handed practices and become self-employed, or established or joined group practices, in which case their employment contract will tend to be held by the practice itself. Similarly, primary care may be provided by self-employed sole practitioners (perhaps leasing facilities) or by a group practice that acts as the employer (although many do continue to be state employees). Nurses and support staff in all of these settings tend to be employed by the individual or group and therefore lose contact with others in the sector (Slovakia). It is likely that employment, job, work, representation and income security for the self-employed or employees of a small undertaking are more precarious than for employees, but there is insufficient evidence to demonstrate this. It is also the case that while hospital sector staff have been little affected

by privatization in terms of who their employer is, the payment mechanisms used to remunerate them have changed and continue to be the subject of reforms (see above).

### Privatization of service delivery

The vast majority of care in hospitals continues to be provided by the public sector. However, there have been significant changes in the provision of ambulatory services in much of CEE and CIS. In some instances, the bulk of such services are delivered through private providers like general practitioners, dentists, and ambulatory specialists, albeit under contract to publicly financed insurance funds (Bulgaria, Croatia, Czech Republic, Latvia, Slovakia). In others there are small markets for private services paid out-of-pocket (Poland, Romania). The effect of privatization of service delivery on the socio-economic security of workers is moderated by the employment contract of the provider and the national arrangements for negotiating fee levels. Nonetheless, where services are delivered under contract to insurance companies, the individual provider may be expected to have diminished leverage over issues like job, work and representation security, unless specific negotiation procedures have been established.

### Privatization of employment

Privatization of employment refers to whether or not individual staff employment contracts continue to be issued by the public sector (whether by a public institution, national or local government) or have been passed to a non-governmental body (either a voluntary or private institution). In those countries with small experiments in private sector development, privatization of employment contracts is negligible (Belarus, Kyrgyzstan). Where private ownership of facilities is relatively extensive it is not uncommon for employment contracts to be vested in the institution in which the individual works (Latvia) and, as has already been discussed, privatization of pharmacies, dentistry and in some instances primary and ambulatory care has increased self-employment (Croatia, Czech Republic, Poland). It has also seen nursing and support staff become employees of single-handed or small enterprises (Slovakia). Nevertheless, most staff continue to work for the public sector, often hospitals, local or national government (Latvia, Lithuania, the Republic of Moldova, Poland, Romania, the Russian Federation). The BSS of the Czech Republic suggests staff of private hospitals receive pay in line with that in the public sector and that other private facilities have their own regulations but pay close to the general average. Evidence elsewhere is mixed, with Georgia reporting fewer private sector staff paid at or below the minimum wage than is the case in the public sector, and the reverse being true in Latvia.

Existing evidence is scarce but suggests that the socio-economic security of health sector staff, while compromised by the economic constraints facing health care and challenged by successive waves of reforms, has yet to be unduly undermined by the privatization of employment. Nevertheless, increased redundancies, poorer working conditions and anecdotal evidence from the health sector itself, suggest that fears around privatization are not unfounded.

### Contracting out

The use of private contractors to deliver functions like cleaning, catering or computer services has immense implications for the privatization of employment contracts and for the socio-economic security of staff, particularly given concerns as to "the extent to which overall budget savings from contracting, particularly when previously publicly operated services are let to private providers, come predominantly from reduced wages and benefits (especially pension payments) paid to health sector support workers, thus reducing wages and benefits to an already low-paid sector of the workforce" (Saltman and Figueras, 1997).

However, the present study has not generated evidence of contracting out making significant in-roads into service provision in CEE or CIS.

It seems that privatization has had a similar impact to decentralization on the socio-economic security of the workforce. It has raised the issue of fragmentation of employment by tending to disperse employees amongst a number of (often small) employers. It also threatens to undermine variously labour market security (since the private sector might be expected to cut jobs), employment security (as private clinics or hospitals are unlikely to offer the same conditions as the public sector), representation security (because evidence suggest that the private sector is less favourable to unions) and possibly job, skill and work security which may all suffer as a result of losses in representation security.

Introducing health care markets and contract culture with its high transaction costs may also lead to wider problems for staff, as high trust relations are replaced with low trust ones and accountability is undermined. Privatization has been explicitly linked with instability and fragmentation, and private sector employers have been shown to rely increasingly on short-term contracts, demanding changes in skill-mix, and applying downward pressure on pay. Concerns also exist as to the impact of privatization on professionalism and its tendency to erode a caring ethos (Hunter, 1998).

## 4.5 Other structural issues

Other key issues affecting health systems and socio-economic security are:

- primary health care reforms;
- restructuring or management changes;
- budget cuts or expenditure below a given GDP threshold;
- World Bank intervention.

### Primary health care reforms

All the countries concerned have initiatives in the area of primary care. Particular emphasis on developing a primary care "gate keeping" function implies that primary care will be a patient's first point of contact of with the system and that access to secondary and tertiary care will only be on the referral of a primary care practitioner. This model has various benefits in terms of cost containment and the creation of ongoing relationships between primary care providers and patients. In terms of socio-economic security, it implies a need for retraining, the redefinition of nurse and physician roles and possibly, changes in payment mechanisms. All these will impact on job security, skill reproduction security, voice security, income security and even, as home visits and night duty increase, on work security.

### Restructuring or management changes

Reforms have also addressed health care management, prompting a renewed focus on public health and instituting a revised approach to financial management and accounting practice. All these will impinge on the workforce, creating new opportunities for some staff and threatening the position of others. The role of parallel health care systems has also been called into question. It was common practice in the centrally planned economies for Ministries other than Health to run clinics and hospitals specifically for their own staff (so the Interior Ministry, Railways and Post Office often had their own dedicated health service). Large enterprises too were important health care providers and employed medical and nursing staff with a great deal of accumulated and specialized knowledge of hazards within their own industries. Policy-makers across CEE and CIS have typically called for

rationalization of parallel systems and for them to be brought within the main stream. Staff within the parallel systems will experience considerable socio-economic insecurity as the continued role, or even the existence, of their services are debated; it is unclear how their rights will be addressed by trade unions.

### Budget cuts or expenditure below a given GDP threshold

It is particularly difficult to analyse expenditure issues in much of CEE and CIS due to fluctuating (often decreasing) levels of GDP and a lack of knowledge about the extent of under-the-table payments. Nonetheless, the economic constraints affecting health care systems are of real importance and while it is common to blame lack of funds for public sector shortcomings there is good evidence that once health sector spending falls below a certain level it becomes impossible to deliver adequate and efficient services (WHO, 2000). Some of the countries covered by this report enjoy levels of public expenditure that compare well with other CEE countries and are not far below Western European averages (figure 4). Others have lower expenditure yet remain within a manageable range, although private funds make an important contribution to expenditure in each case (Karaskevica et al., 2001; Cerniauskas et al., 2000; Karski et al., 1999). Six, however, appear to experience real difficulties in terms of overall spending and these have a direct impact on the socio-economic security of staff. Armenia for example, is believed to spend in the region of 1.4 per cent of GDP on health, and has structured health care system payments with the explicit recognition that it can fund only about 25 per cent of health care provision. Only vulnerable groups and particular conditions are covered, and providers are obliged to treat them, but are reimbursed less than their costs. Hospitals therefore have to generate sufficient fee income to subsidize the basic package and to pay their staff (Hovhannisyan et al., 2001). Public health expenditure in the Republic of Moldova has dropped dramatically as a share of GDP and in real terms per capita. The lack of funding is described as severe and the World Bank Project Application Document suggest that 70 per cent of public spending goes on electricity, heating and basic maintenance of the 55 regional and tertiary hospitals. Informal, under-the-table payments seem to play a major part in financing health care staff (MacLehose et al., forthcoming). This picture of low expenditure with an ill-defined contribution from formal and informal out-of-pocket payments also applies in Kyrgyzstan, Romania and Ukraine as well as in Georgia where in 1998 the local UNDP office estimated health expenditure to be as low as 0.6 per cent of GDP. Inevitably under these circumstances the income security of staff will be threatened and there is a high probability of physical conditions deteriorating and work security being compromised.

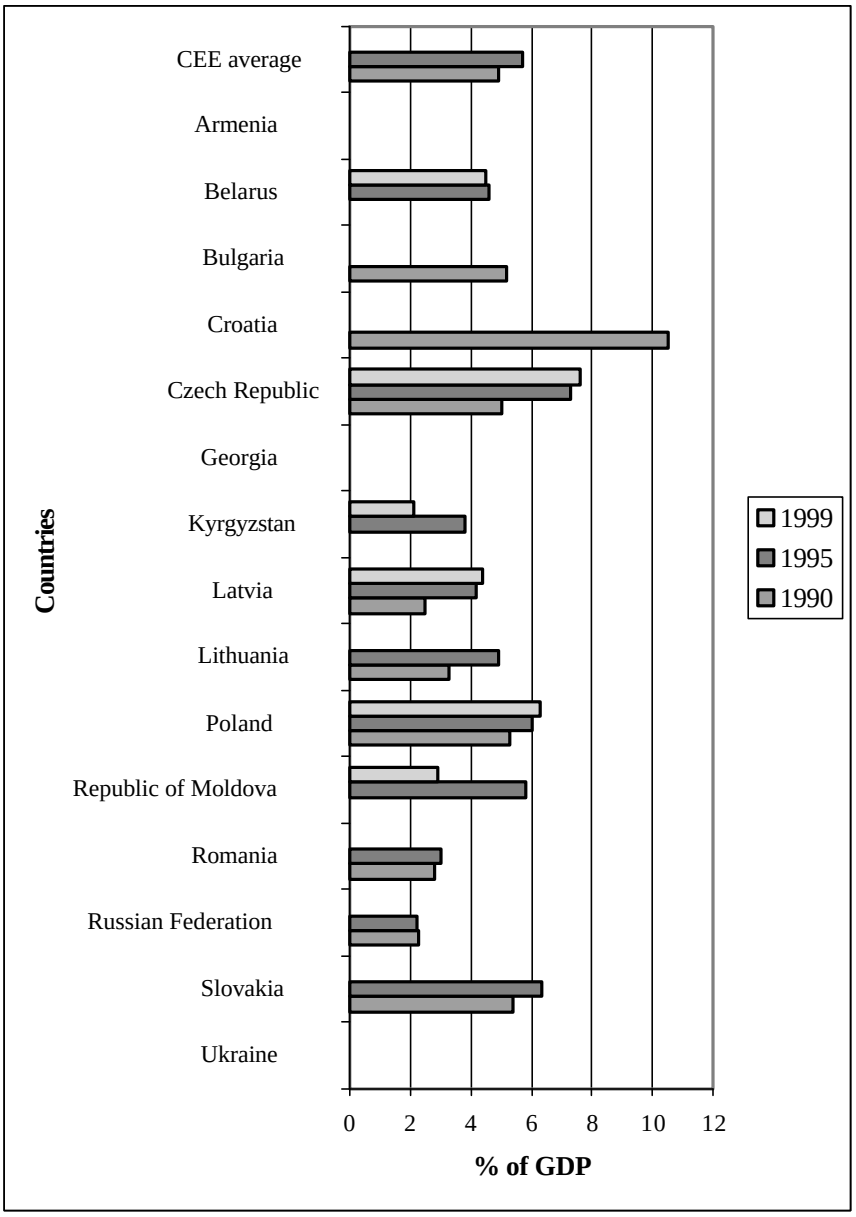
### World Bank

The World Bank has played an important role in many of the countries concerned, by supporting the restructuring of funding and the separation of provider and purchaser functions (Armenia, Georgia), primary care reforms (Kyrgyzstan, Romania), restructuring of pharmaceutical markets (Lithuania, Poland) and the physical reconstruction of facilities (Croatia) as well as taking a role in promoting broad health system reform (Kyrgyzstan, Latvia, Romania). Bulgaria and Latvia have also received IMF credits as part of their economic policy implementation, which includes streamlining state administration, structural reform and privatization. It is unclear whether the policies promoted have had a consistent, discernable effect on labour market, employment, job or representation security or whether those countries which did not receive assistance (Czech Republic) or have not yet received assistance with a reform process emphasis (Belarus, the Republic of Moldova, Ukraine)[2] treat staff differently. However, the World Bank does not routinely consult with

[2] Belarus and Ukraine have received loans to address TB/AIDS only and the loan to the Republic of Moldova for health care reform and structural adjustment has only been disbursed from mid-2001 (Source: http://www.worldbank.org).

trade unions or staff associations, thus undermining voice representation. The restructuring and reforms they promote imply changed working circumstances and therefore disruption to workforce socio-economic security.

**Figure 4. Total health expenditure as a percentage of GDP, by country, 1990-1999**




Source (WHO, 2001).

## 5. Socio-economic security in CEE and CIS

This chapter examines the country evidence generated by the IFP-SES/PSI BSS. It provides a descriptive analysis of issues around each of the seven security dimensions and compares countries through a statistical (SPSS derived) analysis. Finally, it considers whether there are discernable correlations between the various approaches to reform or to privatization and changes in different security dimensions and touches on the patterns that

might be expected to emerge as sectoral reform and structural adjustments are consolidated.

## 5.1 Labour market security

Labour market security entails the existence of adequate employment opportunities, through state-guaranteed full employment. It addresses job numbers, and will be adversely affected by the focus of many reforms on excessive staff numbers and the overprovision of beds and hospitals.

Health policy literature suggests that evidence of overprovision and underutilization (particularly relative to western European norms) was valid. In CEE and CIS however, some facilities and beds are included as health sector that might elsewhere be seen as part of the social care network. Nevertheless, the closure of facilities has been limited in scale and has often focused on very small in-patient clinics. Many institutions that were under threat have not closed down altogether but have changed affiliation and now provide non-health sector social care. The BSS suggest that in Kyrgyzstan and Slovakia the number of hospitals has actually increased slightly over the last decade while there were significant closures in Armenia (1999) and the Republic of Moldova (1998). It should be noted, however, that despite the cuts in the Republic of Moldova, the World Bank's analysis is that it still has higher levels of provision than anywhere else in Europe.

Survey data also illustrate shifts in staff numbers. However, despite concerns around over staffing not all countries surveyed have instituted job cuts. Some do report falls in job numbers (Armenia, Bulgaria, Czech Republic, the Republic of Moldova and Ukraine), but in Croatia and Latvia,[3] staff levels have remained more or less stable, although there has been some movement between public and private sectors. Belarus, Kyrgyzstan, and Poland all report some increases in numbers. Staff levels in Lithuania have risen since 1990, but have nevertheless slid back from the high levels of 1996. It is not possible to make firm assertions about emerging trends, as accurate data for the private sector and parallel health systems are not available.

Where details are provided for the private sector it is noticeable that there appears to be a substitution effect in which the private sector absorbs staff losses in the public sector (Croatia, the Czech Republic and Poland). However, there is not enough information on the type of work lost or the private sector jobs created to state categorically that new jobs replicate those lost. It may be that a different skills mix is called for and that the private sector is employing quite different groups of staff.

**The movement of jobs from the public to the private sector**: In Croatia the total number of staff (for the public and private sectors combined) fell by just over 1,000 between 1990 and 1999 with a slight rise in numbers of female staff. The WHO *Health for all databases* suggests that numbers of doctors, dentists, nurses, midwives and pharmacists all increased slightly between 1995 and 1997 (but provides no figures for support or administrative staff). The union records that the commercialization and privatization of services and restructuring all increased jobs. The total figures seem relatively stable, but this masks a pronounced shift in jobs from the public to the private sector. In 1990 just 2.2 per cent of health sector staff worked in the private sector compared to a little over 14.5 per cent in 1999.

[3] The WHO Regional Office for Europe H*ealth for all databases* indicates significant drops in physician and nurse numbers, perhaps due to migration of ethnically Russian staff. Survey figures however, suggest this had little impact on total numbers of health sector staff.

It has been difficult to obtain unemployment data for the sector as a whole. In many countries it is not numerically significant (Belarus, Czech Republic, Latvia, Lithuania) but may nonetheless be perceived as a problem (even in Kyrgyzstan where job numbers have risen) or give rise to stress (Czech Republic, Lithuania). Unemployment has increased significantly over recent years in Armenia, Bulgaria, the Republic of Moldova and Ukraine (attributed by unions to budget cuts) and also in Poland despite rising staff numbers. Interestingly, privatization, changes in management systems and restructuring were sometimes cited as having contributed to rising health sector unemployment in countries where unemployment levels were low and there was little evidence of extensive privatization. Overall it is difficult to attribute changes to particular reforms. Job losses were sometimes believed to follow the introduction of fee paying services (Latvia, Poland) while in other cases fee paying was associated with increasing levels of employment (Belarus, Lithuania). Similarly the impact of privatization, commercialization and restructuring were cited as having a positive effect in some instances (Lithuania, Poland) and a negative one in others.

**The impact of low staff costs on health sector unemployment**: In Belarus it is suggested that there is no health sector unemployment as such despite the excessive numbers entering medical and nursing schools simply because graduates are all absorbed by the system. Planners are aware that physician and nurse numbers are high relative to the rest of Europe but are less concerned to adjust levels than they might otherwise be because of the low cost of staff in the health sector. Staff continue to be employed in line with outmoded norms in relation to bed numbers, expected outpatient visits and anticipated vacancies rather than being made redundant (Karnitski et al., 2002).

The picture as regards part-time work is also incomplete and there are no data for many countries. In general terms, there has been less reliance on part-time staff in the health sectors of CCE and CIS than would be typical of Western Europe (particularly given the high levels of female employment) and this may be in no small part, because of the traditional strength of childcare provision. The Czech Republic is interesting as, in explaining the pronounced drop in numbers of part-time staff over the last decade, it emerges that part-timers in 1990 were almost exclusively pensioners. The data available indicate that Croatia, Latvia, the Republic of Moldova and Slovakia also have relatively low levels of part-time employment (although this rises to 5.3 per cent in Latvia), whereas Poland has a very high dependence on part-time staff (40 per cent), most of which are women. It would be well worth examining this area more closely in future studies, although a preliminary review of secondary data suggests that a split shift system operates whereby staff work part-time for both the private and public sectors and so in effect are in full-time employment.

There are similar problems with the statistics on short-time work. Where figures are available however, there are worrying signs that significant labour slack exists. In Armenia the incidence of short-time work has increased from a level of 2 per cent in 1990 to 20 per cent in 1999, whilst in Latvia 5.3 per cent of staff work less than their contracted hours. The use of administrative leave is also a common feature. In Georgia, 50 per cent of staff were either unpaid or only partially paid in 1999 while 12 per cent of the Kyrgyzstan workforce were on administrative leave. In Armenia and the Republic of Moldova the figures were 5 per cent and 7.5 per cent respectively, but only 0.4 per cent in Latvia. Evidence suggests that there seems to be at least a casual link between the use of administrative leave and low levels of GDP.

There is an increasing global trend that, whilst some face a lack of work, others both skilled and unskilled have to cope with an increasing workload. Long hours are a feature in CIS and CEE particularly when considering the number of staff combining their formal roles with additional work. In the Russian Federation for example the percentage of health staff doing so stood at 50 per cent in 1999, whilst in Georgia the figure was 40 per cent. It

is not always clear to what extent workers rely on additional wage packets but it is often a significant component of income, as in Poland where as much of 50 per cent of doctors' wages come from their secondary roles in private practice. The reliance on second jobs is not universal however as only 0.7 per cent of workers in Croatia combine their formal roles with other work.

With a few exceptions contracted hours have remained constant across the region, as have the actual hours worked by staff. There have only been marked changes in three instances, with actual hours worked rising in the Czech Republic and the Russian Federation and the opposite occurring in Lithuania. This seemingly secure picture however hides consistently long hours for many workers. In Poland doctors have the longest hours with some 90 per cent of them working 66-90 hours per week. In Latvia and Ukraine, actual hours for both doctors and nurses have remained high at an average of 60 hours per week, whilst in Belarus, the Republic of Moldova and the Russian Federation support staff work 52, 58 and 68 hours per week respectively. These figures contrast with Lithuania where average hours are now only 30-40 hours per week.

Doctors perform much of the overtime worked which suggests that it is a structural part of their professional arrangements. In the Czech Republic for example, 93 per cent of doctors work overtime and in Latvia 60 per cent worked extended hours. In Armenia, 30 per cent of doctors routinely working approximately 15 hours overtime a week "watching in the hospitals" while in Croatia 70 per cent of all doctors and specialists routinely work 8 hours overtime a week. It is likely that there is a formal reliance on overtime to cover night or on-call duties. In Kyrgyzstan, on the other hand, almost half of all administrative staff and a quarter of support staff work overtime compared to only 1.5 per cent of doctors and 5.5 per cent of nurses. In Latvia, approximately, 65 per cent of nurses, along with 60 per cent of allied health workers, work overtime hours, in Belarus 54 per cent of doctors, 35 per cent of nurses and 58 per cent of support staff work beyond their set weekly hours and in the Russian Federation 98 per cent of nurses work overtime.

Pensioners still play a significant role within the health systems of CEE and CIS, due in no small part to the low levels of benefit paid to retirees. In those countries where details are available it seems that the number of pensioners working is falling, with the exception of Belarus and Poland (table 1).

**Table 1. Pensioners in work, selected countries, 1990 and 1999**

| | % of staff who were pensioners 1990 | % of staff who were pensioners 1999 |
|---|---|---|
| Belarus | 10 | 15 |
| Bulgaria | 20 | 2 |
| Georgia | 36 | 28 |
| Kyrgyzstan | 32 | 18 |
| Lithuania | 22 | 12 |
| Poland | 2 | 6 |
| Russian Federation | - | 40 |

Emigration of health care professionals has detrimental effects on health care systems, and squanders national investment in training. Details on the number of health care staff who have left CEE and CIS are scarce, but in the Republic of Moldova over 6,900 health workers have left for neighbouring countries, while in Bulgaria 25 per cent of redundant trained health sector employees have gone to find employment abroad. In Croatia and Georgia this figure was 30 per cent and 31 per cent respectively, although in both cases this may be due to war and population displacement. It is too early to identify a trend as regards brain drain but there is clearly a potential threat, particularly to accession countries and the Czech Republic already reports recruitment efforts by Austria, Germany and Italy targeted at nurses.

