

Socio-Economic Status of Health Care Workers in the Russian Federation

By

**Natalia Stepantchikova,
Liana Lakunina and
Tatyana Tchetvernina***

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* Natalia Stepantchikova, Liana Lakunina and Tatyana Tchetvernina are with the Centre for Labour Market Studies, Institute of Economics, Russian Academy of Sciences, Russian Federation.

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Introduction

The Constitution of 1993 declared the Russian Federation a social state. This implies that State authorities have responsibility for human rights, including decent living and working conditions. This in turn gives the State duties in public health prevention and the improvement of health care.

Unfortunately, radical political, economic and social reforms in Russia have had a negative effect on almost all aspects of health, as shown by low birth rates, unsatisfactory maternal and child health, poor living standards and nutrition quality (especially in the non-protected segments of the population), bad drinking water as well as by a general decrease in the health of the population. Overall, the sanitary and epidemiological situation in Russia is considered as tense, and its negative effect on public health as substantial.

In the Russian Federation today, the average lifespan of men is 10-15 years shorter, and for women, 68 years shorter, than in economically developed countries. This negative tendency is due to persistent adverse changes in public health and basic medicine, a shortage of high-performance medication for the majority of the population, together with a high level of stress, a decrease in living standards and an increase in crime.

In the existing situation a special role is given to the organization of health care, to the quality of medical treatment and to the preventive measures taken among the population.

The present report reviews the situation of health care today, especially in relation to the socio-economic status of those employed in this sector. Working conditions and labour protection for health care workers, salary issues and social guarantees, opportunities to improve professional knowledge and qualifications and to acquire advanced medical technologies - all these factors have a considerable influence on the quality of medical services provided, and consequently, on public health in general.

This paper is based on official documents and statistics, provided by the Ministry of Health Care and the National Statistics Committee, as well as on interviews with workers in the health care sector and trade union representatives. However, official statistics do not provide complete information, especially on issues of employment in the health care sector - almost all the data aggregate three branches: health care, physical education and social security. Information about the private sector (and, with few exceptions, about the departmental medical institutions) is not available since these institutions do not provide any statistics about their activity.

1. Health of the population in the Russian Federation

The domain of health care institutions is in many ways determined by the health of the population of a country. Regretfully, this domain has substantially broadened in the recent decade, due to the fact that there has been a radical decrease in the health of the country's citizens.

The annual incidence of acute and chronic disease is between 155 to 185 million, in a population of 145.6 million people on January 1, 2000. In the last five years the primary disease incidence rate has increased by 9 per cent, and the general disease incidence rate by 15 per cent. The increase in incidence is especially rapid for congenital anomalies, at 1.5 times greater than the general incidence rate; for urogenital diseases, at 1.3 times greater; and for neural diseases and diseases of sense organs at 1.2 times. The general incidence rate, according to the number of citizens visiting health care centres, is growing and

amounts to 1,724.7 cases per 1,000 for children (1,384.2 in 1993); 1,462.8 (1,051.1) for adolescents and 1,141.5 (1,002.1) for adults.

The general incidence rate for diseases tend to increase for all age groups and most of the increases concern socially preconditioned diseases.

- Compared with the situation in 1990, tuberculosis incidence has more than doubled, and amounts to over 75 cases per 100,000 of the population. Tuberculosis incidence in prisons, among migrants and people without a registered place of residence and occupation (460-700 cases per 100,000 of these people) forms an especially serious problem. The percentage of tuberculosis at an advanced or destructive stage has increased. For this reason, the death rate has increased threefold.
- The epidemiological situation with regard to sexually transmitted diseases (STDs) has worsened. In the recent decade the incidence has grown 44 times - from 5.3 cases per 100,000 of the population in 1990 to 234.8 in 2000. Even this is an underestimate since many of these patients consult private doctors.
- There is a menacing situation with HIV-infection, especially in Moscow and in the Moscow, Kaliningrad, Tver and Irkutsk regions. By the end of 2000 there were over 70,000 registered HIV-positive people and over 400 people with AIDS. The number of HIV-positive increased twofold during 2000 alone.
- The number of registered drug addicts is 185.8 per 100,000 of the population and it has increased almost nine-fold in 10 years (1991-2000); among adolescents this number is 125.1 per 100,000 of adolescents. Drug addiction incidence among adolescents is 70 per cent higher then for the whole population.
- There is a serious increase in the consumption of alcohol and its imitations; the number of registered alcohol addicts in 2000 is 1,513.1 per 100,000 of population; the number of alcoholic psychoses has increased threefold in the last 10 years. Every year 25,000-27,000 people die of alcohol poisoning.
- The number of patients registered with psychiatrists has increased by more than 18 per cent in the last decade and there are now 2,600 registered patients per 100,000 of the population (Ministry of Health Care, 2000).
- Poor working conditions have led to a high level of occupational illness, accidents and disability. According to the National Statistics Committee, the work places of over 5 million people (about 8 per cent of the employed), including over 1.5 million women (6 per cent of employed women), do not meet national standards. Over 1 million people are involved in hard manual labour. The vast majority (95.8 per cent) of all occupational diseases, including poisoning, result in restrictions on professional aptitude and disablement, and 1.77 per 10,000 of all workers are affected in this way. Table 1 shows the consequent loss of working hours.

Table 1. Cases and days of temporary disability as a result of employment injuries, 1990 – 2000 (per 100 workers)

	1990	1996	1999	2000
Number of cases of temporal disability	109.5	63.7	69.1	73.3
of which, as a result of injuries and poisoning	-	6.2	6.1	6.4
Number of calendar days of temporal disability	1 246.2	1 023.0	908.6	952.4
of which, as a result of injuries and poisoning	-	128.1	129.5	135.9

Source: Ministry of Health Care, 1996 and 2000, pp. 57,60 and pp.73- 77.