## 5.2 Employment security

Command economies were characterized by secure employment with highly centralized regulation of employment issues. The decentralization of authority for hiring, particularly to small institutions, is likely to undermine this. Evidence however shows that employment security remains relatively good in CEE and CIS, although there are some worrying trends in regard to contractual status.

The BSS reported all employees maintaining their entitlement to severance pay, although levels did vary across national boundaries, from one month (Armenia, Latvia) to six months (Poland). No difficulties were reported in securing entitlements. Advance notice of redundancy is also a common feature of the countries surveyed, and tends to be in the region of two months.

Data on any shift from labour to commercial contracts are limited. A weakening of employment security in respect of contract type has been noted in Kyrgyzstan and Poland, where around a quarter of staff work on temporary contracts, placing many of the benefits of permanent employees out of reach. In Latvia the reported situation is even worse, with 90 per cent of health sector staff on temporary contracts. This is not a universal problem though, and only 0.5 per cent in the Republic of Moldova are on temporary contracts while the number affected in the Czech Republic has fallen from 14.5 per cent in 1990 to 6.35 per cent in 1999, improving employment security. It is reported that 100 per cent of health sector workers in Belarus and Lithuania operate as contract labour or on commercial contracts rather than on labour contracts while in Georgia the figure is 86 per cent. It is not entirely clear what the status of contract labour is however, (particularly as privatization in Belarus is limited and 80-100 per cent of Georgian staff are also reported to be on temporary contracts) but the position merits further examination as it indicates a potentially major blow to employment security.[4]

Women are entitled to maternity pay in all countries surveyed and may return to their posts after leave. Again, there appear to be no problems receiving entitlements. The duration of maternity benefits is often relatively generous as shown in table 2, and seems if anything to have improved over recent years with only Kyrgyzstan reporting a reduction in duration of benefits.

**Table 2. Examples of entitlement to maternity leave, selected countries**

| | |
|---|---|
| Armenia | 140 days |
| Belarus | 4 months of compensated maternity, with an additional allowance in the zone affected by the Chernobyl disaster (an increase over the last decade). |
| Bulgaria | 24 months |
| Czech Republic | Usually 28 weeks at the birth of 1 baby; up to 37 weeks at the birth of 2 or more babies or if the mother lives alone; up to 22 weeks at the adoption of 1 baby; up to 31 weeks at the adoption of 2 or more children or if the mother lives alone; 31 weeks if the father taking care of the child lives alone or up to 22 weeks if the father takes care of the child instead of the mother; 14 weeks if the baby is born dead (unchanged over the last decade). |
| Kyrgyzstan | 3 months (a decrease over the last decade). |

[4] The International Classification of Status in Employment (ICSE-93) and System of National Accounts (SNA 1993) suggest "remuneration for a commercial contract is directly dependent upon the profits (or the potential for profits) derived from the goods or services provided" so their application in the health sector is likely to be relatively constrained (ILO, 2000).

**Table 2 (contd.).Examples of entitlement to maternity leave, selected countries**

| | |
|---|---|
| Latvia | 112 days or approximately four months (an increase over the last decade). |
| The Republic of Moldova | 4.2 months. |
| Poland | 26-39 weeks (an increase over the last decade). |
| Russian Federation | 18 months (unchanged over the last decade). |
| Slovakia | 7 months (unchanged over the last decade). |

## 5.3 Job security

Job security covers protection of occupation, skill area or "career", and job insecurity may be a temporary but inevitable consequence of reform. Skills in the health sector are likely to move from being the preserve of one professional group to another as technology diffuses and as efforts to contain costs encourage the substitution of nurses for doctors, and role enlargement for support staff. New technologies will also create demands for new skills and impose new responsibilities while professional bodies and associations are likely to play an increasing part in regulating standards on behalf of governments.

Broadly speaking, health care in the region remains labour rather than capital intensive, but there is already a shift of tasks from medical to nursing staff in some countries (Czech Republic, Poland). There is a strong regional trend for the number of job tasks undertaken by all categories of staff to increase (Belarus, Czech Republic, Kyrgyzstan, Latvia, the Republic of Moldova, the Russian Federation, Ukraine) although in some countries this is more pronounced in the private sector (Bulgaria, Slovakia). This further emphasizes the need for training in the sector.

Different national circumstances will exert different pressures on the number of job categories which may need to increase or decrease (particularly if like the Czech Republic they are seeking to meet the EU *acquis communitaire*), and this is reflected in BSS responses. Overall, there is a tendency for countries to attempt to upgrade job categories (Belarus, Czech Republic, Kyrgyzstan, the Russian Federation, Ukraine) and for the number of job categories to be left unchanged (Armenia, Croatia, Georgia, Latvia) or to rise (Belarus, Kyrgyzstan, Lithuania). Bulgaria, the Republic of Moldova, Poland and Slovakia report differing trends in the public and private sectors. Job categories in the Bulgarian public sector have increased while those in the private sector have decreased, with the exact opposite happening in Slovakia. Similarly, Polish private sector job categories remained stable with numbers in the public sector rising, while in the Republic of Moldova the reverse is true.

## 5.4 Skill reproduction security

Access to initial education and training in CEE and CIS was traditionally planned in line with central estimates of expected demand for both doctors and nurses. However, high staffing norms meant that in practice there were few restrictions over numbers entering training. There was a long tradition of ongoing, professional education for doctors but less in-service training for nurses, and little attempt to develop or enhance the skills or development of support or administrative staff.

Access to medical and nursing schools has undergone a number of changes in the region. Governments have sought to cut places in order to address the over-provision of staff in the sector (Kyrgyzstan, the Republic of Moldova) and to increase standards (Latvia). However, at the same time private medical and nursing schools have opened (Armenia, Georgia, the Republic of Moldova) albeit without formal sanction and with

considerable uncertainty about their graduates' status and indeed, whether or not they will be allowed to practise.

The BSS reports the majority of employees as being able to use and maintain their skills (Armenia, Belarus, Bulgaria, Croatia, Czech Republic, Georgia, Kyrgyzstan, Latvia, the Russian Federation, Slovakia, Ukraine), however, a number of problems remain. For example, in Poland, doctors and nurses are reported as being able to maintain their skills, whilst allied health services, administrative staff and support staff are not. In Lithuania, staff are only able to maintain skills to a limited extent and in the Republic of Moldova only administrative staff are able to do so. In the Polish instance, skill erosion is identified with a lack of opportunity for certain occupational groups to specialize and to obtain computer skills. Evidence that the system cannot address the training needs of all staff, regardless of occupation is a major cause for concern.

Diminished skill reproduction security may be linked to the erosion of the previous approach to in-service education, which has not always been replaced with adequate provision. Although training has increased in some cases to meet new legal requirements (Croatia, Kyrgyzstan), or to conform to EU standards (Czech Republic, Slovakia), provision has declined in Armenia, the Republic of Moldova and Poland. New training needs have arisen from the creation of new roles within the sector, for instance, family doctors/general practitioners and public health nurses. New computer, accounting, administrative and financial skills are also called for by the management reforms. To a lesser extent there are also retraining needs associated with new technologies and pharmaceuticals. However, the availability of appropriate training has not kept pace with these demands.

Increased provision of training is sometimes linked with greater difficulties in access (Georgia, the Russian Federation, Slovakia). Barriers to access are often due to shortages of time and money (as mentioned for Latvia and Lithuania below) and in the case of Kyrgyzstan to regional variations. The BSS for Georgia and the Republic of Moldova suggest that training is also hampered by a lack of enthusiasm on the part of staff suggesting considerable demotivation in the face of socio-economic pressures.

Unions and associations frequently regard training as an important area of concern and include in their list of responsibilities securing access to training and maintenance of professional status. In many instances they are directly involved in training development and design (Bulgaria, Latvia, the Russian Federation, Slovakia) while in others a balance is struck between the role of educational authorities as training providers and unions who may contribute at the level of determining policy and by lobbying for conditions like paid leave or allowances for staff undertaking training (Czech Republic). Nonetheless, many national unions are excluded from the design of training and retraining (Croatia, Lithuania and Poland), and this may undermine skill reproduction security.

**Paying for and applying training:** In Latvia and Lithuania there has been a particular focus on the training and retraining of physicians and nurses to meet new primary care requirements. However, doctors in Latvia have often had to fund their own retraining and there are concerns in Lithuania about the indirect costs of nurse training being borne by individual trainees. In both countries, those wishing to retrain, or complete training, have difficulty in finding opportunities to apply their new skills (Karaskevica et al., 2001; Cerniauskas et al, 2000).

## 5.5 Work security

Work security could be expected to suffer in more market oriented economies and as regulatory frameworks have fallen into abeyance. However, as with employment security,

the legislative protection in place remains relatively good. Some aspects of health and safety may have improved, albeit that workers face considerable stresses.

In many instances, there has been a significant reduction in the number of work-related injuries (Armenia, Kyrgyzstan, Latvia, the Republic of Moldova, Slovakia, Ukraine). In parallel, absence due to injuries has decreased in Armenia, Belarus, Kyrgyzstan, the Republic of Moldova, the Russian Federation and Ukraine, sometimes by as much as 80 per cent (Latvia). There are less data on work-related disease, although the reported number of days lost have fallen (Latvia, Ukraine). Interestingly, despite less incidence of injury in the Czech Republic, the average length of an absence from work resulting from injury has risen. There are also noticeable differences between countries, with men in Belarus experiencing a majority of injuries, whereas in Armenia all absence through injury was attributed to women workers. Not all data in this area are positive however and despite reports of falling work-related injuries in the Republic of Moldova, the number of work-related diseases rose, albeit by a smaller number. Falls in reported injuries and disease may also reflect falling numbers in employment or reluctance to report accidents.

The payment of disability and invalidity benefits has remained largely unchanged across the region with no reported difficulties in receiving benefits. The amount of benefit available to recipients in different countries does however vary widely. In Armenia, Georgia and Kyrgyzstan for example, the average benefit amounts to 100 per cent of wages, comparing favourably with Croatia where benefits stand at 10 per cent of the average wage. The most frequently cited range however, is from 80-100 per cent and the duration of entitlement, while it also varies, is most often given as "till the time a person is fully recovered or a group of disability determined" (Belarus, Kyrgyzstan).

**Table 3. Reasons given for falling absenteeism**

| | |
|---|---|
| Armenia | Increased desire to earn more. |
| Latvia | Fear of losing job, and disability benefits rate is lower than wage rate. |
| The Republic of Moldova | Need to earn a living. |
| Poland | Sick leave is only 80 per cent of your salary, and fear of dismissal. |

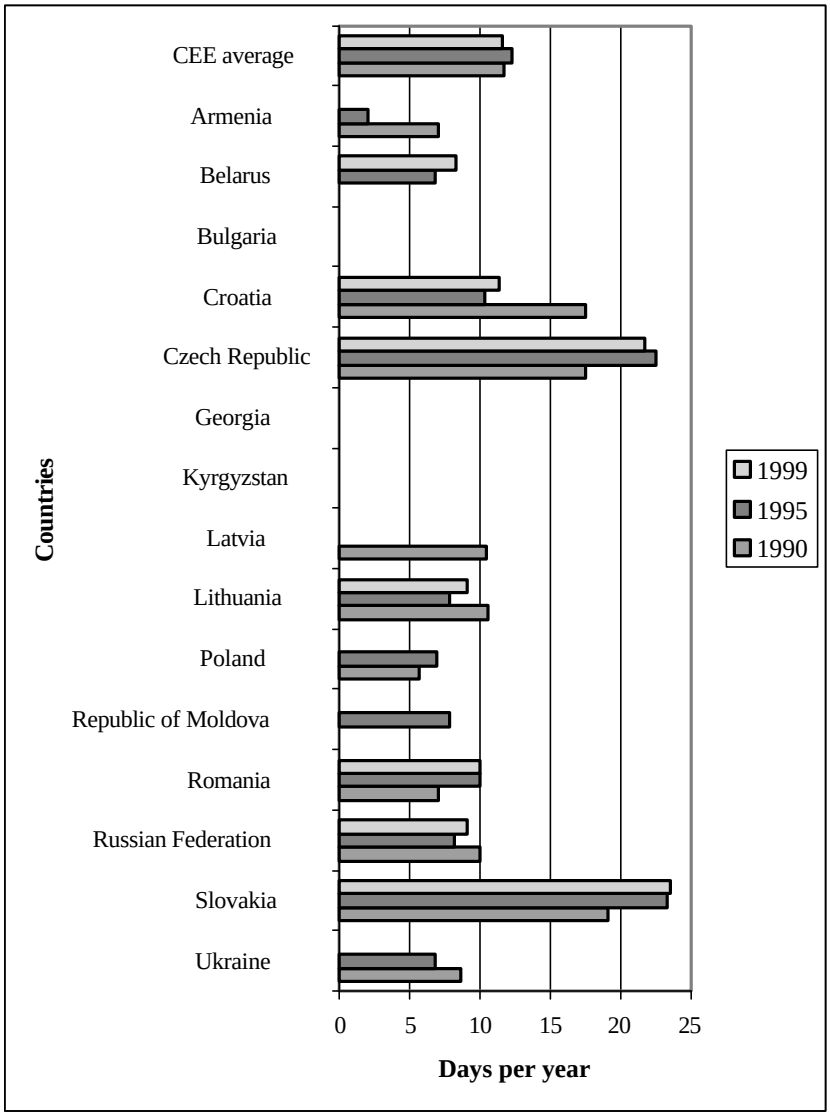
**Table 4. Reasons given for staff going to work when they might be absent**

| | |
|---|---|
| Armenia | Real income derives only from payments by patients, absence from work reduces earnings. |
| Kyrgyzstan | Financial motivation |
| Lithuania | Employees are afraid to loose job and to earn less. |
| The Republic of Moldova | Financial needs. |

Absenteeism in most countries is falling (figure 5 and table 3) although data are sketchy. Key reasons continue to be sickness or sickness of a child or family member. It may be, however, that the decline in absenteeism is less positive than might be first imagined. Evidence suggests that the incidence of employees attending work despite being ill is increasing (only the Czech Republic, the Russian Federation and Ukraine are exempt from this trend). This is explained by "fear of dismissal" (Belarus, Croatia), and to loss of earnings, or a combination of the two (Latvia, Lithuania, Poland, Slovakia). In Armenia's case the suggestion is that reluctance to take days off even when unwell is directly related to the fact that staff rely heavily on direct payments from patients (table 4). Many BSS responses show the seriousness of stress for staff. Nonetheless, stress has remained constant in the Czech Republic and even fallen in Croatia and Latvia. However, even

where stress is not as severe as it has been, it is consistently associated with economic hardship, threats of job losses and the inherent strains of working in a medical environment. Even where unemployment is low, the BSS still identifies fear of job losses as being stressful for workers (Czech Republic, Lithuania).

**Figure 5. Absenteeism from work due to illness by country, 1990-1999**




Source (WHO, 2001).

It is clear that working in the health care system, particularly when resources are constrained, places real burdens on staff. In Latvia the "increasing number of those having serious illness" is identified as stressful while in Ukraine the sudden death of a patient is singled out. Responsibility for patients (Slovakia) and absence of medicines (Bulgaria) are also contributing factors in staff stress. In addition to these common concerns there are also nationally specific sources of stress: in Ukraine, deception is cited as being an important issue; in Poland, privatization causes anxiety; and in the Russian Federation high communal payments and social instability are mentioned. It is also possible to draw direct parallels between how health systems operate and the causes of stress. In Armenia, the system of out-of-pocket, fee-for-service payments creates anxiety in staff, who suffer the consequences when patients cannot afford fees.

Health and safety are areas in which unions need a strong voice. Almost all the countries in this survey, (with the exception of the Czech Republic and Kyrgyzstan) report that management are required to involve trade unions as members of Health and Safety Committees although participation has not guaranteed improved conditions. Notwithstanding the situation is felt to have improved in Croatia, Latvia, Lithuania and the Russian Federation with changes including replacement of obsolete equipment, introduction of new technology, construction of new buildings (the Russian Federation) and stronger health and safety measures.

However, conditions are worsening in Armenia, the Republic of Moldova, Poland and Slovakia despite a statutory role for unions. There is some evidence that this deterioration may stem from antiquated equipment and under-investment. In the case of Armenia, worsening conditions may be attributed to the fact that, despite official involvement of both management and unions in health and safety committees, only 10 per cent of hospitals actually involve both parties in practice. The negative situation is compounded by a lack of compulsory inspections in any facilities, a situation that is mirrored in Kyrgyzstan despite the fact that "public inspectors on occupational health and safety are elected in each structural unit". This contrasts with the Czech Republic where unions are able to use their delegated powers of compulsory inspection at the branch level and their state remunerated experts to exert considerable influence on conditions in hospitals and clinics and on draft legislation even though the execution of safety measures is exclusively an employer competence.

Even where there are falling numbers of injuries at work, conditions may be unchanged or deteriorating (Belarus, the Republic of Moldova, Poland), and the formal involvement of trade unions and existing sanctions (Bulgaria, Slovakia) may not be enough to ensure work security. Further steps need to be taken to ensure health care establishments adhere to the principle of union cooperation, if necessary with reinforced regulation through government inspection.

**Table 5. Causes of stress, selected countries**

| | |
|---|---|
| Armenia | 1. Threat of being laid off, transition to a contract system.<br>2. Arrears in wages.<br>3. Insolvency of the majority of patients. |
| Bulgaria | 1. Bad working conditions.<br>2. Crisis in medical institutions, absence of medicines. |
| Croatia | 1. War situation (1990-1995).<br>2. Fear of dismissal. |
| Lithuania | 1. Fear of losing job.<br>2. Fear of reduced or unpaid wages.<br>3. Economic situation in the country and anxiety caused by wish to provide services of good quality. |
| The Republic of Moldova | 1. No guarantees of work.<br>2. Poverty and impossibility to support a family.<br>3. Uncertainty about the future. |
| Russian Federation | 1. Low income.<br>2. High communal payments.<br>3. Social instability. |
| Ukraine | 1. Sudden death of a patient.<br>2. Unexpected dismissal due to staff reduction.<br>3. Deception. |

## 5.6 Representation security

For the CEE and CIS, the past decade has seen the ending of automatic trade union membership, the undermining of the unions role in employment issues and the birth of new types of professional association.

The near 100 per cent union membership typical of the former centrally planned economies has not proved sustainable. Significant decreases were witnessed between 1990 and 1999 in Lithuania (100 per cent to 20 per cent), the Czech Republic (93.5 per cent to 32.5 per cent), Latvia (99 per cent to 50.2 per cent) and in Armenia (80 per cent to 30 per cent), whilst in Poland the already low 1990 membership level of 40 per cent has halved to 20 per cent. Only in Georgia, Kyrgyzstan, and Ukraine has membership stayed at the previous levels of between 94 and 98 per cent, although some uncertainty around the data has been expressed. The Russian Federation and Slovakia also record relatively high membership at 81.2 per cent and 75.2 per cent respectively.

In some cases, most notably Latvia, it would be tempting to attribute the steep decline in employee participation in unions to the hostility of management. However, this assertion does not hold up to rigorous analysis since many of the countries experiencing declines in membership (Armenia, the Czech Republic, Lithuania, Poland) record no outward hostility in the public sector towards unions but rather see management as neutral. Even though the private sector is felt to discourage union membership, this cannot account for the steep fall in union members, as private sector employment is still relatively limited in most of the region. In Georgia, for example, unions were felt to be discouraged in both the public and private sectors; yet union membership saw one of the smallest decreases in the region.

In many countries, the number of unions operating in the sector has remained unchanged, with often a single union representing the workforce (Armenia, Belarus, Kyrgyzstan, the Republic of Moldova). In others however numbers have increased, as is the case in Croatia, Lithuania and Poland where there has been a rise from 1 in each case to 10, 8 and 7 respectively. This is often the result of new representation being established for professions allied to medicine or due to the establishment of parallel unions who have broken away from the original organization. These are sometimes seen as fragmenting the workforce and allowing the interests of small groups or individual professions to be promoted at the expense of general agreement and wider representation (Czech Republic).

**New unions - Lithuania and Poland:** In Lithuania the bodies now in place are the Union of Doctors-Managers of Lithuania, Trade Unions of Health Workers of Lithuania, Trade Union of Doctors-Administrators of Health Sector of Lithuania, Union of Young Doctors of Lithuania, Trade Union of Medical Workers of Lithuania, Union of Nurses of Lithuania, Lithuanian Trade Union of Specialist on Taking Care for Sick, Association under Health Department of Lithuania.

In Poland there exists the National Trade Union of a) Solidarnosc b) Physicians c) Anaesthesia workers d) Nurses and Midwives, e) Technicians, f) Radiology workers, g) Dentistry workers.

Numbers of associations have increased in some countries (Croatia, Czech Republic, Lithuania, Slovakia) and membership appears very high in many (Latvia 60 per cent, Lithuania 85 per cent, the Republic of Moldova 79 per cent, Slovakia and the Russian Federation 80 per cent). There is also some significant overlap with union membership in particular countries (in Latvia 26-50 per cent of staff are members of both and in the Republic of Moldova, Slovakia and the Russian Federation 76-100 per cent). Only Poland has experienced a recent decline in association membership levels to 40 per cent. The *Health Care Systems in Transition* series suggest that associations together with professional medical societies play an increasing role in standards and licensing for medicine, dentistry and pharmacy (Bulgaria, Croatia, Czech Republic, Georgia, Latvia,

Lithuania, Poland, Romania, Slovakia, the Russian Federation) although they are not always seen as influential (Armenia, Kyrgyzstan).

In most national systems, trade unions focus on the core areas of negotiating wages, benefits and training (Armenia, Bulgaria, Kyrgyzstan, Latvia, the Republic of Moldova), wages and benefits (Czech Republic, Poland, Slovakia, Ukraine) or primarily wages (Belarus, Croatia, Lithuania). There is also a monitoring role whereby unions ensure compliance with regulations on remuneration and conditions (Slovakia, the Russian Federation) and exercise some "control over timely payment of wages" (the Russian Federation). Negotiating powers of unions seem to vary, however, depending on the sector. For example, in the Czech Republic and Poland, the role of unions is felt to be significant in determining public sector wages and benefits, but uncertain in the private sector. In addition to these core activities, several countries report union involvement in hospital management, particularly as it touches on workers' rights, (Armenia, Lithuania, Poland, Slovakia). In Lithuania this involves unions designating representatives to County Councils. In Belarus, Latvia and Ukraine unions directly disburse benefits, while in Latvia unions also give "financial support in covering the costs of training courses and certification".

Associations also appear to be involved in consultations on wages and training, in those countries in which they operate. In addition some associations are reported to be active in training and management (Poland) and the protection of legal rights (in the private sector in the Republic of Moldova). Many of the associations listed for the Czech Republic and Slovakia, however, seem to address institutional needs and may be targeted at organizations rather than at individual members. Secondary sources suggest that associations and other professional bodies are playing an increasing role in standard setting and regulation and are taking on certain of the functions of Ministries (Georgia, Slovakia, the Russian Federation). They have also, in some instances, acquired rights to negotiate directly with insurance companies on payment rates (Bulgaria, Slovakia). It is unclear what implications this has for the role of the trade unions.

**Associations and professional bodies in Slovakia:** Trade unions include the Slovak Trade Union of Health and the Medical Trade Union Associations.

Associations consist of the Association of Hospitals of Slovakia, the Association of Independent Polyclinics, the Association of Middle Health Schools, the Association of State Health Institutes and the Association of Private Doctors. This last association is able to bargain collectively within the private sector.

A series of statutory professional bodies to which non-state health personnel must belong ensure professional standards and play a part in inspecting facilities. These are the Slovak Medical Chamber, the Slovak Chamber of Dentists, the Slovak Pharmaceutical Chamber, the Slovak Chamber of Paramedical Personnel (covering nurses, laboratory technicians and other paramedical staff) and the Slovak Chamber of University Graduated Health Workers.

Notwithstanding the growth in associations, it is unions who are most frequently involved in collective bargaining. In the bulk of countries this takes place at three levels, the national, provincial and hospital (Armenia, Belarus, Bulgaria, Georgia, Kyrgyzstan, Lithuania, the Republic of Moldova, Poland, the Russian Federation). To some extent, the number of negotiating levels calls into question how binding national agreements can be on institutions. Key exceptions are Croatia and Slovakia where collective bargaining takes place at the national level only (although in Croatia, the Government has breached collective agreements), Latvia which has negotiations at national and hospital level only and the Czech Republic where only hospital level negotiations take place (see below).

In addition to undertaking collective bargaining, most trade unions engage in consultations with national partners. However, there is great divergence in the periodicity of consultations, the type of issues discussed, and the sense that unions have that

discussions are successful. It seems that in some cases consultations are formalized and regular (Lithuania has meetings twice a year, Poland every month) and in others that they are ad hoc (Latvia has meetings 3-4 times a year, the Republic of Moldova "as needed" and the Russian Federation "1-2 times a month, whenever deemed necessary"). Topics discussed often include wages or remuneration (Belarus, Croatia, Latvia, Poland) but also cover training or retraining issues (Lithuania), work and rest hours (Belarus) as well as the wider issues around reform, legislation and privatization (Armenia, Kyrgyzstan, Latvia, Poland, Slovakia). BSS responses indicate huge differences in perception about the usefulness of such meetings with the percentage of occasions on which consultations are considered helpful ranging from 6 per cent (Lithuania) to 60 per cent (the Republic of Moldova, the Russian Federation) and 40-70 per cent (Poland), with no clear pattern emerging as to whether these have tended to be more or less useful in recent years.

**Collective bargaining in the Czech Republic:** Although consultations in the Czech Republic take place with national level partners on wage policy, labour conditions and the network of health care facilities and its funding when needed, these do not constitute binding negotiations. Discussions are held to be useful no more than 10 per cent of the time and the major problems listed in the BSS are

- limited opportunities for collective bargaining in the public sector;
- collective bargaining is possible only on the level of individual enterprises;
- fragmentation of trade unions.

Even agreed bargaining powers and consultation procedures do not guarantee a voice as was found in Croatia where the 1999 round of talks broke down resulting in the collapse of the arrangements in place and a unilateral declaration by the Government of a round of pay cuts, in breach of International Labour Organization's *Convention on Private Employment Agencies 1997*. The BSS records that "Government is not prepared to conduct genuine social dialogue" and that the usefulness of consultations is "currently very low" and diminishing.

Traditionally, health sector workers have avoided strike action, although the right to strike remains unrestricted for most occupations. However, there are constraints on strike action for doctors (Poland), doctors working on essential functions (the Republic of Moldova), both doctors and nurses (Armenia, Slovakia) and nurses only (the Russian Federation). Furthermore widespread restrictions have been introduced in Lithuania, although the extent of these is still unclear. Only in Bulgaria do health sector workers have no right to strike. Notwithstanding their rights, health sector workers have scarcely used strike action and only in Georgia, the Republic of Moldova and Poland were any days lost to strikes in the reference period. However, demonstrations took place in almost all countries surveyed, and work slowdowns were reported in Georgia and Poland. It is clear that the reluctance of health system staff to withdraw their labour persists, which makes counting days of action a weak proxy for content or discontent in the sector.

## 5.7 Income security

It is particularly difficult to comment on income trends in CEE and CIS countries because of the extensive inflation and stagflation experienced during the reference period. This makes it all but impossible to state categorically the worth of wages across the region or the real fluctuations over time. The picture is further complicated by extensive reliance of staff on informal, out-of-pocket gratitude payments, which are not easily quantifiable. Nonetheless, the BSS suggest that health sector workers have witnessed a fall in the real value of their wages over recent years.

Some of the countries reporting a fall in income relative to national average wages do so for doctors, nurses and allied health professionals (Armenia, Belarus) or all occupations (the Republic of Moldova, the Russian Federation), while in others the phenomenon is more pronounced for nurses and allied staff (Lithuania, where fear of dismissal is cited as a reason for accepting falling income values). In Latvia, the relative pay of doctors and nurses has fallen while administrative and allied staff wages have increased compared to national averages. In Bulgaria, all relative wages have fallen except those of doctors, which have grown over recent years. Even where wages are reported as rising, problems persist, as in Croatia where recent rises have been undermined by cuts imposed by the Government in 2000 and 2001, or in Kyrgyzstan and Georgia. These last two countries report increases for all occupations, yet wages in Kyrgyzstan are said to be lower than subsistence minimum (although interestingly they seem not to fall below the national legal minimum) and in Georgia, they are at or below minimum levels for 90 per cent of the public sector. Only in two countries does evidence suggest remuneration packages rising significantly, in the Czech Republic, doctors' salaries in the public sector are twice the national average; Poland reports a 20-30 per cent increase for doctors, nurses and administrative staff from 1989 (despite which salaries of support staff and allied professions have fallen and minimum wages are commonplace). Few data are available on differences between public and private sector pay but the Czech Republic reports similar wages applying in both. In Latvia lower pay is reported in the private sector while in Slovakia, private sector doctors are believed to earn more than their public sector counterparts while nurses earn less than in the public sector. It also seems that doctors in private practice or in more entrepreneurial organizations in the Czech Republic can generate substantial additional income.

Where data are available the percentage of the workforce paid at or below the minimum wage range from zero per cent in the Russian Federation, rising to a worrying 70 in Poland and 90 in the Georgian public sector (table 6).

**Table 6. Percentage of workforce paid at or below the minimum wage, selected countries**

| | Percentage of workforce paid at or below the minimum wage |
|---|---|
| Armenia | 30 per cent |
| Bulgaria | 25 per cent a rise from 1996 when only 20 per cent were affected |
| Georgia | 90 per cent of staff in the public sector<br>50 per cent of staff in the private sector |
| Latvia | 2.3 per cent of staff in the public sector<br>13.9 per cent of staff in the private sector |
| Poland | 70 per cent |

The way that wages in the sector are determined varies between occupations, between countries and over time. Although there have been shifts in the elements making up remuneration packages and despite differences in public and private sector approaches, it is not easy to identify a clear pattern. It is certainly typical that tariff elements play a part (Armenia, Belarus, Poland) often in combination with payments by results and/or time rates (Croatia, Latvia, Slovakia). Income security may be undermined by a shift away from salaries, but evidence suggests that piece rates and payment by results (fee-for-service approaches) actually increase system costs (Latvia). More important for income security may be the increased power of individual institutions or insurance companies in determining pay and incentives at the expense of national, collective agreements.

Interestingly, doctors' pay has often risen relative to nurses' pay (Belarus, Bulgaria, Croatia, Czech Republic). The BSS survey responses tend not to address the differentials between different occupations in the sector in detail (although Belarus and Croatia are

looking to reduce wage differentiation). Respondents broadly support modest differentiation of individual pay to reflect work rate and effort (Czech Republic, Latvia, Poland) or between categories of workers "taking into account complexity, tension, harm, quality of work" (the Russian Federation) or to create incentives increasing "workers' interest in the intensiveness and quality of their work and get a guaranteed and additional wage" (Kyrgyzstan).

**Anomalies in pay – challenges to income security:** The BSS for Croatia describes the shift to capitation and fee-for-service, promoted by the insurance system as having a mixed impact on income security. Some staff have seen wages fall as a result, while others have experienced wage increases. In Poland, while salaries in the hospital sector confer a degree of income security, the reforms seem to have led to staff in the same institution being employed by different levels of local government (*gmina* or *voivodship*), with unknown consequences for pay or relative income security. In other cases there is a suggestion that hospital directors will play an increasing role in determining incentives and so substantial parts of wages (Armenia, Lithuania), which makes it likely that representation security, if not income security, will suffer.

Secondary income is of enormous importance in many of the countries surveyed. Total income from secondary jobs contributes roughly one-third of wages for doctors, administrative staff and those in allied health services in Belarus, 12 per cent of nurses wages and 35 per cent of doctors pay in Armenia, 35 per cent of wages for front line staff in the Russian Federation, 30 per cent of wages for staff in all categories in Kyrgyzstan (where a further 20 per cent of pay is derived from payments made by patients) and plays a particularly dominant role in Poland (see above). This phenomenon can only challenge income security.

The fact that health sector wages are widely regarded as inadequate and, furthermore, are falling in many countries makes delays in wage payments particularly worrying. In Armenia, 100 per cent of the workforce received at least some of their wages late in the three months leading up to the survey, and in the Republic of Moldova, late payment affected 76 per cent of public sector health workers, an increase on earlier years. The picture is only a little more positive in Georgia where delays in wage payments still affect 50 per cent of the public sector workforce (but only 10 per cent of private sector staff) and Kyrgyzstan where delays in wage payments are decreasing, but nevertheless affect 40 per cent of the workforce. The situation is also reported to be worsening in Lithuania and Poland.

Entitlement to benefits seems to depend on national regulations and not to be associated with any particular structural aspect of the health care system. Government benefits are unavailable to public sector workers in some instances (Croatia, Lithuania, the Republic of Moldova) and to private sector staff in others (Poland). Enterprise benefits are often not available to staff (Belarus, Croatia, Kyrgyzstan, the Republic of Moldova, Slovakia), or the existing levels of enterprise benefits are felt to be decreasing (Lithuania, Poland), or enterprise-paid benefits are only reaching some categories of staff (Georgia).

Pension payments and contributions covering the entire workforce, are in place in Armenia and have remained unchanged over the reference period a positive picture which is replicated in Croatia with 100 per cent of all occupations covered by a "pay as you go" pension scheme. In the Republic of Moldova, Poland and the Russian Federation, pension provision, while available, is not universal. In Poland's case this means only around 20 per cent of all occupations within the health sector are covered by the pension scheme, while in the Russian Federation only 30 per cent of nurses and 10 per cent of administrators have coverage. Similarly, contribution rates vary across national boundaries, with both increasing contributions (Kyrgyzstan) and decreasing contributions (Georgia, Lithuania), making it difficult to determine a trend across the region.

Income insecurity across the CEE and CIS appears to be relatively high, but not associated with a single structural reform. The shift to insurance, for example, was believed to increase income for some staff in Croatia, yet to be responsible for greater income insecurity in Lithuania and Slovakia (where the affiliates cite low fee-for-service and the indebtedness of sickness funds to hospitals as having negative consequences for staff). Similarly, privatization of pharmacies and the introduction of "chargeable medical services" are reported to have created new opportunities for workers to gain financial aid and bonuses in the Republic of Moldova but to have undermined income security in Latvia. It is the case though that where health expenditure is low, workers often experience considerable income insecurity.

# 6. Summary and conclusions: linking security and structural change

## 6.1 Summary

The BSS collected evidence of how this period of economic upheaval and structural transformation have impacted on the people working in health care.

There is no clear regional pattern of labour market security. Jobs overall have fallen in some countries while increasing in others with data being inconclusive in many cases, particularly where some shift of employment to the private sector seems to have taken place. Unemployment appears not to be numerically significant in most countries nor is there a consistent explanation of its causes (with privatization sometimes cited as decreasing job numbers and sometimes increasing them). Part-time work is not particularly prevalent, except in Poland, and data on short-time working are uneven. Contracted hours remain fairly constant across the region, but long hours and the combining of formal roles with a secondary job are commonplace if not universal.

Employment and work security provide a more uniform picture with entitlements to severance pay, notice periods and maternity leave as well as disability and invalidity benefits generally standing up well over time. Similarly, injuries at work and absenteeism are both in decline throughout the region, although falls in absence from work often reflect insecurity on the part of staff. There is however, no clear trend in levels of stress, although the factors contributing to it are frequently linked to economic hardship, fear of job loss and the general pressures of work in a medical setting. More importantly, perhaps, it seems that contract types are beginning to change in some countries with temporary contracts playing an important and increased role in Georgia, Kyrgyzstan, Latvia and Poland.

Skill reproduction security, the ability to gain and maintain skills, varies between countries and occupations. Training provision is uneven with increases reported in some countries and a decline in others whilst barriers to access have emerged in others still. Changes in the job security of staff are also uneven, with different trends across the region in job category numbers and job category upgrading, although there is a clear tendency for numbers of job tasks to increase.

Representation security has changed extensively, although clear region wide trends are not always discernable. Trade union membership has fallen in most countries (sometimes as in Lithuania to a fifth of 1990 levels) but has been fairly stable in Georgia, Kyrgyzstan and Ukraine. The number of unions has not changed in several countries but has increased in others, while associations appear to have emerged in many, but not all, cases. The role of unions is more consistent both over the reference period and across the survey sample and collective bargaining and the traditional issues of wages, benefits and conditions continue to feature strongly. There is considerable divergence in the extent to

which negotiations are seen to be effective, with the Lithuanian affiliate regarding only 6 per cent of consultations with national partners as helpful, in contrast to the Polish experience of negotiations helping 40-70 per cent of the time.

Income security does allow some generalization as to trends across the region but again the detailed position varies from country to country. Overall the BSS suggest that health sector wages have fallen relative to average income but the trend varies for different occupation groups in different countries. Only staff in the Czech Republic and Poland have seen pay improve consistently. Data on staff receiving at or near the minimum wage are incomplete but there are huge variations. While the numbers on a minimum wage in the Latvian private sector are significantly higher than in the public sector, privatization has in some circumstances been seen to enhance income levels and income security (Czech Republic, the Republic of Moldova). There is no consistent picture as regards late payments although these tend to coincide with a reliance on administrative leave and often affect workers in CIS countries with low GDP, particularly Armenia, Georgia, Kyrgyzstan and the Republic of Moldova.

## 6.2 The effect of decentralization

Just as the diversity of the region makes authoritative statements about socio-economic security trends problematic, it also rules out definitive or statistically significant judgements on the links between different approaches to reform and dimensions of socio-economic security. Nonetheless, some qualitative consideration of themes does allow an understanding of the range of issues involved, and highlights areas for further research.

Decentralization for example, has featured large in all the countries considered except Belarus and Ukraine. It has involved a range of changes including a shift of funding and management responsibilities from central to local government, the introduction of insurance funds and the empowerment of hospitals, and more particularly hospital directors, in hiring and in negotiating pay and incentives. The evidence to date suggests that decentralization does create some socio-economic security problems. This is the case where funding responsibilities are passed to authorities who do not have the resources or capacity to meet their obligations, for example in Lithuania, where fund indebtedness to hospitals is linked with low pay settlements. It is also the case where sub-national disparities bring about differences in access to training as in Kyrgyzstan. The key concern is that decentralization tends to give rise to the fragmentation of employment with myriad institutions or small practices directly employing staff (Armenia, Croatia, Poland, Slovakia). This has implications for all types of security but most particularly perhaps for representation security. Questions, which remain to be answered, include:

- How far have employment contracts in CEE and CIS been passed to individual provider units?
- Has union membership fallen in these instances?
- How effective is collective bargaining at the institutional, relative to the national, level?
- Is there evidence of emerging staff inequalities, both between and within institutions?

## 6.3 The effect of insurance-based financing

A shift from tax to social insurance has taken place in all the countries surveyed except Armenia, Belarus, Latvia and the Republic of Moldova. It is in many respects a form of decentralization, and as with decentralization the socio-economic security of staff

is likely to be affected by the viability and management capacity of the new organizational arrangements. It does not follow that insurance-based financing or contracting mechanisms necessarily prejudice staff security, but it does seem that the shift has prompted experimentation with payment formulae. These changes may have increased perceptions of insecurity, but it remains to be seen what the overall impact of insurance will be. It is possible that insurance funds will negotiate coverage and reimbursement with direct reference to institutions (Georgia) or "professional associations" (Bulgaria, Czech Republic, Slovakia) and that, whatever their relationship with trade unions at the outset, they may eventually overlook them, thus undermining representation security. It may also be that anomalies like payment fluctuations for staff (Croatia) will prove to be more than teething trouble. Further work might address the following questions:

- Is there evidence that insurance based financing and contracting with its emphasis on fee-for-service and capitation payments, will pass risk on to staff and detract from income security?
- What are the implications for trade unions of negotiated contracts between insurance funds and hospitals, and will they restrict the scope for collective bargaining?
- Does insurance tend to encourage family doctors to employ practice nurses directly and if so, what are the implications for job, work and representation security?

## 6.4 The effect of privatization

Some privatization has taken place in most of the countries surveyed, but it has often been restricted to pharmacies, dentistry and spas. There are now private primary care and ambulatory services in Bulgaria, the Czech Republic, Croatia, Latvia and Slovakia, but private provision remains most unusual in the hospital sector and governments are still the major employers of health system staff. Privatization might be expected to have the most adverse impact on workers' security of all the reforms to date. However, the BSS suggest a mixed picture, perhaps because privatization is quite limited. It seems not to be strongly associated with job losses or to be linked statistically to falling pay, and it is unclear whether, in the long term, income security and pay will necessarily be worse in the private sector (as is currently the case in Latvia) or whether remuneration will perhaps be better, at least for doctors, as is suggested by the experience of the Czech Republic and Slovakia. Nor is there a clear picture as regards work or job security where public sector standards may be compromised by spending constraints and under-investment (the Republic of Moldova). It certainly seems likely that representation security will be affected in the long run, although there is still only preliminary, if widespread, evidence of a more negative attitude to unions within the private sector. It is also unclear what happens to pharmacists, dentists or primary care practitioners when they are privatized and if, when they become self-employed, they cease to be included in the health system union movement. There is a need for further research on contracting out cleaning, catering and information management services. It has proved difficult to get a clear picture of the extent of contracting for services and it may be necessary to survey private firms in order to assess the scope of their role in health care delivery. Questions for the future might be:

- Is there evidence that private employment contracts are worse for workers' socio-economic security, or that they necessarily cause pay levels to fall relative to the public sector?
- Does national regulation adequately protect benefit entitlements for private sector staff?

- What is the position of the self-employed (pharmacists, dentists, family doctors)?
- To what extent does contracting out of services take place?
- What are the socio-economic security conditions of staff working on service contracts?

## 6.5 The effect of low health expenditure

Finally, it is notable that in reviewing the issues that have affected health care systems and their impact on workers' socio-economic security, resource scarcity seems to have a discernible impact. The countries with low public expenditure on health (Armenia, Belarus, Kyrgyzstan, the Republic of Moldova, Romania and Ukraine) are those, which figure repeatedly where salaries are paid late, where administrative leave is extensive and where wages are paid at or below minimum levels. This is not to say that the picture is a simple one. Salaries in Kyrgyzstan for example have risen for all occupations over the last 3 years whereas Latvia and Lithuania with higher GDP spend on health report falls in income for many staff. It is also the case that benefits and entitlement in many of the low spending countries are intact and that union membership is often high. Nonetheless, it does appear that at least in some respects health sector spending provides an important key to understanding the conditions of health care workers. Future research might ask:

- Do low levels of investment in health care systems inevitably undermine the socio-economic security of staff?