2. Legislation on health protection

The health care system occupies an important place in the legislative activity of all branches of Government. Over 30 laws regulating health care issues have been passed since 1990, of which 7 in 2000 alone. Some of the principal acts are listed in the appendix.

The bill “On Health care in the Russian Federation” provides a new legal basis for the functioning of a unified system, and proclaims the principles of the national policy on health care. The significance of this bill is that according to the Constitution, separate health care systems have been developed independently at the national and municipal levels and by the private system, but there is no legal base regulating their activities. The bill aims at uniting the different levels in a single health care system that will function according to a common legal base and plan. All major aspects of the organization, financing and provision of medical care are covered in the bill.

The bill “On the Regulation of Private Medical Practice” concerns medical organizations and individuals involved in private practice and their relations with national and municipal health care systems. It aims at stimulating the development of private health care, at providing legal protection for users of private health care and at creating an alternative medical care system. This will improve the quality of medical aid in general by the healthy competition. The financial situation of the national health care system will also improve, because some well-to-do people will use the paid health care system, and consequently, the unspent compulsory medical insurance (CMI) funds will be spent on providing services for the less well off. Furthermore, the economic situation in the regions will improve due to taxation of the private sector.

This bill also allows the development in Russia of the family doctor, an institution acknowledged all over the world. Private doctors will be able to work within the system of compulsory medical insurance, and their services will be free for the patients.

The formation of a single legal basis for the health care system aims at the following:

- regulation of the new developing social relations in health care;
- property management of health care organizations - national, municipal, private, and the relationships between them;
- regulation of civil and economic responsibility for maintaining and strengthening medical services by Governmental authorities, employers and individuals and securing the guarantees and rights of patients for free, timely and qualitative health care;

-
- legal and social protection for medical and pharmaceutical workers.

Unfortunately, the problem of insuring the professional responsibility of medical workers has not been solved yet. Article 63 of The Foundations of the Legislation of the Russian Federation “On Citizens' Health Protection” states that medical and pharmaceutical workers have the right to insure those professional mistakes unconnected with the *actus reus* of the medical worker and that result in non-deliberate damage or harm to a patient's health. However, medical workers cannot enjoy this right at the moment since there is no corresponding law.

3. Health care management and financing

Governmental management, including in health care, is decentralized. The vertical system of administrative subordination of health care bodies was dismantled in the early 1990s and became separated into federal, regional and municipal health care systems. This decentralization in management has resulted in an irrational use of resources. Many examples exist of excessive capacity in one municipal unit, while another neighbourhood lacks means. The purchase and use of expensive medical equipment is virtually uncontrolled.

3.1 Budget financing

At the moment health care financing is organized by the State from two major sources: the State budget and compulsory medical insurance (CMI) funds.

The State budget is the main source of financing federal health care institutions, federal programmes and centralized activities of the Ministry of Health Care, whose budget for 2001 was 19,536.5 million roubles (approx. \$ 664.5 million). In the period between 1991 and 1999 State health care financing, including budget allocations and the CMI system, decreased in real terms by at least a third, and are no longer sufficient to cover the real needs of the sector. The economic conditions of the country, the growth of inflation in services of communal enterprises that provide for the vital activities of the population - all this has had an impact on the financing of health care. Only 53.4 per cent of the requests received from health care institutions are fulfilled: 20 per cent for the purchase of new equipment; 37.1 per cent for thorough repairs; 65.4 per cent for educating medical staff; 20-25 per cent for science; and 41.8 per cent for sanitary and epidemiological activities. Federal funds allotted to the Ministry of Health Care in the 2000 budget were spent, amongst other things, on wages, 36 per cent; medication, 32.7 per cent; and meals, 5 per cent.

Spending on expensive types of medical aid in 2000 covers only 510 per cent of the population's demand, nor are there sufficient funds for providing medical establishments with even the most indispensable medicines, bandaging materials, chemicals, soft implements, medical instruments and equipment. There is a lack of resources for paying communal bills, business trips and thorough repairs.

Apart from the fact that not enough budget funds are being allotted to the sector (the volume of State health care financing today amounts to only 4 per cent of the GDP), there is a long-felt need for the revision of the system of financing health care institutions.

At present the Government suggests the introduction of a system to make the recipients of budget funds responsible for the results of their use. The increase in the effectiveness of budget expenditures will require development of records of services

provided; of quantitative and qualitative analysis of the socio-economic results; of competitive principles and clear procedures for the allotment of budget funds.

In 2000 the Ministry of Health Care introduced a new system of covering the expenses of federal medical institutions - the full fee for a patient, within the stipulated.

It seems also necessary to start using a radically different method of funding by the creation of a state order for providing patients with high-technology medical aid in the institutions of the Ministry of Health Care (Ministry of Health Care, 2001b).

3.2. Insurance financing

One of the main directions of reform in the 90s was a transition to the system of compulsory medical insurance (CMI). The main aim of the law «On Medical Insurance of Citizens in the Russian Soviet Federative Socialist Republic (RSFSR)», in force since 1993, was to secure the constitutional rights of citizens to free medical aid of the guaranteed volume and quality. Today, a new financial infrastructure has evolved - the system of State, non-budget, compulsory medical insurance that aims at maintaining financial stability of medical centres and at providing the population with free medical aid.

At the moment 90 territorial funds and their 1,123 branches, 500 of which act as insurers, work within the system of compulsory medical insurance. Premium payers number 5.1 million and provide about 30 per cent of the funding (Government Report, 1999, p.66). Thirty per cent of the medical institutions work within the CMI system and over 60 per cent of the patients receive medical treatment there.