## 6.6 Conclusion

This report provides part of the background story of the events that are shaping the working lives of health sector staff in the CEE and CIS countries. The BSS have helped identify key pressures on health systems and highlighted the implications for workers' socio-economic security. They do not allow conclusions about the correlations between reforms and security, which is not to say that these links do not exist or that they are not vital in understanding the health sector environment. More data and further analysis are required to allow for such correlations to be made. Further research will also help trade unions identify how regulatory and organizational structures affect the security of their members. It should signal which steps need to be taken to protect staff and what the international community can do to support the trade unions of CEE and CIS. This is particularly important if the experience of trade unions and their insights are to be harnessed to support the reform process.

# 7. Appendices: Country profiles

Each profile summarizes the relevant Basic Security Survey (BSS) and is introduced by a section on structural changes, which also draws on the literature reviewed for the main report and referred to in the References. Job security is not reported in each of the country profiles because the questionnaire did not include a separate section on this security dimension. The reference period is 1990 to 1999.

## 7.1 Armenia

### Structural changes

The BSS singles out the decentralization of management and the launch of paid services in 1997 as influential reforms, together with the introduction of state enterprise joint-stock company status for all health care institutions in 1999. A programme of hospital closures has reduced the number of hospitals and clinics from 176 (1990) to 143 (2001). The most marked falls coincided with the introduction of joint-stock status and a shift in emphasis away from small and medium sized establishments. Numbers of jobs have decreased too but this trend predates hospital closures.

Secondary data suggest that decentralization has been extensive. Some responsibility for regulation and for ensuring provision has passed to regional governments (the *marz*) but the main focus has been to strengthen provider independence. The reforms have created highly autonomous not-for-profit provider units with joint-stock status. Hospital and polyclinic directors are responsible for managing finances, setting prices for services paid out-of-pocket, determining staffing levels and negotiating contracts with staff for pay and terms and conditions of service. There has been little real movement towards social insurance although the State Health Agency (SHA) has been established as the first step away from a tax-based system. Although it acts as third party payer it's funding is from tax revenue and it has no real insurance functions. It did however; recentralize some of the functions that had been passed to local government.

Privatization has been limited, but has affected retail pharmaceuticals and dentistry. Most pharmacies now operate as private-for-profit enterprises and there has been a shift towards freestanding dental practices increasing levels of self-employment. The very, highly specialized private or partially private facilities (a proctology centre, an institute of surgery, an obstetrics centre and the not-for-profit Arabkir Medical Centre) have little impact on mainstream health care and employ few staff. There are also 5 private medical and 10 private nursing colleges although they are not accredited and their students are not entitled to sit the final state medical examinations.

Public expenditure on health is as low as 1.4 per cent of GDP. It is estimated that only 25 per cent of health care expenditure is covered by the State, 15 per cent by humanitarian aid and 60 per cent out-of-pocket, but these figures may understate the magnitude of individual payments. The Ministry of Health has structured finances with the explicit recognition that it is unable to cover the bulk of provision. Only vulnerable groups or people with particular conditions are entitled to free treatment and providers are obliged to treat them although the State reimburses less than the cost of care. Hospitals and polyclinics charge for all other services, setting prices within regulatory limits and generating funds to cross-subsidize services to the protected population. The World Bank has played an active role in the reforms, helping establish the SHA and working with regions on "optimization plans" for restructuring. It has also provided funds for pilot work and guideline development for primary care and financing reform.

### Labour market security

Staff levels in the public sector have fallen over the reference period by around 12,000 with the brunt of the decline felt by women, although they still make up the majority of the workforce. No details are provided for the private sector. The BSS attributes decreases in the level of employment to privatization of services, despite the fact that this is limited and to budget cuts of more than 20 per cent. Unfortunately, no details are provided of levels of unemployment within the sector.

No data are available on levels of part-time employment. Details of increases in short-time employment are, however, worrying. Short-time work has actually increased from 2 per cent in 1990 to 20 per cent in 1999, whilst administrative leave in 1999 was believed to stand at around 5 per cent. No specific data were available on the percentage of staff combining their formal role with other work; however, support staff were felt to be carrying-out these dual roles.

The number of hours that staff are contracted for has remained unchanged over the decade, but no data are provided on the actual number of hours worked. There are no details of overtime for most occupations, but 30 per cent of doctors are said to be working an average of 15 hours per week overtime. This routine "watching in the hospitals" role may equate to on-call duties but is not included in staff contracts. Existing legislation makes no pension for early retirement.

### Employment security

A high percentage of employees are entitled to severance pay, and no difficulties in securing entitlements are reported. Severance pay in both the public and private sectors is limited, however, to one month's pay. In case of redundancy, two months advance notice is usually provided to employees. Women are entitled to maternity pay and to return to their posts after leave, and appear to receive their entitlements of 140 days of compensated maternity.

No data are available on the percentage of workers in the health sector working as contract labour, on commercial contracts or on temporary contracts.

### Skill reproduction security

Employees are reported as being able to use and maintain their skills, and retraining is provided, although unions are not involved in the design of training. Access to training has decreased due to a lack of funding and because of staff responsibilities, such as family.

The number of job categories over the past three years has remained constant, whilst the number of job tasks within the sector has increased for doctors and administrative staff and stayed the same for nurses, support staff and those in allied health services.

### Work security

Work-related injuries have dropped significantly, and it seems that only women take days off for this reason. Nevertheless, working conditions and health and safety are described as having deteriorated. There are no data on the number of work-related diseases. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. On average these benefits amount to 100 per cent of wages, for up to 6 months.

The only cause given for absenteeism is sickness. The affiliate considers that the incidence of employees attending work despite being ill has increased, due to dependence on the part of employees on direct payments by patients ("absence from work prevents

getting earnings"). It may be that this is a reference to informal (under-the-table), gratitude payments.

Stress is considered as a serious issue in Armenia with the three main causes identified as: "the threat of lay offs and the transition to short term contracts; arrears in wages; and insolvency of the majority of patients". Management are required to involve trade unions as members of Health and Safety Committees; however, with only 10 per cent of hospitals operating a joint union/management Health and Safety Committee, conditions in hospitals and clinics are reported to be getting worse, due also no doubt to the lack of compulsory inspections in any facilities.

## Representation security

The percentage of employees in the sector who are members of unions has decreased sharply from 80 per cent in 1990 to approximately 30 per cent in 1999. This decline may be due in part to perceived hostility towards unions by the private sector. Nevertheless, management in the public sector, who employ the majority of the workforce, were neutral towards union membership. The number of unions operating in the sector stands unchanged with only one registered union in the country. No data are provided on workforce involvement with associations; however, the membership is felt to have been static over the past three years. Secondary data indicate that doctors, nurses and various medical specialities including cardiology, surgery, gynaecology and neurology, have separate associations

Only one day was lost to strike action in 1999, although some demonstrations also took place during the reference period. The right to strike is restricted for both doctors and nurses but not for administrative and support staff.

The role of unions in the public sector includes negotiating in the traditional areas of wages, benefits and training. In addition, the Trade Union of Health Workers of Armenia participates in hospital management on issues that affect workers' rights. Secondary data suggest that neither the physicians association established in 1992 nor the nurses association set up in 1996 are of significance in terms of health policy or professional influence. Moreover, these data suggest that doctors and nurses now negotiate individual contracts with employers (i.e. with hospital or polyclinic directors) and that the Ministry of Health consciously dismantled the mechanisms that controlled remuneration so as to allow provider units to take decisions on pay.

Notwithstanding, the Basis Security Survey records collective bargaining taking place at the national, hospital and provincial levels and reports that unions have regular consultations with national level partners to discuss reforms, draft laws and financing issues. The three key problems unions face representing members are: "absence of law enforcement mechanisms; loss of control sticks from higher authorities under conditions of elemental labour market and; lack of finance support of the branch by the State".

## Income security

Lack of data on price inflation within Armenia makes it impossible to quantify the rise or fall in salaries in real terms. The affiliate feels that wages have fallen over the past three years for doctors, nurses and allied health service staff. Wages in the sector are determined by a number of arrangements. Administrative and support staff remuneration is based on a tariff, whilst nurses pay is based on a time rate. Doctors and allied health staff payments are based on results. Over the last three years, delays in wage payments have increased and over the past three months none of the workforce received their full wage on time.

Secondary data report that the introduction of a system of explicit out-of-pocket payments was intended to rule out under-the-table payments, but suggest that it is unclear if this has been effective. These data also suggest that although a basic minimum salary is now guaranteed, fixed basic salaries will be abandoned over time, and staff will eventually only be paid a percentage of out-of-pocket payments and a percentage of the third-party payments for each case treated. Hospital directors will calculate the revenue each doctor and nurse generates and from that, their pay entitlement. On this basis, from 20-40 per cent of the cost of each treatment episode will go to salaries.

The percentage of the workforce receiving wages at or below the minimum wage stood at 30 per cent in 1999. Enterprise-paid benefits are available in Armenia as are government-paid benefits. The entire workforce is covered by the pension scheme and contributions have remained unchanged.

## 7.2 Belarus

### Structural changes

The affiliate identifies changes to the financing of state health institutions and the transition of primary health to a general practice model as the key reforms. It seems that capitation will feature increasingly strongly with the suggestion that "financing of state institutions will be made counting on one inhabitant a year". The number of hospitals and clinics has decreased over the last decade, by a little over 50 establishments, mostly small. Public expenditure on health care has increased to 4.9 per cent of GDP from a low of 2.6 per cent in 1990.

Secondary data suggest that legislation has been passed paving the way for private sector development but to date this has been negligible with the exception of pharmaceuticals, which were, by and large, passed to pharmacists who run them as small businesses. Physicians were allowed to register for private practice, and although up to 1,800 did so, only a small number are believed to be offering private consultations and operating on a fee-for-service basis; they work almost exclusively at the low technology end of medicine. A few pilot examples of quasi-private dental and cosmetic polyclinics have yet to make a tangible impact on the mainstream health care system, and numbers employed in a quasi-private setting are very low.

There is a stated commitment on the part of the Government to decentralization but the system is still highly centralized. The Ministry of Health still determines norms, standards of practice and employment conditions, but now issues recommendations rather than directives on policy. It is also acknowledged that while local government is expected to roll out national programmes it may introduce local priorities. It seems likely that decentralization will progress incrementally, particularly if the economy improves and local government's financial contribution increases.

Belarus funds its health care system through general taxation. There are no payroll or compulsory health insurance contributions and efforts to introduce an insurance model were rejected on a number of occasions with suggestions that it was unconstitutional. Voluntary insurance plays a minimal role, providing as it does for non-essential services only.

### Labour market security

Staff levels have risen steadily since 1990 by around 50,000, to a high of 322,400 in 1999 in the public sector. Unfortunately, there are no details of unemployment within the sector. The overall rise in employment levels is attributed to a shift to fee-paying services, changes in management systems and to restructuring.

Secondary data suggest that staff numbers are high with low unemployment. Numbers of staff in the sector continue to be planned in line with norms for number of beds, expected outpatient visits and the number of vacancies.

No data are provided on the level of part-time, short-time employment or administrative leave within the sector. The percentage of staff combining their formal role with other work stood at 30 per cent in 1999, and was thought to affect all but administrative staff.

The number of hours that staff are contracted for has remained relatively unchanged (falling by an hour for administrative and support staff) over the decade, as has the number of hours actually worked. Support staff work the longest actual hours, with an average week of 52 hours in 1999. Administrative and support staff are contracted for 40 hours a week on average, compared with 35-38.5 hours a week for doctors.

Differences in contracted and actual hours exist for doctors and support staff but not for administrative staff: only 2 per cent of the latter perform overtime while doctors work an additional 10 hours a week and support staff an additional 12. 54 per cent of doctors work overtime, 35 per cent of nurses and 58 per cent of support staff.

Approximately 15 per cent of employees in the health sector were also pensioners in 1999, a rise of 10 per cent since 1990. Existing legislation makes no provision for early retirement.

### Employment security

A high percentage of employees are entitled to severance pay and no difficulties are reported in securing entitlements. Severance pay in both the public and private sectors lasts three months. Women are entitled to maternity pay and to return to their posts after leave. Indeed, maternity leave entitlements are reported to have increased over the decade and women are entitled to four months of compensated maternity, with an additional allowance in the zone affected by the Chernobyl disaster.

100 per cent of workers in the health sector were recorded as working as contract labour or on commercial contracts as opposed to labour contracts.

### Skill reproduction security

Employees are able to use and maintain their skills and retraining is provided, with unions involved in the design of training. It seems that training may be particularly associated with the shift of doctors into primary health care.

Job categories have been upgraded over the past three years. Likewise, the number of job categories has increased, as has the number of tasks undertaken. The increase in tasks applies to all categories of staff.

### Work security

Work-related injuries have decreased significantly over the decade from a high of 296 in 1990 to 138 in 1999. The majority of reported cases affected men. Likewise, the number of days lost to work-related injuries has fallen by over 2,000 days per year. No details exist on work-related diseases.

The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. The benefit is 100 per cent of average wage and usually paid “till the time a person is fully recovered or a group of disability determined”.

No statistics are available on absenteeism, but the affiliate believes that the level has remained constant. Management is required to involve trade unions as members of Health and Safety Committees. Conditions in hospitals and clinics are reported to have remained the same over time. All primary, secondary and tertiary facilities are inspected regularly.

## Representation security

The percentage of doctors in the sector who are members of unions has decreased, albeit less dramatically than in neighbouring countries. From a figure of 98.9 per cent in 1990 the number of doctors who are union members has fallen to 89 per cent. This decline cannot be attributed to hostility of management in the public sector, which was felt to be neutral in attitude to union membership. There remains just one union operating within the sector. No days were lost to strike action in 1999, although some protests have taken place over the reference period.

The role of unions in the public sector lies mainly in determining wages but also in material aid and training. There is no reference to associations operating inside the country.

Collective bargaining takes place at the national, hospital and provincial levels, and there are regular consultations with national level partners. Consultations concentrate upon remuneration, work and rest hours and employment issues, and have been increasingly successful over the last three years, despite falling wages. This tallies with the union's functions, which are described as "public control over full and timely payment of wages, improvement of conditions of remuneration of wages, material aid, periodicity of training and attestation". The main problems faced by the affiliate are "low wages and working conditions".

## Income security

As we have no data as yet on price inflation within Belarus it is not possible to quantify the rise or fall in salaries in real terms, however the affiliate feels that wages have fallen over the past three years for doctors, nurses and for support staff.

The ratio between doctors' pay and that of nurses and support staff has shifted slightly in favour of doctors but the information on wage differentiation is difficult to interpret. The responding union states "trade union of health sector workers is cooperating on a permanent basis with the Government on increase of wage rate of 1 rank and of minimum wage. In 2001 the wage rate of 1 rank has decreased twice and starting from the 1 of November it will be decreased for the third time."

Wages in the sector are generally determined by tariff, but highly skilled employees are provided with performance payments. Bonus payments are also used: "highly skilled employees (specialists) are provided extra payments rating to 50 per cent of wage rate", and "workers, to 32 per cent of wage rate".

Secondary jobs provide roughly one-third of wages for doctors, administrative staff and those in allied health services. No data are available on delays in wage payments or on the percentage of wages paid below the minimum wage. Employees are not usually entitled to enterprise-paid benefits. No further details are provided.

Secondary data suggest that the Finance Ministry blocked efforts to change the basis of physician payment to create incentives in primary care. The overwhelming reliance is still on salary and the options for hospital directors to introduce bonus elements is very constrained (except in the quasi-private facilities). The Ministry lays down centrally fixed rates and increments based on years of service and level of qualification. It is suggested that under-the-table payments play a substantial role.

## 7.3 Bulgaria

### Structural changes

The most notable reforms affecting the socio-economic security of the health sector staff have taken place in the past 4-5 years and include the introduction of the Law on Health Protection (1998), the Law on Doctors' Organizations (1998), and the Law on Medical Institutions (1999). Restructuring of institutions now gives hospitals the legal status of nominal business associations. The number of hospitals has increased from 256 to 280 (1990-99), although there are no details of the type and size of hospital given. Secondary evidence suggests, however, that 1997-78 saw reductions of 30.2 per cent in the number of hospital beds, associated with the introduction of accreditation and the closure of some TB and mental hospitals, which led to job losses.

Health systems analysts indicate that the shift in status to "in-patient health care trade companies" (accomplished by the end of 2000) does not imply the privatization of the ownership of in-patient facilities. Rather, they compete as autonomous quasi-public bodies and must meet emerging quality control thresholds for licensing purposes as well as regulations on salaries. Municipalities continue to hold the title to buildings. The same is true of most larger outpatient clinics and group practices in medical centres, which tend to be state or municipality owned. Privatization has, nonetheless, played an important part in the reforms. Dentistry, pharmacy, laboratory and diagnostic services and outpatient provision are now delivered almost exclusively by private practitioners, and single-handed practitioners often own the premises they work from and are counted as independent contractors. Six per cent of hospitals are private, although these account for only 0.5 per cent of all beds. No private hospitals hold contracts with the national insurance fund, and patients must cover costs themselves. In the first instance, individual users of private outpatient services also paid out-of-pocket but increasingly these "private entrepreneur" providers are being drawn into the insurance system and are signing contracts with the social health insurance fund, albeit that the rates of reimbursement are lower than those charged previously. Medical and nursing education is still wholly in the public sector.

The introduction of social health insurance along with National and Regional funds has been intimately bound up with the introduction of accreditation and privatization and the decentralization of authority. Insurance is still not responsible for the bulk of financing within the health care system, but operates alongside the traditional budgeting arrangements of central and municipal government. Nonetheless, it is clearly having an impact in terms of setting standards and addressing unit prices and efficiency. Payment of general practitioners is based on a national framework with locally negotiated variations and through a mixture of capitation and top-up payments (linked to the deprivation of the population covered and special services delivered) while outpatient doctors are independent contractors paid on the basis of the number of consultations at a nationally agreed rate that is locally adjusted. Only hospital staff continue to be conventionally employed and to work for a monthly salary. Insurance has not been the only form of decentralization. There has also been pronounced devolution of authority to the 28 regions (*oblasts*) and to the 262 municipalities, which raise local taxes and have considerable discretion in allocating funds.

Public expenditure on health is at the lower end of average for the region, standing at 4.5 per cent of GDP in 1999, having risen from 4 per cent in 1994. It is, however, difficult to be entirely accurate about trends, not least because of the severity of economic difficulties: inflation and the difficulty of accounting both for formal co-payments and what seem to be very significant informal gratitude payments. It is clear though that the influence of external agencies has been considerable, with IMF intervention in 1997 and major World Bank, Council of Europe and European Union loans and inputs.

## Labour market security

Staff levels in the public sector have fallen over the reference period by around 23,000, with the brunt of the decline felt by women. Secondary data suggest that a particularly steep fall after 1996 was linked to the reforms. The number of people remaining in the health sector in 1999 stood at 104,223, 70 per cent of whom were women. There are no details of the numbers employed solely in the private sector. The survey attributes decreases in the level of employment to the commercialization and privatization of services and to budget cuts of more than 20 per cent, suggesting that public health expenditure, as measured in terms of percentage of GDP, belies a shrinking public purse. A shift to fee paying services, restructuring and changes in management are however, seen as having increased the number of jobs in the sector.

There were 15,000 people seeking work and regarded as unemployed in 1999, 45 per cent of whom were women. No details are provided for earlier years. Many employees made redundant over the previous two years were still seeking work in the health sector despite a disheartening rise in the average length of time staff were unemployed: from 6 months in 1990 to 12 months in 1999. This feature of the labour market may explain why 25 per cent of redundant trained health sector employees have felt it necessary to move abroad to find employment. No data are available on part-time and short-time employment. Similarly there are no details of administrative leave in the sector, although employment freezes were reported in 1990 and 1996. No freezes were reported for 1999.

The year 1999 saw 30 per cent of employees combining their formal job in the sector with other work, with all categories of workers being affected. There appears to be little available overtime or additional work in the sector, with all categories of staff reported as working on average 40 hours per week or less (which includes 4 hours of overtime for doctors and nurses and 2 hours overtime for support staff).

The percentage of employees who were pensioners stood at 2 per cent in 1999, representing a significant reduction since 1990 (20 per cent). 35 per cent of the workforce is reported to have been put on early retirement in the 12 months following the restructuring of the health care system.

## Employment security

A high percentage of employees are entitled to severance pay and no difficulties in securing entitlements are reported. Severance pay in the public sector amounts to 2 month's pay whereas in the private sector it is limited to one month. In cases of redundancy a one-month advance notice period is usually provided to employees. Women are entitled to maternity pay and to return to their posts after leave and again appear to receive their entitlements of 24 months of compensated leave.

The percentage of staff on temporary contracts has risen to 20 per cent in recent years, having previously stood at 10 per cent in 1990. The same statistics are presented for both contract labour and those o n commercial rather than on labour contracts, suggesting that the data refers to the same group, and that temporary contracts are common commercial policy. This may reflect the impact of insurance mechanisms on employment.

## Skill reproduction security

All c ategories of employees are reported as being able to use and maintain their skills and retraining is provided, with the involvement of the union. Access to training has remained constant. The number of job categories over the past three years has increased in the public sector whilst decreasing in the private sector. The number of public sector job tasks increased for nurses and stayed the same for doctors, administrative staff, support

staff and those in allied health services, whilst in the private sector they rose for doctors and remained constant for all other categories.

### Work security

There are no data given for work-related injuries or diseases. The payment of disability and invalidity benefits has remained unchanged and employees are, in theory, still entitled to both. Nevertheless, this entitlement belies the fact that benefits are not usually paid in Bulgaria.

There are no specific data given for absenteeism, although it was felt that the rate has remained the same over the past three years. The main (and only) cause listed is sickness. It is suspected by the affiliate that the incidence of employees attending work despite being ill increased, because of jobs reduction. Stress is (and was) considered as a serious issue, with the two main causes identified as "bad working conditions"; and "crisis in medical institutions, absence of medicines".

Management is required to involve trade unions as members of Health and Safety Committees, and around 90 per cent of hospitals in the public sector do operate such a committee. Occupational health services are also a feature of the sector. Conditions in hospitals and clinics are reported to have remained the same, despite new legislation. There are penalties for employers who do not respect laws and regulations governing health and safety, labour inspections or maternity protection, although there are none covering the payment of disability/ invalidity benefits.

### Representation security

Employees in the sector who were members of unions have decreased from 80 per cent to approximately 65 per cent over the reference period. The reported decline may be due in part to perceived hostility towards unions in both the public and private sectors. The role of unions in the public sector includes negotiating in the traditional areas of wages (via collective agreements), benefits (leave and meals) and training. The role of unions in the private sector is not thought to be significant.

Associations also play a role in negotiating wages and benefits in the public sector (participating in collective agreements) as well as in the training of trade union leaders. Indeed, secondary sources indicate that the Bulgarian Medical Association, the Bulgarian Doctors Union and the Bulgarian Associations of Pharmacists and Dentists have acquired rights to negotiate with the Insurance Fund, (although nurses have not won this degree of recognition). Details of membership in associations were not provided, but it was felt to be higher in the public sector.

Bulgarian health sector workers do not have the right to strike and thus unsurprisingly there were no days reported lost to strike action in 1999, although some demonstrations took place over the reference period.

The BSS records collective bargaining at the national, hospital and provincial levels and reports that unions have regular consultations with national partners to discuss work places, wages and working conditions, although only in 40 per cent of cases were these consultations felt to be useful.

### Income security

Average wages in the sector, as of April 2001, were 186.56 LEV (US$88), having risen from 100 LEV (US$50) in June 1998. This rise however belies a trend of falling average wages for nurses, administrative staff, support staff and those working in allied health services. Only doctors are reported as having seen a growth in their wages over the

past three years. No data are available on wage determination or on the percentage of wages derived from secondary payments, although secondary data suggest much of the economy depends on informal or barter payments. Over the past three years a worrying 45 per cent of the public sector workforce did not receive their full wage on time. These delays represent a rise on previous years and are reported as being due to the limited budget of hospitals.

More worrying still, 25 per cent of the workforce seem to be have been paid at or below the minimum wage in 1999, a rise on the 1996 level (20 per cent). No details are presented on staff entitlements to either enterprise or government paid benefits. The health sector's pension scheme provides recipients with 26-30 per cent of their wage across all categories and over the last three years an additional voluntary pension security system has been introduced. No details are provided of the percentage of registered unemployed receiving benefits.

## 7.4 Croatia

### Structural changes

The responding unions do not have access to complete data but stress that wages in health care were reduced by 5 per cent in 2000 and that in 2001 the Government determined wages by a special decree without the usual collective agreement, resulting in an average wage reduction of 10 per cent (and in some cases of 35 per cent). The PSI affiliates have notified the ILO of the breach of ILO Convention 98.

The affiliates identify the key reforms of the 1990-1999 period as the privatization of pharmacies and special health care facilities and the introduction of fee paying services for certain hospital services and drugs. The number of hospitals and clinics remained the same while expenditure on health care compares favourably with many CEE countries. The recorded expenditure at 7 per cent of GDP is on a par with the Czech Republic for 1999.

Secondary data highlight consolidation of the health insurance system and the vesting of ownership of health care facilities in distinct public sector bodies as key reforms. Teaching hospitals are owned by the state, general hospitals and health centres (including primary care) facilities by the counties, and the large hospital-health centre conglomerates were broken up to allow separate elements to be run as individual enterprises. Hospitals and health centres are managed by boards whose members include employees and appointees of the owner (state or county). Primary care facilities have been leased to private providers and ambulatory services have been privatized. There are also private polyclinics operating from private premises.

The previous system was highly decentralized and based on self-management, with poorly defined ownership and a lack of management accountability. The current system has seen some recentralization with more clear responsibilities at county and state (formerly federated state) level and a single main third-party payer. Notwithstanding, there is still considerable local management control by semi-autonomous or private providers.

The health care system of Yugoslavia was insurance based but, given its high level of decentralization, did not have a single, major third-party payer. The establishment of the Croatian Health Insurance Fund has consolidated the system and standardized out-of-pocket payments.

The World Bank has loaned funds to reconstruct health facilities in remote areas, to develop emergency services and to build and equip certain tertiary care facilities. The funds amounted to 3 per cent of revenue in 1995 and 1 per cent in 1997.

## Labour market security

The total number of staff (for public and private sectors combined) as reported has fallen by only just over 1,000 over the reference period, with a slight rise in numbers of female staff. However, secondary data indicate that numbers of doctors, dentists, nurses, midwives and pharmacists all increased between 1995 and 1997, suggesting either significant falls amongst administrative staff or more prevalent redundancies outside this period. Employment shifted markedly from the public to the private sector, with just over 14.5 per cent of persons employed in the private sector in 1999 compared to 2.2 per cent in 1990. The commercialisation and the privatization of services and restructuring are felt to have increased jobs.

Unemployment was 5,039 in 1999. The average period of unemployment after redundancy was 18 months. Part-time staff numbers appear to be low at only 723, the majority being women. Only 0.7 per cent of all employees combine their formal role with other work (and only doctors and nurses are affected). 30 per cent of redundant health sector employees are reported as having emigrated but there is no total figure given to set this in context nor is it possible to isolate the affect of the war. Despite privatization, contracted hours have remained roughly the same and the actual number of hours worked have decreased slightly. Only doctors are reported as working any overtime and this appears to be a standard contractual arrangement in Croatia, with 70 per cent of all doctors working 8 hours overtime a week.

## Employment security

All health employees, in both the private and the public sector, are entitled to severance pay and no significant difficulties in securing entitlements are reported. Women are entitled to maternity pay (with a benefit period of 12 months) and to return to their posts after leave and again there appear to be no difficulties associated with receiving benefits.

Five per cent of the workforce was reported to be on temporary contracts in 1999, although this was a new phenomenon and did not exist at all in 1996. The concept of contract labour is listed as not applicable. Secondary data describe how both public and private providers can contract with the Insurance Fund, private insurers or employers. Up to 30 per cent of doctors may be working in private practice. This suggests there may have been considerable fragmentation in employment.

## Skill reproduction security

All occupations report being able to use and maintain their skills, and retraining is provided, but without union involvement in its design. The number of job categories has remained the same and no change is reported in the number of tasks carried out.

## Work security

There are no available data on work-related injuries or absence from work due to injury, although the affiliates report that conditions have been improving with new equipment and stronger health and safety measures, and employees entitled to disability benefits. Benefits appear low however, at 10 per cent of the average wage, although there seem not to be limits to the period of entitlement.

The main reasons for absenteeism are given as illness and child's illness. It is felt that absenteeism had decreased and that employees are more likely to work when unwell because of "fear from dismissal". It is reported in 1999 that stress is serious, an improvement relative to 1990 when it is listed as very serious. There are only two causes given: "war situation (1990-95)" and "fear from dismissal".

Considerable emphasis is placed on the mandatory role for trade unions in Health and Safety Committees, and conditions in hospitals and clinics are reported to be improving.

### Representation security

The percentage of employees in the sector who are members of unions has decreased in a more controlled fashion than in the Czech Republic, and remains high at 70 per cent in 1999 (from 100 per cent in 1990). The public and private sectors are felt to be neutral on union membership. The number of unions has risen from 1 to 10 with professions allied to medicine represented by their own unions. Although data is limited, membership of associations was felt to have increased.

The affiliates list the main professions protected by specific unions or associations as nurses, medical radiology engineers and biochemists. Secondary data suggest that for physicians, dentists, pharmacists and biochemists, statutory professional chambers are responsible for professional standards, licensing and representing professional opinions. In addition, each health institution has a professional council (as distinct from the governing management board) of heads of departments who advise the director, and provide technical and professional inputs.

Collective bargaining operates at the national level, although as noted above this arrangement has collapsed since 1999. No laws restricted the right to strike, but this tends not to be exercised.

Unions seek to consult on "wages, other material rights and health reform", but do not have regular consultations with national level partners, since (at least most recently) "the government is not prepared to conduct genuine social dialogue". The percentage of consultations regarded as useful is "currently very low" but has been usefulover the last three years. The main problems faced by the union are "lack of social dialogue and slow operation of judiciary".

### Income security

Lack of data on price inflation within Croatia mean it is not possible to quantify the rise or fall in salaries in real terms. Nonetheless, it is felt by the affiliates that all occupational salaries have risen (although this is not borne out by the actual figures provided, perhaps due to recent falls). The figures show that doctors' salaries rose by 23.5 per cent and nurses salaries by 10 per cent between June 1998 and June 2001, while administrative and support staff salaries appear to be unchanged. Doctors' salaries were equivalent to 170 per cent of nurses' salaries in 1998 and to 190 per cent in 2001. Nurses' pay fell from 59 per cent of doctors' pay to 52 per cent over the 3-year reference period (although their salaries did nonetheless increase), while for administrative staff the drop was from 44 per cent to 35 per cent and for support staff from 35 per cent to 29 per cent. The affiliates state that "unions aim at reducing wage differentiation". Pay is received on time. All details on pay must, however, be seen in the light of a footnote written by the affiliates explaining that "in 2000 wages in health care were reduced by 5 per cent. In 2001 the Government interrupted the social dialogue and determined wages by a special decree (instead of a collective agreement) which resulted in an average wage reduction by 10 per cent and in some cases by 30 per cent".

Payment structures have remained unchanged between 1996 and 2001, the public sector maintaining a tariff whilst the private sector seems to combine a time rate with payment by results. Wages are determined by the number of insured persons except in primary health care and that some salaries have risen and others fallen as a result. It is to be assumed therefore that national collective agreements are for rates on which pay is based. Secondary data suggest that physician salaries as determined by national pay scales with income dependent on "professional qualification which determines the coefficient by

which the basic salary (the salary of a cleaner) should be multiplied". Physicians in primary care contracted to the insurance fund are paid using a mix of capitation and fee-for-service; they charge for services not covered by insurance. Payment of contracted physicians in secondary care is based upon fee-for-service.

In both the public and private sectors employees are not usually entitled to enterprise paid benefits, and all benefits are "stipulated by the law and collective agreement".

## 7.5 Czech Republic

### Structural changes

Decentralization of management and privatization are the key reforms. The situation is now relatively stable compared to 1996, with slight improvements in socio-economic security. Expenditure on health care has risen, as has the number of hospitals.

Most health care is delivered by primary providers under contract to the insurance funds (which are publicly funded). Similarly, 90 per cent of pharmacies operate privately along with two-thirds of health resorts. Ownership of facilities is either state-owned (Ministry or district authority) or non-governmental. Most hospitals are owned by the State and are contracted to provide services to the insured. Only 9 per cent of hospital beds are in private hospitals. Health centres and polyclinics, where the majority of primary care and ambulatory services are based, also tend to be publicly owned and are rented to the private practitioners who operate from them.

The previous health system was tax based and centralized. A key delegation of authority has been the shift of financing health care to the insurance funds. In addition, some regulation has been devolved to the district level or to professional chambers.

Nine independent companies now administer the compulsory health insurance that replaced the tax-based system. Competition between 26 funds, on the basis of the supplementary services offered, proved untenable and some collapsed with unpaid debts to providers. Funds no longer compete and are not permitted to make a profit but must keep any surplus in a reserve. The largest fund, the General Health Insurance Company, covers 75 per cent of the population and has a key role in negotiating health care finances. Weak regulation is being reviewed and it is hoped that cherry picking can be prevented, risks pooled more effectively and the funds strengthened financially.

Health expenditure is 7.36 per cent of GDP, which is relatively high compared to much of CEE but slightly lower than the average for Western Europe.

### Labour market security

Staff levels have fallen slightly, although secondary data suggest a slight rise in the number of doctors. More marked however, is the shift from public to private sector employment. Unemployment is low with 1,058 reported as seeking work within the sector. However, this decrease must be seen in context. As the affiliate reports "in 1990, there were many old-age pensioners working in the public health care sector for shorter hours. By 1999 the number of them dropped. They either now work full-time, or do not work at all, or work in the private sector which is not reflected in the statistics of the Ministry of Health". Part-time work decreased significantly between 1990 and 1999 from 8,700 to 1,970, and the majority of those now working part-time are women.

Some 13 per cent of staff are reported as combining formal activity with other work, with all except nurses affected. Six per cent of redundant health sector employees are reported as having emigrated but there is no total figure given to set this in context.

Nonetheless, it is clear from the affiliate that countries like Austria, Germany and Italy seek to recruit Czech nurses to meet their own staff shortfalls. Despite privatization, hours contracted have remained roughly the same but actual hours worked have risen slightly across all occupations, most significantly for doctors. Furthermore, some 93 per cent of doctors work overtime.

Many pensioners continue to work although the figure has fallen slightly and the affiliate gives a positive review of pension arrangements (noting that 100 per cent of occupations are covered).

### Employment security

A high percentage of employees are entitled to severance pay and no difficulties in securing entitlements are reported. Maternity leave has stayed the same and is compensated for "usually 28 weeks at the birth of 1 baby; up to 37 weeks at the birth of 2 or more babies or if the mother lives alone; up to 22 weeks at the adoption of 1 baby; up to 31 weeks at the adoption of 2 or more children or if the mother lives alone; 31 weeks if the father taking care of the child lives alone or up to 22 weeks if the father takes care of the child instead of the mother; 14 weeks if the baby is born dead". The number of staff working with temporary contracts has fallen from 14.5 per cent in 1990 to 6.35 per cent in 1999.

### Skill reproduction security

Employees are reported as being able to use and maintain their skills; retraining is provided, but with only limited union involvement in its design. The details of training remain the competence of the state educational system, but unions are able to influence legislation by commenting on bills. At the enterprise level, unions negotiate conditions to facilitate employee access to training (specifically paid time off for training, allowances, and inclusion of specialized courses for certain groups of workers). The number of job categories reported has decreased, but the categories have tended to be upgraded, no doubt due to the *acquis communitaire*. The range of job tasks has increased for all staff in all sectors.

### Work security

The number of injuries has decreased slightly, although the average length of an absence from work for injury has risen. No fatal injuries were reported in 2000. No law exists requiring management to involve trade unions as members of Health and Safety Committees, and the execution of safety measures is exclusively an employer competence. Unions nevertheless do have a key role in the inspection of health and safety provision, both at the branch level and through their state remunerated experts. Unions are also able to comment on draft legislation concerning health and safety issues. While it remains the duty of employers to secure safety and health protection at work, compulsory inspection of all facilities is the province of trade unions and this may help to account for the fact that conditions in hospitals and clinics are reported to be improving.

Czech workers are generally entitled to disability/invalidity benefits and usually receive them, although problems are reported on "how the range of disability is calculated and how much the invalids are paid". Disabled workers as a group are described as "one of the very vulnerable ones". The Government is looking for ways to improve their situation or at least employability, despite the fact that they are often not union members.

Absenteeism is attributed to illness and non-occupational injury and is believed to have remained at similar levels in recent years. There is no perceived change in the numbers attending work that could be absent. Stress is seen as somewhat serious and not to

have increased, the main causes being unemployment, social insecurity and low income levels.

## Representation security

The percentage of employees in the sector who are members of unions has decreased sharply form 93.5 per cent in 1990 to 32.5 per cent in 1999. This may be in part due to discouragement by the private sector. The public sector is felt to be neutral on union membership.

Although no specific data are held on the percentage of the workforce who belong to associations it was felt that membership had increased, although interestingly the examples of associations given were clearly aimed at institutional, not individual, membership. Secondary data mention chambers (professional self-regulating bodies) taking a role in standards and licensing for medicine, dentistry and pharmacists as well as professional medical societies and associations. The affiliate states that "the different trade unions and associations have different priorities and spheres of interest, therefore their individual role and importance is rather different in individual cases".

The union has consultations with national level partners, the main topics being "wage policy and remuneration, labour claims and conditions and the network of health care facilities and its funding". These are held to be useful no more than 10 per cent of the time. The major problems faced by the union are listed as "limited opportunities for the range of collective bargaining in the public sector, no partner for collective bargaining on a higher (regional, national) level, collective bargaining being possible only on the level of individual enterprises and fragmentation of trade unions". After 1990, several unions were established to represent the interests of rather small groups of individual professions in the sector. It is suggested that the fragmentation and promotion of partial interests is sometimes at odds with general representation and hinders reaching a general agreement.

The role of unions in the public sector in determining wages and benefits was felt to be significant, whilst in the private sector it was felt small. The affiliate also reports the role of unions in pushing for greater wage differentiation. It has a key part in addressing the current system of graded pay scales with defined steps or increments per scale linked to a Catalogue of Work Tasks agreed legally with the Government. These are due to a change to 16 grades with 12 steps in 2002. Private sector grades are also set out although these are slightly simplified.

There are no laws restricting the right to strike.

## Income security

Absence of data on inflation makes it impossible to quantify the rise or fall of salaries in real terms, but the affiliate feels that over the last three years, wages have risen in all occupations other than support staff. Secondary data suggest that doctors' salaries are twice the average national income and that specialist doctors in private practice earn four times the national average. Salaries for nurses have increased significantly since 1990 and are reported as almost equal to the state average. The literature attributes much of the impetus for reform in the first instance to medical professionals and their unhappiness with relative levels of pay. It suggests that, despite improvements, they are still frustrated about their position *vis-à-vis* other higher earning groups in Czech society and their Western European counterparts.

Reimbursement in both the public and private sectors involves payment by results, but it is unclear precisely what this term means. Fee-for-service approaches are increasingly constrained by limits to volume and in hospitals, tend to be replaced by lump sums to counteract incentives to overtreat and escalate costs.

The affiliate suggests that decentralization contributed to a marked increase in salaries and greater differences between groups. Specialists are reported to have done well, as have "workers performing the up till then undervalued tasks, e.g. accountants, programmers etc". Differences are recorded between "entrepreneur" and "non-entrepreneur organizations", with more wage differentiation in entrepreneurial organizations with foreign company involvement and slower wage growth in non-entrepreneurial settings. Private hospitals pay at similar levels to the public sector but other private facilities (outpatient clinics, spas etc.) have their own regulations. Nonetheless, average wages usually do not differ very much from the general average.

## 7.6 Georgia

### Structural changes

The BSS reports a significant programme of hospital closures with numbers having decreased from 480 in 1990 to 280 in 1999, 175 of which were small institutions with less than 100 beds. Secondary literature highlights the dislocation of the health care system, which took place on independence and during the subsequent economic collapse. Civil war in the region saw population displacement and hospitals damaged or used to house refugees, while economic crises resulted in huge cuts in public health expenditure per head, and extensive reliance on out-of-pocket payments. Demand for services fell radically as users were expected to pay and as the fabric of buildings and equipment deteriorated. Many people are still deterred from seeking medical attention due to inability to pay. Consequently, radical reforms are being introduced and have already had a huge impact on socio-economic security. Key changes, first mooted in 1995, include social insurance, official user fees and new provider payment mechanisms.

Decentralization has made up one strand of the reform process, with 12 Regional Health Administrations taking on decision-making and funding responsibilities at a local level, while the Ministry of Labour, Health and Social Affairs increasingly restricts itself to a broad role in policy development, health promotion, public health, research and education. The 65 Municipal Health Authorities are in turn responsible for hospitals, polyclinics and primary care. Parallel health systems continue, although with some integration into mainstream health care provision. High profile national and regional committees are being established to guide health policy implementation and cross-sectoral work and to provide coordination and oversight of the management structures in place.

The State Medical Insurance Company is a major step in deconcentrating the role of the Ministry and is itself decentralized in structure. It was set up in 1997 and has special status being neither a state owned enterprise nor a private corporation. It is a publicly owned, non-profit venture that collects mandatory premiums from the population and contracts providers to ensure delivery of a basic benefits package. It has 12 regional branches and works alongside, but independently of, regions and municipalities who cover some basic services themselves out of their own funds.

Privatization has been extensive and linked to decentralization and new insurance mechanisms. Hospitals and clinics were first made financially and managerially autonomous from the Ministry in the 1995, with subsequent reforms strengthening their independence. They operate contracts with the state insurance company (for cases covered by the basic package) or the municipalities (for delivery of municipal programmes) or central government (immunization or other national programmes). Pharmacies, spas and dentists were the first to be privatized outright in 1996. Increasingly, other providers are becoming either limited liability or a joint stock companies. Limited liability companies are more common and confer fewer rights on staff to participate in decision-making. They

also vest property rights in the Ministry of State Property. There has also been a huge growth in poorly regulated private medical and nursing training schools.

Public expenditure on health care has been low, with spending in 1994 recorded as only 1.1 per cent of Gross Domestic Product, as compared to 2.6 per cent in 1990 and 2.1 per cent in 1996. The survey suggests it rose to 4.3 per cent of GDP in 1999, but UNDP figures set it as low as 0.6 per cent for that year. Spending is clearly less than needed to finance basic care. Direct out-of-pocket payments, both formal and illegal, are central to the system. The World Bank estimates only 22 per cent of all health expenditure is from governmental sources. The Bank and other agencies have played an active role in health system reform, and in financial loans and other support to the country. They are also central to recent poverty initiatives.