According to the Ministry of Health Care, an important result of the introduction of CMI is that it represents the real economic forces present in medical activities, whether state, municipal or private. The introduction of the CMI system has created medico-economic awareness and broadened the use of economic calculations in health care.

However, there is an opinion among health workers that the medico-economic standards do not give the necessary results - first of all, because these standards are usually unrealistic (more often than not, they are understated). In addition, many medical services (for instance, the primary examination of a patient, medical inspection, consultation, etc.) are difficult to standardize on the basis of the duration or the number of patients examined since different cases require different amounts of time. If medical personnel are submitted to the standards (which determine wages!), the risk for the patient is poor quality medical care.

Taxes paid by employers and employees are the main source of funds of the CMI. The second source comes from payments for the compulsory medical insurance of those who do not work and therefore do not pay this tax and is raised through general taxation. However, the average amount paid for one unemployed citizen is less than one fifth the amount required: according to the Ministry of Health Care, in 2000 an unemployed person received 172.1 roubles, whereas the estimated amount needed was 954 roubles. It is because of insufficient financing of the CMI system and its obligation to provide free medical aid that the potential capacity of the system has not been realized.

The Ministry of Health Care considers it useful to provide for the introduction of a unified pricing system within the framework of the State Guarantees of the Compulsory Minimum of Medical Services Programme. At present each region has its own pricing system, which is different as far as both methods of payment and number of items included in the rate are concerned. This situation hampers mutual settlements between the various regions and provides for no control of the real implementation of the Programme.

Nevertheless, the reform has led to a certain redistribution of public resources in favour of health care. But the price paid for this additional source of funds is dividing financing into two subsystems - budget and insurance - both having the same recipients of funds and at the same time acting according to different and poorly coordinated rules. This has hampered the process of the financial planning of implementation of the territorial CMI programmes.

Despite the introduction of CMI, health care still lacks funding. The imbalance between State obligations to citizens and real financial capacities has a destructive influence on the whole system of health care. There is a decrease in preventive measures and an increase in medical service provided on a paid basis. Medical costs are being transferred to households. Legal and "shadow" payment for medical services and medicines constitutes, according to different estimates, between 24 and 45 per cent of the total expenditures of the Government and the population on health care.

A report of the Ministry of Health Care (2001) states:

In order to achieve a real balance between the governmental guarantees of providing medical services for the population and providing funds for them, and to reduce the "shadow" market in health care we cannot do without a certain alteration of the constitutional norm concerning free medical service (Article 41 of the Constitution). We should amend Article 41 of the Constitution and legalise what we have in practice.

However, funding problems are not a justification for refusing free medical aid. A state that claims to be a "social" state cannot act according to the let-the-drowning-man-save-himself principle.

The perspectives of reforming the health care financing system involve the creation of a system of compulsory medico-social insurance by integrating the existing systems of compulsory medical insurance and social insurance, which, by the new legislation, must be introduced as of January 1, 2003. It is expected that this will enhance the level of social protection by replacing the principle of medical insurance with the principle of insuring the health of the population. The basis for the unification of state social insurance and compulsory medical insurance is the idea of a single insurance for accident and sickness employers and employees, as well as the integration of these systems at the functional and technological levels. The official opinion of the Government bodies that have initiated the reform is that the integration of the two insurance funds will lead to an increase in the effectiveness of public funds.

However, even today, after the unified social tax was introduced and funds end up in the common moneybox of the Federal Treasury, it is extremely difficult for the to get the funds when accidents occur. Additional red tape means that in the end it is the insured, i.e. ordinary citizens, who suffer. These real difficulties that have occurred in practice after the unified social tax was introduced must force the Government to be more careful in approaching such financial issues.

4. Organization of medical assistance and health care resources

By the end of 2000 there were 8,862 hospitals working within the system of the Ministry of Health Care (including 5,632 working within the CMI system); 1,532 prophylactic centres (282 within CMI), 17,689 outpatient clinics (8,537 within CMI), 3,172 ambulance stations, 580 convalescent homes and health resorts and 927 dental clinics (764 within CMI).

In the recent decade there has been a certain decrease in the number of health care institutions which continued in 2000: the number of in-patient clinics decreased by 2.4 per cent, out-patient clinics - by 0.5 per cent, and prophylactic centres - by 1.9 per cent. However, the level of patient's hospitalizations increased by 0.6 per cent (Ministry of Health Care, 2000, p.100; Government Report, 2000, p.62).

Unfortunately, many health care facilities still have unsatisfactory equipment at their disposal. In 1992, 23 per cent of hospitals had no water supply; 33 per cent, no sewage system; 30 per cent, no central heating; 60 per cent, no hot water supply. Over 60 per cent of the patients were placed in 6 to 10-bed wards, and 15 per cent - even over 10 beds. According to a questionnaire of the Ministry of Health Care in 2000 in 51 regions, the average deterioration of buildings was 47.5 per cent (over 60 per cent in 15 regions); depreciation of medical equipment, 61.8 per cent (over 80 per cent in 5 regions); and depreciation of transport, 61.4 per cent (over 80 per cent in 13 regions). The average depreciation of other equipment was 55.7 per cent, and the highest rate was in the Moscow region, at 84.1 per cent.

4.1 Rural areas

In the rural areas in 2000, 8,301 outpatient clinics, with an overall capacity of 469,000 visits per shift, were in operation. As a result of the huge radius of a rural medical district, low-power health care institutions predominate in these areas. The rural population is provided with medical assistance by 1,185 ambulance stations, 4,051 rural hospitals (their number has grown by 699, or 17.3 per cent, in the recent decade), and 43,362 paramedic-obstetric stations (POS) - their number has decreased by 3,300, or by 7.6 per cent, despite the fact that it is at the POSs where, due to the low density of the population in some areas, medical aid is provided.