### Labour market security

The BSS suggests that restructuring of the system has led to job losses, noting that the number of employees (and not all staff) shrunk from 184,080 in 1990 to 85,520 in 1999. This is consistent with government data on falling staff-to-population ratios. No details of unemployment in the sector are given, although it is reported that many unemployed staff are not seeking jobs in health care, as they believe that no work is available. Some of the difficulties in measuring workforce change from 1990 may be attributable to the disruption on independence and the separatist pressures in autonomous regions, which led to population displacement and emigration. Data for the Abkhazia region are not available.

No data are provided on levels of part-time or short-time employment. However, administrative leave is clearly endemic, with 50 per cent of employees being either unpaid or partially paid in 1999. This is a reduction on the 1990 level (65 per cent), but is still worrying. In addition, 40 per cent of staff combine their formal role with other work. Nurses, administrative and support staff most commonly carry out dual roles. The pressures staff face must help explain why 31 per cent of redundant trained employees have left the country to seek work elsewhere.

The number of hours that staff are contracted for has remained unchanged over the decade and is in the range of 40 to 45 hours per week. 55 per cent of doctors and nurses work overtime, whilst 58 per cent of administrative and support staff work additional hours. Doctors and nurses work on average 35 hours overtime per week, and support staff 40 hours, that is double their contractual hours.

Pensioners represented 28 per cent of those in the workplace in 1999, a reduction from the 1990 level of 36 per cent. Early retirement schemes have been introduced, with 12 per cent of the workforce taking up the option.

### Employment security

A high percentage of employees are entitled to severance pay and no difficulties in securing entitlements are reported. Severance pay in the public sector stands at two months for regular employees, the same period as advance notice of redundancy. Women are entitled to maternity pay and to return to their posts after leave and again appear to receive their entitlements of four months of compensated leave. 26 per cent of women in the health sector were reported as being on maternity at the time of the survey.

Worryingly, staff working on temporary contracts rose from 46 per cent in 1996 to between 80 and 100 per cent in 1999. The percentage of staff working as contract labour or on commercial contracts has also grown from 75 per cent in 1996 to 86 per cent in 1999. This tallies with government policy that provider units should hold employment contracts directly, with market forces determining how many employees each institution could support.

### Skill reproduction security

Employees are reported as being able to use and maintain their skills and retraining is provided, but without unions involvement in the design. Despite an overall increase in the availability of training, access is limited by age restrictions and a lack of funding, as well as by reluctance of staff to participate. The number of job categories over the past three years has remained constant, as has the number of job tasks for doctors and administrative staff.

### Work security

The number of recorded injuries is unusually low as are the number of days lost to work-related injuries and diseases. The first is falling slightly, whilst the second shows a marginal increase. The payment of disability and invalidity benefits is unchanged with no difficulties reported in securing entitlement. Average disability/invalidity benefits stood at 100 per cent of wages and last for up to six months, although in the past coverage was for one year. In-kind benefits are also provided to employees.

The absenteeism rate has risen rose slightly over the reference period, and was strikingly high in both 1990 and 1999 (16 per cent and 18 per cent respectively), but in the past three years the level is thought to have dropped. This may be explained by the perceived increase in the number of employees who attend work even when ill. Absenteeism in the sector is attributed to "gastrointestinal diseases and taking care of sick children".

Stress is now considered to be very serious in Georgia compared to serious in 1990. The three main causes identified are staff reduction, low income and family reasons.

Management is required to involve trade unions in Health and Safety Committees, with some 60 per cent of public hospitals operating such a committee. Cooperation with management in implementing health and safety is reported as a recent development, but health workers are not provided with occupational health services. Conditions in hospitals and clinics are reported to have remained the same over the past three years, although observance of safety measures has worsened. Regular inspections of primary, secondary and tertiary care facilities remain in place. There are no penalties for breaches of regulations on joint Health and Safety Committees but disability/invalidity benefits are protected and government labour inspectors liaise with trade unions.

### Representation security

The percentage of employees in the sector who are members of unions has decreased slightly from 99.27 per cent in 1990 to 94.04 per cent in 1999, despite the discouragement of unions in hospitals. 18 per cent of the workforce belongs to an association, an increase on previous years. Secondary data list the Georgian Medical Association, the Association of General Practitioners and Family Doctors and the Georgian Nurses Association (set up in 1998, 1995 and 1996) as influencing education and standards.

Five days were lost to strike action in 1999 compared with 9 in 1990. Industrial action also included demonstrations and refusals to work. No details are provided on the legality of strike action.

Collective bargaining takes place at the national, hospital and provincial levels and unions have regular consultations with national level partners to discuss social and other issues. Such consultations are estimated to be useful in achieving the union's objectives 30 per cent of the time, a percentage that has not changed in recent years. Major union concerns in representing members' interests are social issues, collective agreements and labour disputes.

### Income security

Without data on inflation, it is difficult to quantify the rise or fall in salaries in real terms. However, the affiliate feels that wages have risen for both doctors and nurses over the past three years. This is confirmed by UNICEF data, which show a fall in wages by 1996 to only 42 per cent of 1989 levels, followed by a climb, so that by 1998 they had risen by a factor of 7. Wages are based on results for all occupations, which is in line with government and insurance scheme stipulations. Notwithstanding increases in real pay, 50 per cent of staff working in the public domain and 10 per cent in the private sector did not receive all of their wages on time in the three months before the survey. Furthermore, the percentage of the workforce receiving wages at or below the minimum wage in 1999 stood at 90 per cent and 50 per cent in the public and private sectors respectively. No details are provided on secondary payments made by patients to health sector employees, or on the extent of secondary employment in the sector, but these are reported elsewhere as being very significant.

Enterprise-paid benefits are available with 100 per cent of nurses and doctors receiving the allowances, but only 10 per cent of support staff and those in allied health services. Most hospitals also operate a social fund. No data are available on pensions schemes in Georgia except that contributions paid by employees have decreased in the last three years.

## 7.7 Kyrgyzstan

### Structural changes

The affiliate identifies the "MANAS" programme of health sector reform (1996) and its continuation through health protection (2000) as being of greatest significance. The number of hospitals and clinics has actually increased over the last decade, albeit by a small amount, although bed numbers overall have declined according to secondary data, which might suggest ward or bed closures within large institutions. Public expenditure on health care has decreased to 2.1 per cent of GDP in 1999, from 3.9 per cent in 1990.

Secondary data suggest that the "MANAS" programme was an attempt to reduce over capacity and the share of resources going to hospitals, and to invest more heavily in primary care. The main thrust of the reform has been the introduction of the Mandatory Health Insurance Fund. Reforms have also included the formal recognition and organization of user fees (co-payments), the restructuring of the pharmaceutical sector and pilot work in developing models for integrated primary care.

Only a small private sector exists in Kyrgyzstan, confined mainly to urban areas and concentrated in ambulatory care and pharmaceutical retail. Privatization of employment contracts is negligible, as is private ownership of facilities. Unions are discouraged in private sector hospitals.

The State is still the main purchaser and provider of health care services and some centrally determined norms persist. However, *oblasts* (local government) are being given increasing responsibility and are now required to fund some health care from their own revenue sources.

A loan from the World Bank of 18.5 million dollars was made for health sector reform and to encourage primary health care. A major shift to family medicine and group practices away from polyclinics is anticipated but is still at a pilot stage.

### Labour market security

Staff levels in the public sector have risen since 1990 by around 6,000. Although women still make up the majority of the workforce, the majority of new staff are men. Nevertheless, changes in management, budget cuts and restructuring are all reported as having decreased jobs and there has been an increase in unemployment from 112 in 1990 to 559 in 1999, although this tends to be disguised by rising employment.

No data are provided on the level of part-time or short-time employment within the sector. Administrative leave is significant in Kyrgyzstan and in 1999 stood at around 12 per cent, compared with 4 per cent in 1990. The percentage of staff combining their formal role with other work stood at 24 per cent in 1999, with nurses and support staff mainly affected. For all categories, 30 per cent of total income comes from secondary jobs. Of redundant trained health sector employees, 0.5 per cent have gone abroad to find employment. The number of hours that staff are contracted for has remained unchanged over the decade. Almost half of all administrative staff and a quarter of support staff work overtime. Other occupations such as doctors and nurses work significantly less overtime.

Approximately, 18 per cent of employees in the health sector were also pensioners in 1999, which constitutes a significant fall on 1990 figures (32 per cent). An early retirement scheme has been introduced to the sector, with 16 per cent of the workforce being placed on the scheme.

### Employment security

A high percentage of employees are entitled to severance pay and no difficulties in securing entitlements are reported. Severance pay lasts for three months and advance notice in cases of redundancy stands at around two months. Women are entitled to maternity pay and to return to their posts after leave, and again appear to receive their entitlements. Nevertheless, maternity leave entitlements have decreased over the decade. Compensation during maternity presently stands at three months.

In 1999, 24 per cent of workers in the health sector were recorded as working on temporary contracts compared with 16 per cent in 1999. Contract labour or commercial contracts employed 36 per cent.

### Skill reproduction security

Employees are able to use and maintain their skills, with unions being involved in the design of training. Access to training has improved, although there still remain some restrictions due to insufficient funding and some concerns about equity of access in different regions. Job categories have been upgraded over the past three years, and in general the number of job tasks has increased across all occupations.

None of the changes in skill reproduction security were ascribed to the reforms but were explained as the “effect of International Conventions and Acts and the inceptive introduction of democratic components in the real life of the republic”.

### Work security

The number of work-related injuries has decreased over the last decade to roughly one quarter of 1990 levels. Consequently, working days lost have decreased to 680 in 1999. There are no data on the number of days lost to work-related diseases. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. On average disability/ invalidity benefits are paid at 100 per cent of the average wage and until the recipient is fully recovered or disability established.

Absenteeism has fallen in Kyrgyzstan. Existing absenteeism is attributed to annual leave and disease. The incidence of employees attending work despite being ill has increased, due to financial motivation. Stress is not considered as being serious, but concern exists over unfavourable situations at home and work, as well as the lack of financial resources.

Management is not required to involve trade unions as members of Health and Safety Committees, however occupational health services are provided. Possibly as a result of the exclusion of unions, conditions in hospitals and clinics are reported to be getting worse over time. There are no regular inspections of facilities by government labour inspectors, although "public inspectors on occupational health and safety are elected in each structural unit".

### Representation security

Union membership which stood at 100 per cent in 1990, reduced to 95.5 per cent in 1999. This continuing high level is perhaps due to the support for unions in the public sector. No days were lost to strike action in 1999.

There is one key trade union federation, of which the Health Workers Union with 100,000 members is one of the biggest affiliates. The Association of Physicians and Pharmacists founded in 1992 has little policy-making influence. It has been joined by an association of nurses and others, the Family Group Practice Association and the Hospital Association (both established in 1997 and closely linked to the Ministry of Health).

Unions in Kyrgyzstan are involved in negotiating wages and benefits as well as in training; there is no reported involvement in hospital management. Associations, by contrast, are reported as active in wage and training negotiations. No details are provided on membership of associations.

Collective bargaining takes place at national, hospital and provincial levels, and unions have regular consultations with national-level partners on legal issues, socio-economic issues and labour issues. These are seen "as useful 40 per cent of the time". The most important problems facing unions are "issues of wage, because it is lower than subsistence minimum and rate of resources allocated for health improvement, it is very low". There are no restrictions on the right to strike.

### Income security

Without data on inflation, it is not possible to quantify the salary changes in real terms, although the responding union feels that wages have risen over the past three years across all occupations. Nevertheless it needs to be remembered that wages are reported as lower than subsistence minimum, even though no workers are receiving wages "at or below the minimum wage".

All occupations are paid by tariff according to time and results. Secondary data suggest that pay is still predominantly salary based, with few incentives for productivity or for working in rural areas. Nevertheless, capitation, case payments and bonuses are all being piloted and may be extended. The union appears to be in favour of differentiation, which it describes as "increase(ing) workers' interest in the intensiveness and quality of their work and get a guaranteed and additional wage".

For all categories except allied health services 20 per cent of wages come from secondary payments made by patients. This suggests that pay is derived from a formal payment system, not informal or gratitude payments, s ince these typically do not reach all staff equally. Secondary data suggest that fee-paying (formal and informal out-of pocket)

is a major source of revenues and includes formal user fees and semi-official charges for consumables, as well as under-the-table payments and private charges.

Over the last three years delays in wage payments have decreased, although this still affects 40 per cent of the workforce.

There is no entitlement to enterprise-paid benefits. No details are provided on government-paid benefits. Details of pension payments are sketchy, but it is reported that the percentage of pension contributions paid by employees has increased.

## 7.8 Latvia

### Structural changes

The introduction of mandatory state health insurance (in 1996) and the development of primary medical service (creation of family doctors) are the key reforms. The number of hospitals has decreased over the last decade, although public expenditure on health care has increased to 3.7 per cent of GDP in 1999. WHO estimates of total public expenditure on health care are slightly higher at 4.4 per cent of GDP.

Responsibility for primary and secondary care provision was devolved to local governments in 1993, and they were given a considerable role in financing (although specialist, tertiary provision remained a State function). A round of re-centralization in 1997 superseded this early and extensive decentralization, limiting local responsibilities to provision and allowing more rational and equitable funding.

The introduction of mandatory state health insurance is something of a misnomer, as the State Compulsory Health Insurance Agency or regional sickness funds do not collect premiums but rely instead on tax revenues. A percentage of income tax is devoted to health but there are no earmarked salary deductions and no risk pooling. Voluntary, private health insurance has been introduced but is relatively restricted. It is used most by companies to give staff additional benefits and easier access to the system.

Secondary data suggest that privatization is extensive and includes ownership of facilities (many polyclinics, most pharmacies and dental practices) and the employment contracts of staff working in a private setting (who are employed directly by the institution). Primary health care reforms aim at a major shift to private provision, but change is still patchy. There has been only minimal privatization of hospitals. The State continues to be the most significant employer, particularly in the hospital sector. Private providers deliver services under contract to the sickness funds (part of the statutory system) and to fee-paying patients. Formal out-of pocket fees are now a major source of revenues, including prospective user co-payments but private care is out of reach of much of the population. The Ministry of Welfare suggests that only 7-10 per cent of expenditure is made up of out-of-pocket payments, whereas WHO European Regional Office data give a figure of 21 per cent in 1998-9 and the World Health Report 2000, 39 per cent. Some of the confusion may be due to the difficulty of estimating under-the-table payments, which are believed to affect only some segments of the population (70 per cent of respondents in a study on perceptions of corruption suggested that they never made unofficial payments or gifts for medical care).

Latvia has received IMF credits twice, first at the time of a banking collapse and then to support economic policy implementation including streamlining state administration, structural reform and privatization.

## Labour market security

Overall staff levels in the public sector have fallen, with losses only partly offset by increases in the private sector. Secondary data suggest that physician numbers and nurse numbers have fallen dramatically since 1991.

Unemployment is low with 721 reported as seeking work in 1999 within the sector. Existing unemployment was attributed to a shift to fee-paying services, to changes in management systems and to restructuring. In 1998, 5.3 per cent worked part-time, the majority of whom were women. Some 5.8 per cent of the workforce worked less than their contacted hours in 1998, 0.4 per cent were on administrative leave and 6.8 per cent of all staff (except administrative staff) were reported as combining their formal role with other work. The number of hours that staff are contracted for is unchanged over the decade as are the actual number of hours worked. Actual hours for both doctors and nurses have therefore remained high at an average of 60 hours a week. Approximately, 60 per cent of doctors, 65 per cent of nurses, and 60 per cent of allied health workers, work overtime.

12 per cent of employees were pensioners in 1999; no early retirement provision exists in the sector.

## Employment security

A high percentage of employees are entitled to severance pay and no difficulties in securing entitlements are reported. Nevertheless, severance pay is less than generous with an average of only one month's pay on redundancy. Women are entitled to maternity pay and to return to their posts after leave, and also appear to receive their entitlements. These entitlements are reported to have increased over the decade, and now stand at 112 days or approximately four months. 90 per cent of workers work as contract labour or on commercial contracts as opposed to labour contracts, a 10 per cent fall on previous years.

## Skill reproduction security

Employees are able to use and maintain their skills and unions are involved in the design of training. Nevertheless, some difficulties are reported, most notably that the employer does not cover all costs.

The number of job categories was felt to have remained the same over the past three years, however the tasks undertaken have increased for much of the workforce, especially in the public sector.

## Work security

Reported incidents of workers missing work for one day or more as a result of a work-related injury fell from a high of 7,002 in 1990 to 860 in 2000. Likewise, the number of days lost fell from 165,900 in 1990 to 26,000 in 2000. Days lost from work-related disease are also down by over 80 per cent. The payment of disability and invalidity benefits is unchanged and no difficulties are reported.

Absenteeism is reported as decreasing although exact figures are not given. The two main reasons for absence are seen as "disease and family reason". The decrease is attributed to "a fear to lose job and disability benefits rate is lower than wage rate". This fear is borne out by more staff working when they might otherwise be absent because "employers do not like workers frequently getting sick."

Stress has diminished from being "very serious" in 1990 to "serious" in 1999. The main causes of stress are given as "socio-economic reasons, a fear to lose job and

increasing number of those having serious illness" (this last despite the fall in absenteeism due to disease and recent increases in life expectancy).

Management is required to involve trade unions as members of Health and Safety Committees, and conditions in hospitals and clinics are reported to be improving over time, due perhaps in part to the compulsory inspections of all facilities.

### Representation security

The percentage of employees in the sector who are members of unions has decreased sharply from 99 per cent in 1990 to 50.2 per cent in 1999. Both the public and private sectors were felt to have discouraged union membership. The number of unions operating within the sector has remained at two. There were no reported days lost to strike action in 1999, although some demonstrations have taken place over the reference period. There are no laws restricting the right to strike.

The role of unions in the public and private sectors in determining wages, benefits and training was felt to be very significant whilst associations in the field were limited to the organization and upgrading of training courses. While 60 per cent of the workforce belongs to an association, 26-50 per cent belong to both a trade union and an association. Secondary data suggest that the Latvian Physicians' Association was influential in pushing for reform and includes representatives of specialities and sub-specialities for professional standard setting and licensing. The Association of Physicians organizes postgraduate studies.

Unions in the public sector are seen to carry out collective bargaining at country and local levels, to provide needy employees with financial aid on different occasions including training and certification, suggesting that unions play a particularly active role in indemnifying members against hardship. Consultations with national partners take place 3-4 times a year and no obstacles are listed. The main topics for discussion are said to be wages, financing and draft laws and health sector reform. They are seen to be helpful only 30 per cent of the time. The main problems are "unwillingness of the Government to consider health sector as a priority, negative attitude of employers towards the wage increase and trade union activists fear of the employer, a fear to lose job and dependence upon the employer".

### Income security

The affiliate feels that whilst average wages have risen for allied health workers and administrative staff, pay for doctors, nurses and support staff has fallen. Remuneration of doctors and nurses in the public sector is reported to be based on performance, although this is dependent upon the type of work being carried out. For doctors delivering ambulatory care, the system is based on the principle of capitation and depends upon the number of patients registered per family doctor. Employers are recorded as determining private sector payment levels.

Over the last three months 0.19 per cent of the public sector and 0.08 per cent of the private sector did not receive their wages on time, a decrease on earlier levels. In the public sector, 2.3 per cent of the workforce received remuneration at or below the minimum wage level, whilst this figure rose steeply to 13.9 per cent for the private sector in 2000. In both public and private sectors employees were usually entitled to enterprise and government benefits.

Secondary data highlight the problems that took place when a shift from salaries as the main form of physician payment took place after 1993. The move in most of the country towards a points systems linked to services delivered (for primary, ambulatory and secondary care) is now seen as an error that created perverse incentives to over treat or

treat more expensively. (A contrasting pilot model combined capitation plus fee-for-service in primary care and retaining salaries for specialists). The move in primary care is now towards a capitation-based mixed formula with a fund holding element included. The capitation payments will include a salary element for both physician and nurse, adjustments for age and mix of population covered and patient numbers, plus additional funds to allow the physician to buy other ambulatory services from specialists on a fixed fee-for-episode-of-care basis. There is resistance however, from both physicians and patients and it is unclear how far it will be implemented. These data also report that salaries in the sector are low, undermining motivation and leading to losses from the professions.

There seems to be a general sense that the union is in favour of wage differentiation and of formula designed to ensure equal pay for equal work (i.e. one which includes incentives and rewards for those working harder). It appears that only modest differences are advocated so "trade unions have developed a system of remuneration of labour with a guaranteed part for all occupations, a 10 per cent bonus for intellectual contribution (certification, responsibility, work intensity) and a 20 per cent bonus for night work and hazardous working conditions".

## 7.9 Lithuania

### Structural changes

The introduction of mandatory state health insurance in 1997 and the restructuring of the system via the division of institutions into three levels are the key reforms. The number of hospitals and clinics has decreased over the last decade, albeit by a small amount, whilst public expenditure on health care has remained steady at around 4.4 per cent of GDP.

There was rapid decentralization on independence; however, there has been some subsequent recentralization to offset the unintended fragmentation and loss of coordination that followed. The main responsibility for paying for health care has nonetheless been transferred to the State Sickness Fund and some 90 per cent of finances came from statutory insurance in 1998, compared to 15 per cent in 1994. However, tax contributions have continued to play a major part in funding, with only 20 per cent of the Fund's revenues actually derived from payroll deductions and the contributions of the self-employed. The balance is transferred to the fund from employers and through state budget transfers. This mixed system is intended to minimize transaction costs with the Ministry controlling prices. Voluntary, private health insurance has been introduced but is relatively limited, mostly covering those travelling abroad.