The quality of medical service at the level of rural medical hospitals (RMH) is problematic. The equipment these RMHs have at their disposal is unsatisfactory: 58.8 per cent of them need thorough repairs, 75.8 per cent have no sewage system, 72 per cent have no water supply, 66.4 per cent do not have central heating, 1.7 per cent are without telephones, 14 per cent do not have any means of transportation. Fourteen per cent of the RMHs were not properly staffed during the year 2000.

The situation in the POSs is even more horrifying: only 23.3 per cent of them are placed in dedicated premises; 49.2 per cent of them need thorough repairs, 87.2 per cent have no central heating; 93.2 per cent no water supply and 93.7 per cent, no sewerage system. Only 77 per cent of them have telephones and a mere 0.1 per cent are provided with transport (Ministry of Health Care, 2000, p.100; Government Report, 2000, p. 63).

4.2 Departmental medicine¹

In socialist times, special departments, institutions and large enterprises (for instance, the ZIL and GAZ automobile plants) had their own network of medical and recreational centres, where workers and members of their families were provided with medical

¹ "Departmental medicine" is a system of medical institutions belonging to a Ministry or an enterprise or university or any other organization. The Ministry of Health Care does not manage, control or finance them. Such institutions appeared in Soviet times as a response to low level of "state medicine". Such "departmental" medical centers served only those who worked for the organization and especially for management; often they were better equipped, better staffed and better provided with medicaments. To work in such medical institutions was better as they had some special privileges.

assistance. Now, many departments have to deny themselves their own medical establishments due to lack of funds - municipal administrations are taking over their functions.

At the present time, this tradition is preserved in the Government bodies (almost all their workers are ascribed to departmental outpatient clinics) and also in many prosperous departments and organizations (for example, the Ministry of Communication Lines has a huge chain of medical establishments all over the country). Such special departments as the Ministry of Defense, the Ministry of Internal Affairs and others also preserve and support their own health care.

Naturally, the state of the equipment in these departmental health care establishments depends on the financial state of the "owner" and differs greatly from department to department.

4.3 Non-government health care

The non-government sector of health care has developed over the last decade. However, there is an unequal distribution of non-government medical establishments among the regions, as well as a clear preference for particular types of medical care (for example, almost 40 per cent of all private medical licences were issued for providing dental services.)

By the beginning of 2001, 5,571 non-government health facilities, licensed to provide medical services, were registered in 51 regions of the Federation. Half of these – 2,787 - were registered in 10 regions: the Republic of Tatarstan (497), the Rostov region (374), St.Petersburg (362), the Kemerovo region (305), the Amur region (232), the Ivanovo region (224), the Primorskiy Krai (region) (223), the Kursk region (199), the Smolensk region (195) and the Perm region (176). In the same 10 regions 1,282 licenses for providing dental medical aid in the non-government sector were issued. (58.6 per cent of all licences for dental care in the 51 regions)

In 5 out of the 51 regions there is no non-government health care sector at all (Government Report, 2000, p.79).

Unfortunately, official data about the situation in the non-government health care sector are practically non-existent. Private medical institutions are not accountable to the structures of the Ministry of Health Care and do not have to provide them with any information about their work. It is only when they apply for a licence that they have to submit some data, including information about the professional level and qualifications of their medical staff. The relevant health care management authorities must periodically confirm the licence. However, these authorities themselves have not yet established a system of control and monitoring of their activities.

4.4 Human resources in health care

Providing human resources for health care is the decisive factor in the successful realization of the Concept of Health Care and Medical Science Development in the Russian Federation.

Over 4 million people work in health care in Russia today; of which over 2 million have received higher or secondary medical or pharmaceutical education. Health care workers constitute 4.2 per cent of the total work force of the country.

Within the system of the Ministry of Health Care, there were 42 doctors and 96.5 nurses per 10,000 citizens in 2000. Although a constant number of medical specialists are being trained, there still is a shortage. There is a deepening problem of disproportion between doctors and the personnel with secondary medical education. There is a certain tendency towards a reduction in the doctors of the first health care echelon. Although the overall number of doctors is constantly growing in the last three years there has been a decrease of 4,500 in the number of physicians and of 2,500 in the number of paediatricians. The number of doctors has decreased in 26 regions of the Russian Federation and nurses in 35. The main reasons are the lack of finance in the sector, low wages and unsatisfactory working conditions.

Table 2. Medical personnel in the Russian Federation, 1992 - 1998

	1992	1993	1994	1995	1996	1997	1998	2000
Doctors								
total, in thousands	637.3	641.6	636.8	653.7	669.2	673.4	679.8	680.2
per 10,000 of the population	43.0	43.4	43.3	44.5	45.7	46.1	46.7	42.0*
Paramedical staff								
total, in thousands	1 709.1	1 674.2	1 613.2	1 628.8	1 648.6	1 626.3	1 620.9	1 563.6
per 10,000 of the population	115.3	113.1	109.7	111.0	112.7	111.4	111.4	96.5*

* in the Ministry of Health Care sphere

Source: Ministry of Health Care, 2000, p. 100.

There are serious regional differences in providing the population with medical staff. Some regions have a relatively high proportion: Moscow (83.9 doctors and 125.9 nurses per 10,000 citizens), St.Petersburg (73.9 and 111.0); the Northwestern region (57.2 and 104.4) and the Central region (53.1 and 113.2). The worst situation is in the North Caucasian region (42.2 and 99.1), the Kaliningrad region (37.4 and 98.9) and especially in Ingushetiya (27.9 and 62.0). Health care centres in some territories are understaffed, and in some centres specialists with secondary medical education only occupy doctors' positions.

The provision of medical personnel for the rural population is much lower than in the cities. By January 1, 2000 50,259 doctors and 233,369 medical workers with secondary education worked in rural areas, which is 8 per cent and 13 per cent respectively of the total number of these specialists, whereas 27 per cent of the population of Russia live in rural areas. At present 8.7 per cent of district rural hospitals and 17 per cent of the RMHs do not have doctors on their staff at all. The problem of providing medical personnel for these areas has always been serious: working conditions and the equipment existing in rural medical establishments are poor. However, if in the past the problem was solved by means of compulsory distribution of young, graduating specialists, today there is nothing to force them to go to rural areas or even to attract them - no housing, no decent working conditions, no decent payment. The only bait is that rural doctors can retire earlier than normal workers do, but this pension is anyway too low. A return to the compulsory distribution of young specialists would be a solution, but such a measure is contrary to international labour standards prohibiting compulsory labour.

The Ministry of Health Care is one of the leaders in the number of educational establishments - 55 higher education establishments (about 10 per cent of all State higher education establishments) and 450 secondary medical and pharmaceutical education establishments (15 per cent of all secondary vocational educational establishments) are subordinate to the Ministry. Over 230,000 students of secondary educational establishments as well as 200,000 students, interns, registrars and postgraduate students, study in establishments of the Ministry of Health Care; about 700,000 specialists with higher or secondary medical education receive additional professional training.

Professional retraining and development courses for medical personnel are held in 7 establishments for post-diploma education and 46 faculties of postgraduate training for doctors.

In order to control the qualifications of medical and pharmaceutical personnel the system of personnel certification was launched in 1994.

4.5 Unemployment of medical workers

Job centres of the Labour and Employment Departments are not obliged to collect and provide information about the professional background of the registered unemployed. The only data about unemployment among health workers date from 1996.

At the end of 1996, 3,000 health care workers received unemployment benefit at job centres, of which 13 per cent were doctors, 64 per cent nurses, and 23 per cent other professionals. At the same date there were over 56,000 job vacancies for doctors and over 84,000 for nurses. Thus there were 140 vacancies per unemployed doctor and 44 vacancies per unemployed nurse.

However, 27 per cent of the vacancies for doctors and 63 per cent for nurses were in the health care centres of rural areas (Government Report, 1996, pp. 126-127) where it is difficult to fill these vacancies.

Table 3. Supply and demand for health personnel in the Murmansk Region, 1990 - 1999

Professionals	Number of applicants in 1990	Number of vacancies in 1990	Number of applicants in 1999	Number of vacancies in 1999
Doctor	2	690	30	170
Veterinary	6	5	12	5
Obstetrician	2	8	3	11
Paramedic	18	96	36	43
Medical nurse	64	1 196	223	229
Medical registrar	0	5	23	5
Medical lab assistant	0	6	0	18
Medical statistician	0	2	1	12
Pharmaceutics	0	8	18	68
Dental technician	0	0	5	0
Male nurse	30	1 233	815	195
TOTAL	122	3 249	1 166	756
% of total unemployment in the region	1.0	13.0	2.5	2.7

Source: Informal data from the Murmansk Employment.

Data available in the Murmansk region shows (Table 4) that the situation has changed radically: whereas in 1990 there were 26.6 vacancies for each unemployed medical worker, in 1999 there were only 1.5 unemployed health care workers for one vacancy. However, there still is a considerable deficit of doctors. The average duration of the unemployment for medical workers in the region is 7 months.

5. Remuneration and other benefits

5.1 Remuneration of labour

Salaries in health care are characterized by extremely low levels of pay, irregular indexation and delays in payment. Furthermore, salaries have not been changed for several

years, and the level of the remuneration of health workers compared with other branches of the economy has been seriously declining over the last 20 years (Table 4).

Table 4. Average monthly salary in health care as a percentage of the average monthly salary in all sectors, 1961 – 2000

Year	1961	1970	1980	1990	1992	1999*	2000*
	72	75	75	68	64	51	46

Source: Government Report on Health Care, 1992, p 110

* Parliamentary Hearings "Socio-Economic Status of Health Care Workers", April 12-13, 2000.

Salaries for health care workers are fixed by qualification according to the Unified Tariff Scale, an official document approved by the Ministry of Labour. In 2000 the remuneration of junior medical personnel (Categories 2-4) was 180-228 roubles per month (about 20 per cent of the subsistence level); nursing staff (Categories 5-12) - 240-552 roubles per month (under 50 per cent of the subsistence level); doctors (Categories 11-14) - from 485 to 702 roubles per month (a little over 50 per cent of the subsistence level); and doctors-in-chief (Categories 14-18) - from 702 to 1,086 roubles per month, which is hardly equal to the subsistence level.

Apart from the basic salary, a number of benefits take into consideration the specifics and peculiarities of their work. There are about 15 different raises, fringe benefits and allowances, such as for working with AIDS patients and HIV positives; or with psychiatric, infectious and oncological diseases, as well as for working next to the source of ionising radiation. All workers of health care establishments have the right to an allowance for uninterrupted periods of employment, both for full-time and part-time work.

Additional allowances exist in the regions and municipalities, causing considerable wage differentials among health care workers of various regions of the Russian Federation. For instance, in 1999 the average monthly salary of health care workers in Moscow was 1,667 roubles, compared with 387 roubles in the Republic of Dagestan!

Delays in paying wages make the situation even worse. By January 1, 1999 the arrears of wages were 4.5 billion roubles; and by February 1, 2001, 238.1 million roubles.

As a consequence of this low and uncertain remuneration, medical workers have to work on the side. Working part-time (occupying several positions either within one's own or in different medical organizations) and combining jobs (doing paid work for an absent employee within one's working time and alongside one's own work) have become normal practice. At the same time, health professionals sometimes have to do work demanding a lower qualification; this is especially the case for of paramedical staff, which often has to work as nurses since there is an enormous lack of the latter.