Secondary data suggest that significant privatization in the Lithuanian health sector is confined to pharmaceuticals (accounting for 100 per cent of wholesale and 73 per cent of retail trade in 1995) and to a lesser extent dental care (79 per cent of dentists), cosmetic surgery, psychotherapy and gynaecology. A few dental polyclinics had been privatized by 1999 but no hospitals. Ownership of facilities is largely unchanged. Guidelines on the privatization of primary health care have been formulated, but the bulk of primary care is still publicly provided. Similarly, private insurance is allowed but was still very limited in its development in 1999. This may be because, although the sickness fund can contract with private providers, these are liable for a high rate value added tax. Most private care (fees for dentistry or other private services) is paid for out-of-pocket and when combined with out-of-pocket co-payments for pharmaceuticals, tests or spa services, may contribute as much as 23 per cent of total health care expenditures.

## Labour market security

Staff levels have risen since 1990 by around 5,000, but this disguises a slight fall in employment since 1996 in both the private and public sectors. Correspondingly, unemployment has grown since 1996 to 2,416 in 1999. Existing unemployment was attributed to restructuring, whilst the privatization of services, a shift to fee-paying services and changes in management systems was thought to have had a positive effect on employment levels.

Secondary sources suggest that staff numbers remain high and that the numbers in training will sustain current trends. Labour force statistics of 1993 and 1998 support the view that the sector suffered little unemployment during the post-transition economic downturn and that female auxiliary staff in urban areas suffered most. This suggests the rising trends are largely in the professions allied to medicine, support and administrative tasks.

No data are provided on the level of part-time or short-time employment. Administrative leave in 1999 was believed to stand at around 0.5 – 3 per cent. No specific data were available on the percentage of staff combining their formal role with other work, however doctors, nurses and support staff were all felt to be carrying-out these dual roles. Contracted hours have remained unchanged over the decade, whilst the actual number of hours worked have decreased for many occupations and thus fallen in line with contractual obligations. Hours worked are relatively short, at around 30-40 hours/week.

Approximately, 12.4 per cent of employees in the health sector were also pensioners in 1999, compared with 21.6 per cent in 1990. No early retirement scheme is provided for under existing legislation, although bi-lateral agreements in this area do exist.

## Employment security

A high percentage of employees are entitled to severance pay, and no difficulties in securing entitlements are reported. Severance pay in both the public and private sectors lasts 2-6 months. Women are entitled to maternity pay and to return to their posts after leave, and appear to receive their entitlements, which have increased over the decade to 12 months of compensated maternity leave.

Worryingly, 100 per cent of workers in the health sector were recorded as working as contract labour or on commercial contracts as opposed to labour contracts.

## Skill reproduction security

Employees are reported to be "partially" able to use and maintain their skills. Retraining is provided, although unions are not involved in it. The availability of training has increased, especially in the area of specialist courses, but also in terms of comprehensive training. Nevertheless, access is limited, most notably by time and money.

The number of job categories has increased over the past three years, as has the number of tasks undertaken.

## Work security

There are no data provided on the number of work-related injuries or diseases, nor on the number of days lost. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. On average disability/ invalidity benefits paid recipients 80 per cent of their wage, with 100 per cent being paid to those whose disability lasts more than 30 days.

The two main reasons for absence from work were disease and care for the sick. Levels of absenteeism have remained constant; nevertheless, it is suspected that the reported incidence of employees attending work despite being ill has increased due to "employees being afraid to loose job and to get lower wage". Stress is considered as very serious in Lithuania and is caused by fear of job loss, late payment, reductions in wages and the general economic situation in the country.

Management is required to involve trade unions as members of Health and Safety Committees, and conditions in hospitals and clinics are reported to be improving over time, due perhaps in part to the compulsory inspection of all facilities.

## Representation security

Employee membership of unions has decreased sharply from 100 per cent to approximately 20 per cent over the reference period, with a small rise since 1996. The decline cannot be blamed on hostility of management in the public sector, who were neutral in their feelings towards union membership. Only in the smaller private sector was union activity discouraged. The number of unions operating within the sector has increased from one in 1990 to seven in 1999. There were no reported days lost to strike action in 1999, although some demonstrations have taken place.

Representative organizations are listed as "the Union of Doctors-Managers of Lithuania, Trade Unions of Health Workers of Lithuania, Trade Union of Doctors-Administrators of Health Sector of Lithuania, Union of Young Doctors of Lithuania, Trade Union of Medical Workers of Lithuania, Union of Nurses of Lithuania, Lithuanian Trade Union of Specialists on Taking Care for Sick, Association under Health Department of Lithuania".

The role of unions in the public sector lies mainly in determining wages but also in hospital management through designating representatives in County Councils (no data is available for the private sector). Approximately, 85 per cent of the workforce belongs to associations, a rise on previous years.

There are collective agreements at all levels and regular consultations with national level partners take place twice a year. The main topic of the consultations (which have no obstacles listed) are "training and retraining, privatization and restructuring and exchange of information on normative documents". They are seen to be helpful only 6 per cent of the time, although they are believed to have become more helpful over the last three years.

Restrictions on the right to strike exist in Lithuania for all occupations, although the extent of these limits is not known.

## Income security

Wages have fallen since 1998 (in US dollar values), and over the past three years, wages for nurses, those in allied health services and for support staff have fallen relative to average wages.

Secondary data suggest that physicians were paid a minimum salary based on a nationally agreed level, supplemented by capitation and fee-for-service elements (in primary and secondary care respectively). The data also suggest health care institutions had considerable scope for paying bonuses that were agreed locally or for setting up their own incentive schemes.

The affiliate identified the introduction of health insurance funds as having led to low levels of fees for hospital services, and in 1999-2000 sick funds were in debt to all institutions, which in turn will have had an impact on rates of pay. Over the last three

years, delays in wage payments have increased, as has the percentage of the workforce receiving wages at or below the minimum wage. Enterprise-paid benefits have also increased. The workforce is generally not entitled to government-paid benefits. There are few data on pension payments, however it is reported that the percentage of contributions paid by the employee has decreased over the past three years.

The affiliate notes that "the problems are less significant provided that the trade unions are strong i.e. money are better calculated. The problem is that majority of workers agree to work for lower wage just to avoid dismissal".

## 7.10 The Republic of Moldova

### Structural changes

The most significant reforms are the reduction of budgets, management decentralization, privatization of pharmaceutical institutions and the introduction of chargeable medical services. The number of hospitals and clinics has decreased considerably over the last decade, with over half closed, small hospitals in particular. Secondary data suggest that there were few changes in the numbers of beds and facilities until very recently, and that despite cuts from 1998, the Republic of Moldova still has a higher level of provision than anywhere else in Europe. Public expenditure on health care has fallen from a high of 5.8 per cent of GDP in 1990 to 2.9 in 2000-2001.

The impact of the failing economy combined with falling resources within the health system have contributed to declines in health status, the break down of basic public health measures including vaccination, the growth of TB and high levels of maternal mortality.

Legislation since 1995 allows for privatization but the vast majority of facilities remain under the ownership of central or local government. Pharmacies and dental clinics, however, have almost all been privatized although the Government remains a shareholder in a number of them.

Steps to decentralize the system have also been taken since independence, with the latest (1999) reforms creating 11 Regional Health Administrations (*judets*) responsible for funding primary care and certain in-patient and emergency services. The centre continues to pay for national programmes and to determine policy and standards overall. The lack of resources severely constrains scope for local government innovation. There has also been decentralization to hospitals, where directors have the right to charge for services, retain profits and take employment decisions, although it is unclear to what extent these are exercised. Privatization as a form of decentralization has been limited.

The lack of funding is described as severe, and is exacerbated by emphasis on tertiary care with the bulk of funds consumed by the physical infrastructure of hospital buildings. The World Bank Project application shows 70 per cent of all health-spending going towards electricity, heating and other aspects of running the 55 regional and tertiary hospitals. Salaries, pharmaceuticals and treatment costs are not included. It is suggested under-the-table payments play a major part in financing health care: the World Bank believes they match direct public sector health expenditure.

Preliminary legislation was passed to allow an insurance model to be introduced, but in practice no major changes have been made and the system continues to be funded from tax revenues. Voluntary social insurance is being piloted in one area but there are no current plans for a large-scale shift to insurance.

In 1999, the Government defined a restricted, basic package of care which was to be delivered free of charge, and which provided for formal out-of-pocket, user-fees for other

services in an attempt to bring more resources into the system and to make transparent the informal payments already being levied. However, deficits in state financing have left informal, under-the-table payments as an important source of income for health sector staff.

Secondary data also suggests that parts of the system have relied heavily on external donors to run vaccination services and provide pharmaceuticals. The World Bank approved a loan package to support structural adjustment in 1999 but due to changes in Government, disbursement only began in the context of a health sector reform project in mid-2001.

### Labour market security

Employment in the health sector was only 82,210 in 1999, compared to 115,236 in 1990. The number of people involved in the private sector was not available. Unemployment stood at 3,217 within the sector in 1999, having risen from 1,060 in 1996, and was attributed to the commercialization and privatization of services, and changes in management systems, budget cuts and restructuring. Many unemployed health care workers are believed to be discouraged from seeking further work in the sector. The bulk of job losses have taken place recently, and result from the financial crisis and efforts to cut back on over-provision.

Part-time employment stood at 1,320 in 1999, the vast majority of which was taken up by women. Some 7.5 per cent of the workforce had been placed on administrative leave in 1999. A high proportion of staff (32 per cent) combine their formal role with other work, this being especially true for nurses and support staff. Such conditions have probably contributed to the 8.5 per cent of redundant trained health sector employees who have left the country to find employment. The number of hours that staff are contracted for is unchanged over the decade as is the actual number of hours worked. Actual hours are particularly high for support staff (58 hours per week).

Pensioners constituted 8.2 per cent of employees in the health sector in 1999. There is no provision for early retirement in the sector.

### Employment security

A high percentage of employees are entitled to severance pay of three months and no difficulties are reported in securing these entitlements. Women are entitled to maternity pay of 4.2 months, and to return to their posts after leave. They appear to receive their entitlements.

Only a small percentage of staff within the sector was recorded as working as contract labour or on commercial contracts, as oppose to labour contracts.

### Skill reproduction security

Only administrative staff are reported as being able to use and maintain their skills. Retraining is provided with unions involved in the design of training. However, access has diminished due to lack of money and lack of enthusiasm on the part of staff. Secondary data describe radical cuts in medical school places in order to reduce over-provision. Retraining for primary care and management is under-way, but it is suggested that career structures are not adequately developed to support those retrained.

The number of job categories has remained the same over the past three years within the public sector and to have increased in the private, with increased tasks undertaken by all occupations.

## Work security

Days lost to work-related injuries fell from 2,988 in 1990 to 1,330 in 2000. However, work-related diseases rose, albeit by a smaller number, the majority of incidents affecting women. The payment of disability and invalidity benefit has remained unchanged with no reported difficulties, but the period covered (12 days) is strikingly low compared to other countries. On average, 85 per cent of a worker's wage is paid as benefit during the period of disability/ invalidity.

Statistics on absenteeism have improved since 1990 with a reduction of around 40 per cent. Absenteeism is attributed to annual leaves, maternity leaves (until the child is three years), temporarily disability leave and unpaid leave. Decreasing absenteeism must, however, be seen in light of a feeling that workers do not take their full entitlement to sickness leave due to financial considerations. Stress has remained "very serious", the main reasons cited as being: "no guarantees on a work place, poverty and impossibility to support a family and an uncertainty in tomorrow".

Management is required to involve trade unions as members of Health and Safety Committees, nevertheless conditions in hospitals and clinics are reported as getting worse, due perhaps in part to the reported aging of medical equipment and technology.

## Representation security

The percentage of employees who are union members has decreased less markedly than in many countries, with membership falling from 98.5 per cent in 1990 to 89.2 per cent in 1999. The public sector was felt to be neutral on membership, whilst the private sector was believed to discourage it. The number of unions in the sector is still one. Notably, 19,850 days were lost to strike action in 1999.

Unions in the public sector are seen to "fight for higher and timely paid wages, fight for benefits increase, and fight of fee-free training". Associations in turn are linked to "material aid, paid leaves, compensation of medical treatment, nutrition, transport in specific cases", although it is unclear which associations are referred to (possibly a women's association under the umbrella of the single trade union). Within the private sector, negotiations are seen as more complex, involving the protection of legal rights. Some 79 per cent of the workforce belongs to associations, and 76-100 per cent belong to both a trade union and an association.

Collective bargaining takes place at all levels (national, provincial and hospital). The main topic of consultations with national partners (which are said to take place as needed and with no obstacles listed) are wages, collective agreement and legislation. They are seen to be helpful 60 per cent of the time and to have become more useful over the last three years. The main problems highlighted for the union are "timely remuneration of labour, wage increase, measures to increase social protection, estimation of reforms in health sector and closing down of medical institutions and staff reduction".

The only restrictions on the right to strike are for doctors in cases of "medical aid for essential functions".

## Income security

In the absence of data on inflation it is not possible to quantify salary changes in salaries in real terms. Nonetheless, the affiliate feels that average wages have fallen for all health sector staff. Salaries are supplemented by extra payment for night work, work intensity, hazardous work, qualifications, continuous work etc. Nevertheless, "the republican, district and medical unit budgets do not (usually) provide the necessary

financial resources for this payment, thus the differentiation of the payments for work practically does not take place."

Secondary data suggest that the vast majority of staff continue to be salaried employees and that there are no plans in place to radically reform payment schemes. The literature mentions incentives for rural staff and family doctors but stresses that salaries are very low and often delayed by 3-4 months. Staff seem to rely extensively on under-the-table payments by patients.

It is felt by the affiliate that the privatization of pharmacies and the introduction of chargeable medical services has led to opportunities for workers to gain financial aid and bonuses.

Significantly, over the last three months 76 per cent of the public sector did not receive their wages on time, an increase on earlier years attributed to "unstable financing of the health sector" (covering only 25-30 per cent of funds needed) and violation of legislation on remuneration. Public sector employees were entitled neither to enterprise nor to government-paid benefits. Pensions in the sector are governed like other schemes in the Republic, and cover only a low percentage of all members of the sector. The scheme is based on a percentage payment of wages and so medical staff, as low paid workers, receive a low level of pension.

## 7.11 Poland

### Structural Changes

The most significant of reforms are the introduction of a new form of health insurance (sickness funds in 1999) and health service privatization (1998). The number of hospitals and clinics has increased slightly since 1990, as has public expenditure (as a percentage of Gross Domestic Product) on health care. The WHO Regional Office for Europe health for all databases suggests that the number of hospital beds fell slightly from 1990 to 1996 and that hospital numbers were relatively low compared to CEE norms. It also expected that bed numbers would be further reduced.

Privatization has been relatively extensive and has affected pharmacies and dental practices and seen the introduction of private medical practice. Nearly 90 per cent of dentists were working privately in 1999 and 66 per cent of all doctors (although many of these also worked in the public sector). Despite this, hospitals have almost all remained in the public sector (with a few handed over to the church or voluntary organizations) and the State continues to be the most significant employer.

The 1990s witnessed a great deal of decentralization, with responsibility for planning, provision and funding moving to the level of the *voivodoship* (region) and ownership of institutions to the *powiats* (districts) and *gminas* (localities). Despite a reduction in the number of regional *voivodoships* from 49 to 16 in 1999, which concentrated authority somewhat, significant decentralization has taken place, not least in terms of passing a financing role to insurance funds. Health care institutions are increasingly autonomous and responsible for their own budgets.

The introduction of insurance (to replace taxation) was delayed while the economy stabilized, and only took effect in January 1999. The scheme is based on 16 statutory regional funds with a seventeenth branch for the parallel health services. Government funding is to be scaled back as insurance cover expands and funds contract directly with providers. Public health and specialized services will remain part of the state budget.

Public health expenditure as a share of GDP stood at 5.2 per cent in 1998 and it is suggested that, adjusted for purchasing power parity, it is lower than in neighbouring countries or much of the rest of Europe. Private (out-of-pocket) expenditures increase this level, as do under-the-table payments.

### Labour market security

Staff levels have risen since 1990 by around 23,000, with a shift of around 1 0 per cent of the workforce into the private sector. The rise in employment has not, however, prevented an increase of unemployment within the sector, which has doubled to 23,498 in 1999. This mixed picture is due to the fact that whilst the commercialization of services and changes in management systems have increased the number of jobs, privatization of services, shifts to fee paying services, budget cuts and restructuring have brought about a decrease. A large proportion of workers are part-time (40 per cent), the majority of whom are women. No data is provided on short-time employment or on administrative leave, but 20 per cent of all employees combine their formal role with other work. The number of hours that staff are contracted for has remained unchanged over the decade (42 hours per week for most workers), as has the actual number of hours worked. The longest hours are those of doctors, 90 per cent of whom work between 66 and 90 hours per week.

Despite the increase in jobs, secondary data suggest that physician, pharmacist, nurse and dentist numbers are at the lower end of European norms and rising slowly.

Approximately 6.1 per cent of employees in the health sector were also pensioners in 1999 (2.4 per cent in 1990). Provision for early retirement exists, with 17.9 per cent of the workforce having taken up the offer in 1999.

### Employment security

A high percentage of employees are entitled to severance pay and no difficulties in securing entitlements are reported. Severance pay in both the publicand private sectors amounts to six months (18 months if both parents are unemployed). Women are entitled to maternity pay of 26-39 weeks and to return to their posts after leave. Entitlement to maternity leave is reported to have increased over the decade.

While 30 per cent of staff worked on temporary contracts in 1999, 20 per cent worked as contract labour or on commercial contracts.

### Skill reproduction security

Whilst doctors and nurses are able to use and maintain their skills, allied health services, administrative staff and support staffs are not. The shortfall in training for these occupations seems to stem from a lack of opportunity to specialize and to obtain computer skills. The training that is provided does not involve unions. Over the past three years the number of job categories has increased in the public sector, whilst remaining constant in the private sphere. Likewise the number of tasks performed by employees has increased in the public sector, whilst in the private sector they have decreased for nurses, and remained the same for allied services, administrative and support staff, but increased for doctors.

### Work security

Work-related injuries have decreased over time from a high of 5,688 in 1990 to 4,231 in 1999. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. Disability/ invalidity benefits provided recipients with 80-100 per cent of their wage, and were payable for the duration of the illness.

Absenteeism is believed to have decreased over recent years and the main causes are given as illness or child's illness. The decrease is linked to insecurity as "sick leave is paid at only 80 per cent of salary and in fear of dismissal". There is also a perceived increase in those attending work who could be absent. Stress was seen as having worsened being serious in 1999 compared to somewhat serious in 1990. It is attributed to loss of job, low salary and a new system of health care service and privatization".

Management is required to involve trade unions as members of Health and Safety Committees, and there are compulsory inspections of all facilities. Nevertheless conditions within establishments are reported to have worsened in terms of meal provision and working hours.

### Representation security

Membership of unions has decreased sharply form 40 per cent (already comparatively low) in 1990 to approximately 20 per cent in 1999. This decline may in part be attributed to discouragement of unions by the private sector. The public sector was felt to be neutral on the matter. The number of unions operating within the sector has increased from one in 1990 to eight in 1999. There were 20 reported days lost to strike action in 1999 and in addition work slowdowns and demonstrations took place over the reference period.

Unions in the public sector are seen to have a decisive role in wages and benefits in the public sector and a consultative role in training and management; it is unclear what role they play in the private sector. Associations, by contrast, are held to have a consultative role in wages and benefits only, and a decisive role in training and management. Secondary data suggest that there is now a role for physicians and nurses' chambers in regulating the professions. Approximately 40-45 per cent of the workforce belongs to associations, although this figure constitutes a decline on previous years.

Collective bargaining takes place at the national, hospital and provincial levels. Restrictions on the right to strike exist for both doctors and nurses, although not for administrative and support staff.

Consultations with national partners are said to take place every month, they seem to face no obstacles and the main topics covered are "wages, collective agreement and acts". They are seen to be helpful 40-70 per cent of the time but to have become less useful over the last three years.

### Income security

Data on average salaries are not provided for 1998, however the affiliate feels that they were around 20-30 per cent lower than in 2001. Wages are reported as having risen over the past three years for doctors, nurses and administrative staff, whilst falling for allied health services and support staff. Determination of wages in the public sector is generally by tariff, although secondary payments for doctors, nurses and allied health staff depend on performance. Secondary data suggest that different doctors in the same institution may have different employers i.e. the *gmina* or *voivodship* (locality or region). It is unclear what impact this has on employment rights but some *voivodships* have experimented with different methods of paying general practitioners including fee-for-service, fee-for-visit, capitation and a points system. Most primary care doctors are now paid on a weighted capitation basis with allowances for the types of population covered.

The introduction of insurance has seen wages become dependent on collective agreements signed in each hospital while privatization has seen wages become dependent on individual contracts. It is unclear how these factors interact. The union's policy is to sign the collective agreements on national, regional and hospital level. Secondary jobs provide doctors with around 50 per cent of their wages, and nurses with approximately 30

per cent, allied services 20 per cent, administrative staff 40 per cent and support staff 15 per cent.

Over the past three months, around 20 per cent of the workforce in the public sector did not receive their wages on time, an increase over previous years. This is significant considering that approximately 70 per cent of the workforce were paid at or below the minimum wage, at least through their primary employment. All employees except support staff are usually entitled to enterprise-paid benefits, although these benefits are reported as having decreased recently. Government-paid benefits are available to all public sector staff, but not to those in the private sector. Staff pay around 40 per cent of their monthly income to the insurance office, however only around 20 per cent of all occupations within the health sector are reported as being covered by the pension scheme.

## 7.12 Romania

### Structural changes

Changes to health insurance systems and reforms to primary medicine are identified as being of primary significance. The number of hospitals and clinics has decreased over the last decade, from 550 in 1990 to around 500 in 1999.

Limited privatization has been introduced, starting with pharmacies and the pharmaceutical sector. Similarly, most dentists now work in the private sector. Few doctors work exclusively in private medicine, and those who provide private services often continue to hold specialist posts within the public sector.

The health system in 1990 was tax based and centralized. A process of decentralization passed considerable authority to local governments, and the College of Physicians was also given responsibility for certain elements of professional regulation. A key delegation of authority has been to shift the task of financing health care to compulsory insurance funds in 1998 to 1999. This triggered some adjustments to the previous decentralization measures, including reshaping district health directorates into district public health directorates and giving colleges of physicians and pharmacists a say in determining basic benefit packages.

Only 2.6 per cent of GDP is devoted to health, according to the WHO. Out-of-pocket payments (formal and informal) are inadequately recorded, but even by including them, it would still appear that total health expenditure in Romania is well below regional norms.

The World Bank has played a considerable role with a loan in 1992 of $150 million that was extended from the planned end date of 1996 to 1999. A new loan of $40 million is now in place and will continue to address health sector reform.

No survey data were available on the seven elements of security.

Secondary data suggest, however, that job numbers have remained relatively unchanged and that there is little unemployment in the sector. Training, at least, for medical occupations, appears to be accessible and there is some focus on complying with EU standards. It is unclear what the implications are of the emergence of unregulated private nursing schools. A number of associations have been established representing the interests of doctors, nurses, managers, economists and others. Data on income determination suggest that payment of physicians depends on the part of the health system in which they work. In the primary care sector for example, payment is based on capitation, with fee-for service top-ups, on fee-for-service in specialized ambulatory care and on a fixed payment per person hospitalized, and/or per service, in the hospital sector. It

seems that other occupations tend to be salaried and that wages across the sector are below average.

## 7.13 The Russian Federation

### Structural changes

Reforms that have radically affected the socio-economic security of the health sector workforce over the past decade included the privatization of services, the introduction of a unified social tax, mandatory health insurance and higher education for nurses. The 1993 shift to health insurance seen as perhaps the most important. Between 1996 and 1999, the number of hospitals and clinics decreased from 9,970 to 8,860. The bulk of closures were of hospitals with less than 100 beds, nevertheless 150 large hospitals (250+ beds) were also closed during the reference period.

Decentralization has been so extensive as to undermine the concept of a single, unified national health system. The Federal Government has retained only limited control over the package of care, levels of regulation and financing. Many regions (formerly 11 Soviet Republics) are highly autonomous, with unevenness and inequalities emerging between them. There are no clear data on the impact of these disparities on the socio-economic security of employees. The introduction of Mandatory Health Insurance has contributed to the decentralization of the system but seems not to have had a uniform or a sustained impact over time or across regions. The 1993 legislation has only been partially implemented and two thirds of public funding continues to come from government (federal, regional or municipal) rather than insurance. A quarter of *oblasts* had no insurance companies in 1999 and in a further 25 per cent Territorial or Branch Funds took on the insurance company role. The initial reforms were linked with increased revenues to providers but this effect appears to have diminished in subsequent years. Nevertheless, in areas where insurance works, it seems to give hospital directors more scope to pay staff bonuses and to confer a degree of stability to funding.

Neither insurance nor decentralization has significantly affected ownership of facilities or responsibility for employment contracts. The vast majority of hospitals, polyclinics and health posts are owned by the relevant tier of government, and it is these government authorities that underwrite the employment contracts issued by institutions, while the Ministry of Labour plays a major role in setting salaries. Privatization has made inroads into the system not least in the guise of insurance companies, albeit that many of these play little more than an administrative role and do not exercise risk pooling or purchasing functions. Pharmacies and dentistry are the branches in which privatization has been most widespread. There are also examples of fee-for-service polyclinics, hospitals and private diagnostic facilities. Staff in private sector settings are either self employed, single-handed practitioners or under contract to a clinic or hospital. Medical and nursing education is still in the public sector. There are also over 20 parallel public health care systems. They treat 15 per cent of outpatients and 6 per cent of in-patients and, with a few notable exceptions, are funded federally, not through insurance. It is unclear how employment security in these systems has been affected by recent reforms.

Public expenditure on health was mere 2.3 per cent of GDP in 1999. It was little better in previous years having stood at 2.6 per cent in 1994 and 1996, suggesting long-term under funding of the sector. The World Health Report 2000 estimates 4.15 per cent of GDP as public and 1.25 per cent as private expenditure in 1997 and Goskomstat gives 4.1 per cent of GDP in 1996 and 4.6 per cent in 1999, of which 80 per cent and 65 per cent respectively was from public sources. These sources tend to confirm that spending has fallen in real terms and that out-of-pocket payment, including unofficial ones, play an important role (estimated by a Boston University survey to amount to 47 per cent of total

financing). The World Bank and other agencies have played an active role in health system reform supporting pilot projects and providing technical advice. Loans have often been concentrated in the newly independent states.

### Labour market security

Staff levels in the public sector fell from around 3.4 million in 1990 to 3.3 million in 1999, with the brunt of the decline felt by women, although they still make up the majority of the workforce. No details are provided for the private sector. Restructuring is seen as having increased the number of jobs in some areas, whilst having reduced them in others and the literature suggests that fluctuations in numbers are linked to changes in the 80s and adjustments following the establishment of the Russian Federation, rather than to concerted efforts to reduce staff numbers.

No data are available on levels of unemployment, part-time or short-time employment or administrative leave. Workers in the sector combining their formal job with other work stood at a worrying 50 per cent in 1999 and affected all staff other than administrative staff.

The number of hours that staff are contracted for is very high, from 44.4 to 49.2 hours per week in 1990. By 1999 these figures had risen to 68 hours per week for administrative and support staff, whilst doctors work an average of 54 hours and nurses for 61.2 hours. Details of overtime in the sector are scarce, but 98 per cent of nurses are reported as working overtime, amounting to an average 30 hours a week. 40 per cent of health sector employees in 1999 were also pensioners.

### Employment security

A high percentage of employees are entitled to severance pay of one month plus bonuses, and no difficulties in securing entitlements are reported. In cases of redundancy, two months' advance notice is usually provided to employees. Protection against dismissal is a feature of the Labour Code. Women are entitled to maternity pay and to return to their posts after leave. They appear to receive their entitlement of 18 months compensated maternity, which is unchanged over time.

No data are available on the percentage of workers in the health sector working as contract labour, on commercial contracts or on temporary contracts.

### Skill reproduction security

All employees are able to use and maintain their skills as well as they were three years earlier. Retraining is provided, with unions being involved in its design. The availability of training has also increased to meet the demands of new technologies and new roles, although a lack of funding remains a problem and participants are increasingly expected to pay. The number of job categories and job tasks has increased over the past three years. In addition, nurses and ambulance staff are reported as having their jobs upgraded, through recent restructuring of the system.

### Work security

The number of reported work-related injuries has fallen from a high of 8,473 in 1990 to 6,177 in 1999 (the majority of accidents involving women), and the number of working days lost has fallen by 117,111. There are no data on work-related diseases. The payment of disability and invalidity benefits is unchanged and no difficulties have been reported. Both benefits provide 60-100 per cent of the average wage, from the first day of notification for disability, and from the sixth day for invalidity. Details of specific

absentee rates are unavailable but the main reasons for absence are given as sick leave and child sick leave.

Low income, high communal payments and social instability all contribute to the serious levels of stress attributed to the Russian Federation health workers. Occupational health services are still in place across the sector, and mandatory Health and Safety Committees operate with management and union members in 50 per cent of hospitals. Regular inspections of all levels of facility continue to take place.

The BSS reports a general improvement in health and safety, due mainly to the pulling down of dilapidated buildings and the construction of new ones along with replacement of outdated equipment with new technology. The wider literature continues to emphasize decay and dissatisfaction.

### Representation security

Membership of unions has decreased over the reference period but remains relatively high at 81.2 per cent. This resilience is perhaps due to the neutral position of public hospitals towards unions. Private hospitals are reported as hostile to unions, no doubt contributing to the higher rate of unionization amongst public sector workers. Two unions were active within the health sector, a figure unchanged from 1996. Doctors appear also to have extended their representation through the Russian Federation Medical Association, which is increasingly taking on Ministry functions for professional regulation.

There are no data on the number of strikes in the past decade, and it seems that demonstrations and pickets have been used in preference to strike action. There is no legislation outlawing strikes, but nurses face some restrictions.

No details are given for the private sector, but unions in the public sector are reported as actively working in "concordance (with) the system of labour remuneration, working conditions and the order of calculating wages including compensatory and incentive payments", and responses on health and safety illustrate success in this area. They also exercise some control over timely payment of wages, and train union staff and activists. Associations are also involved in increasing the level of wages and count 80.3 per cent of the workforce as members. Indeed, it is reported that 76-100 per cent of employees belong to both a union as well as a professional association. The survey lists wages, the pension's code and working conditions as being the major problems faced by the union in representing members.

Collective bargaining takes place at the national, hospital and provincial levels and regular consultations are undertaken with national level partners "1-2 times a month – whenever necessary". These consultations of the Tripartite Committee under the Federal Government are felt to have become increasingly useful over the past three years, with 60 per cent of them now being useful in achieving union aims.

### Income security

It is difficult to quantify changes in salaries in real terms, although the affiliate feels wages have fallen over the past three years for all staff. This is despite an apparent rise in headline pay, attributed to the introduction of the "Mandatory Health Insurance and paid services". Wages disparities have remained constant, with administrative staff earning the highest monetary wage but likely to have less access to informal, gratitude payments. No data are presented on the basis of staff remuneration although it seems that 25 per cent of remuneration is not known in advance. Unions, in turn, lobby for some recompense based on the "complexity, tensity, harm and quality of work".

Although delays are decreasing 6 per cent of the public sector workforce did not receive all of their wages on time in the three months before the survey. Secondary literature suggests that indebtedness of institutions to staff continues to play a part in sustaining health systems finances. Wage insecurity in the Russian Federation is further exacerbated by the fact that secondary payments amount to 35 per cent of front line staff wages. More positively, however, no workers in the sector are paid at or below the minimum wage.

Health workers in the public sector are entitled to enterprise-paid benefits, although private sector employees are only sometimes eligible. Nevertheless, 100 per cent of those entitled actually receive benefits. Public sector employees are also eligible for government-paid benefits, again with no reported problems in securing entitlements. There are three pension schemes covering the sector. The primary pension is universal, the second and third however are dependent on length of service and exposure to hazard. Despite the universality of the primary pension (which covers 99 per cent of support staff), only 30 per cent of nurses and 10 per cent of administrators are covered.

## 7.14 Slovakia

### Structural changes

The most significant reform is the privatization of 1990-98. The process began with pharmacies, all of which were private by late 1995, and has resulted in 93.9 per cent of primary outpatient treatment and 43.7 per cent of specialized, secondary outpatient treatment being delivered through the private sector. In addition, 23 of the 77 polyclinics are no longer under state control, while 53 of the 79 agencies providing home nursing care are private. The number of hospital beds has decreased, although the number of oncological institutes, treatment centres for long-term diseased, rehabilitation centres, mental hospitals and centres for drug addictions treatment have all risen. The total number of hospitals actually increased from 1990-99 from 76 to 92, despite falling bed numbers. Finally, the establishment of health insurance offices is noted as an important change in the health sector.

Secondary data confirm that privatization has been extensive in ambulatory care. The bulk of primary care physicians and of specialists providing private outpatient care operate single-handed practices. They tend to rent space from health centres or polyclinics, although increasingly groups of physicians are seeking to buy premises. Payment for primary and outpatient care is mostly through contracts with health insurance companies and is made to the physician, who employs his own nursing staff. The bulk of hospitals remain within the public sector in terms of ownership and employment contracts. All medical and nursing education is in the public domain. Decentralization, however, other than through the privatization of service delivery, is limited. In-patient facilities continue to be centrally regulated and controlled.

Another key shift has been the introduction of compulsory health insurance in place of general taxation as the main source of health system finance. Employers and employees contribute a percentage of income with a contribution cap, which makes the system effectively regressive. The state contributes on behalf of children, pensioners, carers and soldiers and the Employment Fund does so for the unemployed. The change took place rapidly over two years and subsequent adjustments saw the number of insurance companies fall from a peak of 12 in 1996 to 5 in 1998. The merger of some companies and closure of others left debts to health care providers. Indeed there is significant debt within the Slovakian health care system with insurance companies owed outstanding contributions (not least by the Government), providers owed fees by insurers, and suppliers of goods and services owed monies by providers.

Public expenditure on health is relatively high in Slovakia, although it decreased from 7.54 per cent of GDP in 1996 to 6.46 per cent in 1999. The literature suggests that methods of calculation have varied over the years so figures may not be entirely comparable. Nonetheless spending is similar to neighbouring countries. The majority of spending is public (90.1 per cent in 1999) with co-payments for some pharmaceuticals and medical aids and private, out-of-pocket payments for most dental services and outpatient treatments not covered by insurance. External sources of funding have had a limited role, but the World Bank did grant $510,000 to the Ministry of Health in 1999 to support reforms in 2000.

### Labour market security

Numbers employed in the public health sector (including those on casual contracts) have declined over the past decade. In 1990, state or local authorities employed 112,736 people, however by 1999 the figure had fallen to 84,158. In both years the majority of these were women. It is likely that many of these jobs have moved into the private sector. Commercialization of services, privatization, the shift to fee paying services, changes to management, budget cuts and restructuring are reported as having increased jobs in the sector, although no specific data are provided. Similarly, Institute for Health Information and Statistics data show a rise in the numbers of physicians, nurses and dentists between 1990 and 1998 with a corresponding growth in physicians and nurses graduating. This does not however, rule out job losses in other groups of staff.

Part-time employment is rare in Slovakia and there is no reported use of short-time work or administrative leave to reduce costs. Nevertheless, employment freezes did occur between 1990 and 1999. "Stand-by" employment is however, a feature of the Slovak labour market, with doctors often providing cover in a hospital other than that in which they are employed.

Working hours vary according to shift patterns, however the affiliate reports that "the number of hours worked per week in one-shift operation (for doctors, officers and workers) is 42.5, including 2.5 hours for lunch break". Overtime per week amounts to 5.8 hours for doctors, 0.5 for nurses, 0.13 for administrative staff and, 0.17 for support staff. 4.1 per cent of employees in the health sector are also pensioners.

### Employment security

The majority of regular employees are entitled to severance pay and no difficulties in securing entitlements are reported. Severance pay in both the public and private sectors amounts to two month's pay, with an additional three months being payable if determined within a collective agreement. In cases of redundancy, three months' advance notice is given to employees in law, although this usually translates to two months in practice. Women are entitled to seven months of paid maternity leave and are guaranteed the right to return to the same, or an equivalent, job at the end of that period.

Details on the percentage of workers in the health sector working on temporary contracts are not available. No employees within the health sector work as contract labour or on commercial contracts.

### Skill reproduction security

Employees are able to use their skills as well as they did three years ago, and retraining is provided, with unions consulted in training design. Nevertheless, access has decreased due to a lack of funding. Significantly, most changes to nursing have arisen because of the need to comply with European Union norms.

The number of job categories over the past three years has decreased in the public sector, whilst increasing in the private sector. Job tasks in the public sector have decreased for doctors and nurses, whilst increasing for administrative staff. In the private sector the range of job tasks has increased for all occupations.

### Work security

The reported number of work-related injuries has decreased sharply over the past decade, from a high of 1,489 in 1990 to 648 in 1999. The number of working days lost to work-related injuries or disease has also fallen dramatically. Employees maintain the right to disability/ invalidity benefits, at around 74 per cent of the average wage, and again no problems are reported in receiving them. In-kind benefits are available to employees who have suffered injury in the workplace.

The absentee rate has risen slightly since 1990 to stand at 0.073 in 1999, with the two main causes listed as current work risks and slipping. Worryingly, the cause of the rise in absenteeism is given as increased workload. Adding to these symptoms of insecurity is the reported rise in the number of employees not taking up their right to leave because of fears that they may lose their job or wages.

Stress remains serious with the main causes identified as insufficient breaks, overtime and stand-by's, continuous work under mental pressure and the responsibility for patients. Occupational health services are provided, and hospitals are obliged to operate Health and Safety Committees with the involvement of both management and unions. Regular inspections of primary, secondary and tertiary care facilities are also a feature of the sector. Nonetheless, working conditions are reported as getting worse due to "antiquated basic health equipment".

### Representation security

Membership of unions decreased from 99.8 per cent in 1990 to 75.2 per cent in 1999. As in other countries of the region the reason may be due, in part, to private sector hostility towards unions. The number of registered unions representing the sector has risen from one in 1990 to two in 1999 (the Slovak Trade Union of Health and Social Services and the Medical Trade Union Associations). Approximately 80 per cent of the workforce are members of associations, which include the Association of Hospitals of Slovakia, the Association of Independent Polyclinics, the Association of Middle Health Schools, the Association of State Health Institutes and the Association of Private Doctors. Membership of associations is generally higher in the public sector and 76-100 per cent of staff belong to both a union and a professional association.

There is also a series of statutory professional bodies to which non-state health personnel must belong. The Slovak Medical Chamber, the Slovak Chamber of Dentists, the Slovak Pharmaceutical Chamber, the Slovak Chamber of Paramedical Personnel (covering nurses, laboratory technicians and other paramedical staff) and the Slovak Chamber of University Graduated Health Workers ensure their members' professional standards and play a part in inspecting facilities.

The right to strike of doctors and nurses is restricted, but protests and petitions have been used recently.

The functions of unions in the private sector are reported as minimal. Nevertheless, in the public sector both unions and associations ensure the "observation of prepared regulations" for wages and benefits as well as collective bargaining over issues of hospital management. The Association of Private Doctors is also in a position to bargain collectively within the private sector.

Collective bargaining takes place at the national level and unions have regular consultations with national level partners on health care transformation, privatization, and payment. Consultations are described by the affiliate as being useful 50 per cent of the time and as having become more helpful over the past three years. Employment, pay, conditions and education are the key problems faced.

### Income security

In comparing health sector wages with national averages it can be seen that health staff continually receive lower pay. While in 1998 health sector wages amounted to 92.5 per cent of the national average, by 2000 hospital staff wages had fallen to 85.7 per cent of the average. Private sector doctors are believed to earn more than those in the public sector; however, the nurses in their employment are felt to earn less than their public sector counterparts. Wages in the public sector are mostly determined by tariff and time rates. Secondary payments are not a feature of the Slovak health system.

Generally, wages are paid on time but there was some delay in July 2001 arising from the late publication of tariffs. Potential problems may also stem from the reported insolvency of some insurance funds and hospital indebtedness, which makes payment of essential staff difficult.

No details are available of entitlements to government-paid benefits but certainly no enterprise-paid allowances exist within the public sector although there are hospital social funds. Recent changes to the pension system have seen the introduction of an additional pension (through collective agreements), with employer contributions and tax advantages. However no specific data exist on the coverage of this or the primary pension schemes.

## 7.15 Ukraine

### Structural changes

Primary data from the SES database indicate that the population of Ukraine has shrunk by about two million since it achieved independence in 1991 and now stands at around 50 million. All forms of social and economic security are reported as severely affected by a decade of stagflation and economic decline.

The BSS highlights a range of reforms. Discussions on the introduction of mandatory state health insurance with authorities concerned which was initiated in 1996 is still on-going and the development of primary medical service (creation of family doctors) as key. The number of hospitals has decreased over the last decade, although not significantly and mainly amongst smaller establishments. The percentage of GDP devoted to public expenditure on health care rose in the mid-1990s but has more recently taken a downturn, standing at 2.9 per cent in 2001.

### Labour market security

Staff levels have fallen slightly since 1996, although few data are available. Unemployment rose from 12,017 in 1997 to 20,476 in 1999. The decrease in employment was apportioned to changes in management systems. Despite the recent increase in joblessness there was little discouragement from applying for work within the sector.

Figures on part-time and short-time work and administrative leave are not given. Contractual hours have remained unchanged over the decade, as have the actual number of hours worked. Actual hours for both doctors and nurses have therefore remained high at an average of 60 hours per week. Both doctors and nurses are reported as combining their formal role with other work.

### Employment security

No data are supplied on employment security.

### Skill reproduction security

All employees are able to use and maintain their skills, and retraining is provided with unions being involved. The number of job categories was felt to have remained the same over the past three years, but the tasks undertaken have increased for the entire workforce.

### Work security

Reported incidents of workers losing their ability to perform work for one day or more as a result of a work-related injury fell from a high of 906 in 1990 to 487 in 1999. Likewise, the number of days lost through disease fell from 28,576 in 1990 to 16,377 in 1999. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties.

Absenteeism is attributed to disease and family reasons, and is believed to have stayed the same over recent years. Nor is there a perceived change in the numbers attending work that could be absent. The main causes of stress are given as: "sudden death of a patient; unexpected dismissal due to staff reduction and; deception".

Management is required to involve trade unions as members of Health and Safety Committees, and conditions in hospitals and clinics are reported to have remained the same over time.

### Representation security

The percentage of employees in the sector who are members of unions has remained relatively unchanged, standing at 97.5 per cent in 1999 (99.8 per cent in 1990). Public sector institutions were said to encourage union membership, while the private sector was felt to be neutral. There are no data on associations or on the number of days lost to strike action.

The role of unions in the public sector focuses on determining wages as well as ensuring "provision of needy employees with financial aid on different occasions" and providing training for the "most active members". There are no data on collective bargaining.

### Income security

Absence of data on inflation makes it impossible to quantify the rise or fall in salaries in real terms. Doctors' and nurses' pay are indicated as having both risen and fallen, perhaps signifying that pay is rising for some but not for others. Allied health service staff and support staff were reported as having experienced a rise in their remuneration packages.

There has also been a tendency to upgrade job categories.

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