In medical establishments working in the CMI system (whose number is constantly growing) salaries are paid on the basis of services provided. These are calculated by the CMI fund in accordance with the medico-economic norms. Medical workers provide an estimate of their services, according to established norms. Any payments above this amount are distributed by the administration of the enterprise as bonuses, which represent a substantial addition to basic pay, on average 25-30 per cent of the monthly salary. Workers claim that the administration usually distributes the bonus money according to its own subjective choice. However, the insurance companies working within the CMI system thoroughly examine the quantity of the medical services provided and their justification, and sometimes consciously prune their volume; doctors have to prove why this particular patient was provided with these particular services in this particular volume. This can lead to a reduction in the quality of care and to patient discontent. Together with the detailed accounts that doctors have to provide it adds extra stress to their strenuous work.

However, medical workers themselves admit that their additional earnings, including “shadow” incomes or illegal payments (not only in money terms) from patients or their relatives, make about 50 - 60 per cent of their total earnings. According to different estimates, legal and “shadow” payments for medical services and purchasing medicines amount to 24-45 per cent of the aggregate State and citizens' expenditure on health care.

5.2 Working hours

Most medical workers have a reduced working day, which lasts from 4 to 6.5 hours, depending on working conditions. This suggests that most medical workers work in shifts.

Some categories of health care workers, such as the medical personnel of psychiatric, infectious, radiology and other departments have more than the normal annual holiday of 24 days, and are entitled to 30 to 48 days holiday depending on qualifications and years of service. An additional three-days' holiday is granted to ambulance brigades and brigades of neighbourhood medical services, as well as to general practitioners and their nurses. The teaching personnel of medical departments enjoy paid holidays of 56 days. However, not all medical workers who have harmful and dangerous working conditions have the right to additional holidays. The Ministry of Health Care makes recommendations to the Ministry of Labour about this.

In practice, because of lack of funds many medical institutions do not provide these holidays even for the workers who have a legal right to them.

5.3 Pensions

Retirement pensions for doctors and paramedical staff of medical centres, teaching facilities and sanitary-epidemiological institutions were established in 1959.

When the law “On State Pensions” came into force in 1991, the situation with retirement income security worsened as well as medical workers of educational establishments were denied the right to retirement pensions. Moreover, social security bodies refused to provide retirement pensions for medical workers of health care establishments that did not have the status of a legal entity, which first of all affected medical workers of clinics, professional medical educational establishments, medical research organizations, territorial medical association and other health care institutions.

The situation with retirement income security for health care workers became even more difficult when Ordinance #1066 of the Government of the Russian Federation “On the List of the Positions that Give the Right to Retirement Pensions because of Medical or Other Work Aimed at Protecting the Health of the Population” was passed in 1999. This Ordinance aimed at putting retirement income security in order by restricting the number of workers who have the right to this type of pension. The following categories were excluded from the previously valid list: pharmaceutical workers, pedagogical workers of medical educational establishments (these groups had already been excluded above) doctors-statisticians, hospice directors, chief medical nurses, dietetic nurses, medical registrars, etc.

The new lists of positions that give the right to a privileged retirement pension do not include such categories of medical workers as, for instance, medical personnel of the medical preventoria of collective farms (*kolkhoz*) and state farms (*sovkhov*); medical workers of boarding-schools, children's homes; pharmaceutical workers, etc. The period of professional training, i.e. the period of studies at medical institutes and colleges, is not considered part of the work record.

A third variant of the bill on pensions has now been introduced, proposing that the list of privileged categories of medical workers be expanded in both rural areas and in towns and cities.

Medical workers whose jobs are characterized by harmful or unfavourable working conditions have the right to a special insalubrity pension. The lists of harmful professions include, for example, doctors and paramedical staff working with radiological apparatus or chemicals; paramedical staff and nurses working with psychiatric and psychosomatic patients and in multi-directional medical establishments.

At present the Ministry of Health Care is considering extending the right to a privileged pension to doctors and laboratory assistants of tuberculosis institutions where there has been an enormous increase in the number of occupational diseases in recent years, as well as doctors of psychiatric and psycho-neurological institutions. It is interesting to note that paramedical staff and nurses of these institutions already have the right to such a pension.

5.4 Remuneration in departmental medical establishments

As already mentioned, the status of workers employed in departmental medical institutions depends on the financial standing of their "owner", i.e. of the department or enterprise itself.

For instance, in the departmental health care centres working within the system of the Ministry of Communication Lines, the salaries of medical personnel are as low as those in the centres belonging to the Ministry of Health Care. Apart from the salary, there are no additional allowances paid by the Ministry of Communication Lines. Nevertheless, according to the workers themselves, it is much better to work within the system of this Ministry than within the system of the Ministry of Health Care, since working conditions are more attractive and the equipment is better. Furthermore, they are granted socio-economic benefits in accordance with the sectoral agreement on tariffs, acting within the railroad system, and collective agreements of the department, which means that they receive free railroad travel once a year, material allowances for their annual holidays, and severance pay in case of dismissals due to staff reduction or retirement.

Departmental health care centres of the Ministry of the Interior, the Federal Security Service and the Ministry of Defence are totally financed from the State budget. These departments have traditionally paid particular attention to medicine. The equipment and working conditions there are better than in similar establishments of the Ministry of Health Care and their personnel has a lower workload (by approximately 30-40 per cent), which allows for better quality in medical services. Material security is also better in these departments: salaries are regulated by the departments themselves (the Unified Tariff Scale is just a guideline) and are generally higher than in the Ministry of Health Care by 40-50 per cent. In addition, medical workers receive premiums for the length of service, food allowances, transportation privileges, etc. Military rank is given to chief medical personnel starting from the head of a ward, which entitles them to the corresponding premiums for rank.

5.5 Remuneration in the non-government health care sector

To complete the picture, it is necessary to examine the situation in non-government medical establishments. In the absence of official data, sample interviews were conducted to obtain the following information.

As a rule, non-government medical establishments are technically better equipped and their employees have better working conditions and a higher level of income than those in the Ministry of Health Care. Salaries are agreed upon by both parties of the labour contract and depend on mutual interest and the financial standing of the company. The official salary is often just a part of the worker's income; the other part being paid unofficially, to avoid paying wage and income taxes.

It is common practice to allow workers to use the equipment and the premises for providing medical services (often outside official working hours) to patients who pay the doctor directly. The transaction does not go through the bookkeeping of the company in this case.

Very often employees work part-time in these institutions - they are highly qualified workers of government medical institutions who have to supplement their salaries by outside work.

6. Working conditions and labour protection

Issues of working conditions and labour protection, professional accident rates and occupational hazards constitute a serious socio-economic problem in the health care sector, which directly influences the professional activity of the specialists.

Working conditions of these employees require close attention: they are exposed to various unfavourable factors of the professional environment, such as emotional and analysing stress, uncomfortable working posture and microclimate, deficient lighting, harmful chemical and biological substances, ultrasound, laser and ionising radiation, etc.

6.1 Occupational hazards

Table 5 shows that occupational diseases among medical workers are on the increase: in 1995, only 261 diseases were registered, whereas there were 434 in 1999; relative indices (per 10,000 workers) were 0.71 in 1995 (1.89 for all branches of activity) and 1.74 in 1999 (1.77 for all branches). Although the overall incident rate fell by 6.3 per cent between 1995 and 1999, it increased by 2.4 times in the medical sector.

According to medical workers themselves, the main reasons for this increase in the incidence rate are heavy workloads, poor income security, unsatisfactory working conditions, including lack of equipment, instruments, materials, medicines, etc. In addition, there is a certain "ageing" of health care staff, and, consequently, decline in health and decrease in working.

Occupational diseases are registered annually by medical establishments in 66 (in 1999) regions of the Russian Federation, the majority of cases being in St. Petersburg, in the Moscow, Tomsk, Samara, Novosibirsk, Nizhniy Novgorod, Primorskiy Krai and Chelyabinsk regions. Respiratory tuberculosis, serous hepatitis, bronchial asthma, dermatitis, pharmaceutical allergy, and eczema dominated among the occupational

diseases. The majority of these are chronic. Eighty per cent of cases are women. Many of these diseases lead to disablement.

Table 5. Index of occupational incidents among health care workers compared with the industry average, 1990 - 1999

Year	Number of cases for medical workers	Index per 10,000 health care workers	Industry average index per 10,000 workers
1990	161	0.49	1.96
1991	135	0.25	2.08
1992	134	0.59	1.88
1993	209	0.67	1.85
1994	205	0.57	1.81
1995	261	0.71	1.89
1996	267	0.74	2.33
1997	318	0.88	2.32
1998	415	1.66	1.85
1999	434	1.74	1.77

Source: Ministry of Health Care, 2001a.

Most occupational diseases are registered in tuberculosis hospitals and centres and in outpatient clinics; fewer in hospitals for infectious diseases and sanitary and preventive medical institutions. The main professions concerned are paramedical staff, doctors and laboratory assistants, and occupational diseases are more frequent among workers with less than 5 years of service. Respiratory tuberculosis (50 per cent), viral hepatitis (16 per cent), pharmaceutical allergy (8 per cent), bronchial asthma (8 per cent), and skin diseases (4 per cent) predominate among the occupational diseases of health professionals (unpublished figures of the Research Institute of Labour Medicine). Infection with Btype hepatitis is 10 times more frequent among workers in hospitals for infectious diseases, biochemical and clinical laboratories, and haemodialysis centres than in the population in general.

The major factors that lead to occupational diseases in the production sector are biological factors, 73 per cent (Btype viral hepatitis and respiratory and other types of tuberculosis); high-active medications, 16 per cent; and chemical substances, 11 per cent.

Every year over 50-60 per cent of all registered cases of occupational disease are identified when patients apply for medical help, but these are not usually diagnosed in routine medical examinations. Apparently, in some cases, compulsory medical occupational examinations are treated more as a formality. "Taking care" of the health of medical workers on the part of the State resulted in a campaign of free vaccination against hepatitis. Sometimes medical workers help each other out, usually at a low rate of pay or even free.

6.2 Legislative protection

One of the main reasons for unsatisfactory labour protection and safety in health care is lack of funds. However, obsolete legal norms, incompetence of workers themselves in this area, and irresponsible indifference on the part of the administration are also responsible. The current concept provides for:

Development of the legislation on labour safety in health care institutions; education of the administration of health care institutions and governing bodies and the students of

medical educational establishments in the area of labour protection; adoption of a single policy of establishing benefits and compensations for medical workers for special working conditions (Ministry of Health Care, 2001b).

Although allowances are necessary to compensate for special working conditions, these should be improved to make them safer. According to workers themselves, organization of meals during 24-hour shifts, creation of facilities for rest and relaxation, provision of appropriate working clothes, protective equipment and hygiene would enhance safety in many medical establishments.

This aspect has not been entirely neglected: a Sectoral Programme of Primary Measures to Improve Working Conditions and Labour Protection in 1998-2000 has been adopted. In almost every health care institution labour protection commissions have been created and authorized personnel appointed. However, in the opinion of workers, their activities are not yet sufficiently effective.

7. Representation of medical workers

7.1 Professional and scientific associations

In order to discuss and solve the multitudinous problems concerning the professional activity of health care specialists, doctors' associations are being created.

The Ministry of Health Care cooperates closely with such associations, by for example, using them to solve the questions of evaluation and certification of medical workers, of working out methodological recommendations, etc.

Cooperation of health care management bodies with medical scientific societies proves to be especially effective. At present there are about 60 such societies in Russia, each of them composed of reputable specialists, scientists and practitioners who form the backbone of the doctor community.

In addition, All-Russian Congresses of Doctors (the Pirogov Congresses) are being organized. Here it is planned to discuss the issue of creating a separate independent body - the professional doctors' association - in order to give it some personnel development functions that are now performed by national or municipal health care bodies (Ministry of Health Care, 2001b).

7.2 Trade Unions

The trade union of health care workers unites the majority of the workers of state-owned institutions in this sector. Workers of departmental medical establishments are members of the corresponding sectoral unions. There appear to be no trade unions in the non-government sector.

The trade union of medical workers performs its functions of representing and protecting workers' interests as regards wages, recreation, protection, employment security etc, by means of concluding sectoral tariff agreements at federal and regional levels, as well as by collective agreements at the level of health care organizations.

According to the Ministry of Health Care, their cooperation with the sectoral union has become closer and more fruitful in recent years. Issues of the remuneration of labour, social benefits, guarantees and compensation, labour protection, and employment protection are discussed at joint sittings of the Board of the Ministry of Health Care and

the Presidium of the central committee of the union. The system of social partnership that is being formed now allows serious conflicts to be avoided.

Unfortunately, at the level of primary trade union organizations, medical workers who are union members know very little about the opportunities of union support for protecting their rights. Many of them believe that apart from the distribution of material comforts, which are limited by budget constraints, the unions do not have the right to interfere in anything. Workers also distrust their unions on the grounds that they are totally dependent on the employer's will, and, consequently, unable to protect their members in case of conflict. As for collective agreements and agreements that are concluded in the sector on a regular basis, workers are indifferent, considering them formalities and uninfluential. A similar attitude reigns as to the activities of labour protection commissions, of which union representatives are usually members. The main reason for this situation, according to both ordinary union members and elected union officials, is the lack of financial means for adding realistic provisions to collective agreements.

The answer to the question "Who protects your labour interests?" is usually "No one!" or "I protect myself on my own!"

8. Conclusion

The problems of health care in Russia, including those of the socio-economic status of employees, are complex, interdepartmental and depend on the stabilization and overall development of the economy. The current decline in public health, the decrease in life expectancy and in the birth rate are cause for serious concern. There is a need for substantial measures of socio-economic stabilization, to remove emotional stress and support young people and families in order to stimulate the birth rate.

The level of budget funds allotted to medicine should be radically reviewed without neglecting preventive measures and advertising of a healthy way of living among the population.

It is also important to perfect the insurance forms of financing health care, at the same time guaranteeing basic medical attention free of charge. Particular attention should be paid to the unprotected and poor segments of population.

Health care management needs improving in order to strengthen collaboration between federal and regional health care services. One of the factors hampering improvement in the quality of medical care in separate regions is the outdated mechanism of economic relations within the sector. This is related not to the amount of funds, but to the depersonalized financing of medical institutions. It is therefore important to train specialists with a deep knowledge of the issues of public health organization and management, economics, planning, financing and rational and effective use of resources.

To overcome the serious problem of staffing medical establishments with specialists of all levels, especially with paramedical staff and nurses, it is necessary to organize an effective permanent monitoring system at regional and federal levels and to create a unified register of health care staff potential in order to be able to react quickly to changes.

Remuneration of health workers, including premiums, bonuses and pensions must be improved to enhance the prestige of the profession, and trade unions should be more active in alerting both public opinion and official authorities to the extraordinarily unsatisfactory conditions in this sector.

The development and improvement of legislation on health protection can play a role of no little significance in bringing solutions to these problems. Great expectations are now centred on the adoption of the law “On Health Care in the Russian Federation”, which will include a section “On Social Protection of Health Care Workers”. It is expected that eventually a legal mechanism will be introduced for insuring the professional responsibility of medical workers.

Reasonable decisions on these issues would to a great extent alleviate today’s health care problems and, above all, provide the population with a really accessible medical service and make a unified health care system function effectively.

Appendix

Recent legislation on health protection in Russia

- The Foundations of the Legislation of the Russian Federation on Citizens' Health Protection;
- On Sanitary and Epidemiological Well-being of the Population
- On Medical Insurance of Citizens in the Russian Federation
- On Narcotic Drugs and Psychotropic Substances

At present twenty-one bills are being considered by the State Duma of the Russian Federation, including the following:

- on Health Care in the Russian Federation;
- on the Regulation of Private Medical Practice;
- on the Advertising of Medical Services, Medical Products and Medications.

References

- Government Report. 1992. *On Health Care* (Moscow).
- Government Report. 1999. *On the State of Health of the Population of the Russian Federation* (Moscow).
- Government Report. 2000. *On the State of Health of the Population of the Russian Federation* (Moscow).
- Ministry of Health Care. 1996. *The Health of the Population of Russia and the Activity of Health Care Establishments* (Moscow).
- Ministry of Health Care. 2000. *The Health of the Population of Russia and the Activity of Health Care Establishments* (Moscow).
- Ministry of Health Care. 2001a. *Information Letter About The State of Occupational Incidence Among Health Care Workers* (Moscow, Federal Centre of Governmental Sanitary and Epidemiological Supervision).
- Ministry of Health Care. 2001b. *On the Process of Realization of the Health Care and Medical Science Development Concept, the Tasks for the Years of 2001-2005 and for the Period till the Year of 2010* (Moscow).
- Parliamentary Hearings. 2000. *Socio-Economic Status of Health Care Workers* (Moscow), April 12-13.

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