

ILO IFP-SES PSI

**Privatisation of Health Care
in Central and Eastern Europe**

Report on the

**BASIC SECURITY FOR PSI AFFILIATES
IN THE HEALTH SECTOR
IN CENTRAL AND EASTERN EUROPE**

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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 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 to these reforms and have begun to assess how change, (the process of structural adjustment and privatisation), has affected representation, remuneration, working time, career development and occupational health in the health sector.

This work is now being taken forward by the 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 centralised (Semashko) model of provision with a more responsive and effective approach to service delivery. However, it is undeniable that the need to reduce overall costs and to achieve greater efficiency and/or efficiency savings have also been a prime motivating factor. The last ten years of reform have seen

- health sector 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 health care 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;
- pressures to substitute primary care and preventive services for more expensive secondary care¹.

Reforms have included decentralisation, reorganization of primary care, the introduction of insurance-based funding and the emergence of private models of health care provision, amongst others, which at the very least have created a great deal of uncertainty for the workforce.

The objective of this project has been to use empirical evidence to quantify and assess, the impact of reforms on workers' security as defined by the seven IFP-SES socio-economic components (see below) and to review the position of the health sector workforce in CEE and CIS. Specifically, the project seeks to examine the situation of health workers, objectively and subjectively, by answering the following questions:

- To what extent is job insecurity increasing among workers in the health sector?
- How can work insecurity be tackled given increases in other forms of insecurity?
- Are workers who are rendered unemployed by privatisation in the health care industries able to find other areas in the labour market which can offer them employment?

¹ J. Healy, C. Humphries, Health Care Personnel in Central and Eastern Europe, ILO Sectoral Working Paper, (Geneva 1997)

- What impact is the privatisation trend creating to further increase levels of income insecurity, skill reproduction insecurity, employment insecurity of workers in the health care sector?
- What is the reality of 'social dialogue' when it comes to representing health service employees in CEE countries?
- What are the main threats to workers in health care?
- What do trade union lay as well as official representatives actually do in terms of trying to defend their members' interests in the privatisation environment?
- What constraints do workers face in day-to-day terms and in the wider political and policy arenas?

1.3 Scope of the Report

In an effort to provide answers to these questions a survey instrument was developed around the IFP-SES framework to explore the seven distinct dimensions of socio-economic security – labour market security, employment security, job security, skill reproduction security, work security, representation security and income security – which are defined broadly below.

IFP-SES seven components of socio-economic security²

Labour market security: Adequate employment opportunities, through state-guaranteed full employment;

Employment security: Protection against arbitrary dismissal, regulations on hiring and firing, placing burden of costs on employers, etc;

Job security: Protection of one's occupation, skill area or "career", protection against de-skilling, down-skilling, and restrictive work practices, protection of job qualifications, tolerance for 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.

This ILO-PSI questionnaire (hereafter called Basic Security Survey) was sent to 35 PSI trade union affiliates in order to collect country by country data . Affiliates surveyed in Armenia, Belarus,

² See also the ILO InFocus Programme on Socio-Economic Security – A Medium-Term Workplan (Geneva, 1999).

Croatia, Czech Republic, Kyrgyzstan, Latvia, Lithuania, Moldova, Poland, Romania, and Ukraine returned questionnaires in time for inclusion in the current Report. The data were analysed and the results are the subject of this Report and provide the bulk of its content. Questionnaires for Bulgaria, Estonia, Hungary, Georgia and Slovakia await analysis.

However, it is also the remit of this Report to provide the background ‘story’. To this end a range of materials have been used, not least the SES questionnaires³, which examine the overall socio-economic security of the economically active population in selected countries. In addition, WHO and European Observatory on Health Care System studies have been used to provide technical evidence on the thinking behind changes in health policy. This secondary analysis 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. Where possible correlations between organizational structures and workers’ security will be highlighted and preliminary suggestions of areas requiring further exploration will be made.

In parallel to this Report, four in-depth country studies have been conducted in selected health care facilities in the Czech Republic, Ukraine, Lithuania and Romania using interviews and surveys of management, government representatives, union officials and worker representatives as well as individual employees to provide a balanced picture. The findings of these studies are reported separately.

The results of the survey work conducted through PSI affiliates and the in-depth country studies will be considered at the Technical Review Consultation (ILO, Geneva, December 2001), where recommendations and future directions will be formulated.

1.4 Structure of the Report

This Report is divided into six parts. Chapters 2, 3 and 4 explore the context in which health sector workers operate in CEE and CIS. Chapter 2 addresses the socio-economic conditions found across the region, whilst human resources pressures, as seen through the eyes of health system analysts, are dealt with in Chapter 3. Structural reforms are examined in Chapter 4 with special emphasis given to the impact of privatisation. In Chapter 5 the Report turns to the Survey for evidence on the changes taking place as regards the seven security typologies. Chapter 6 highlights conclusions and outstanding questions. The Report also includes an annex summarising the socio-economic conditions in the health sector for each of the countries that returned a questionnaire.

³ The SES Questionnaires are produced independently of this project by IFP-SES and VoiceNet.

2. The Central and Eastern European 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, levels of dependency on industrial or agricultural production, along with the extent of structural adjustment all vary enormously. Each of the countries experience individual national circumstances and different patterns of change 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

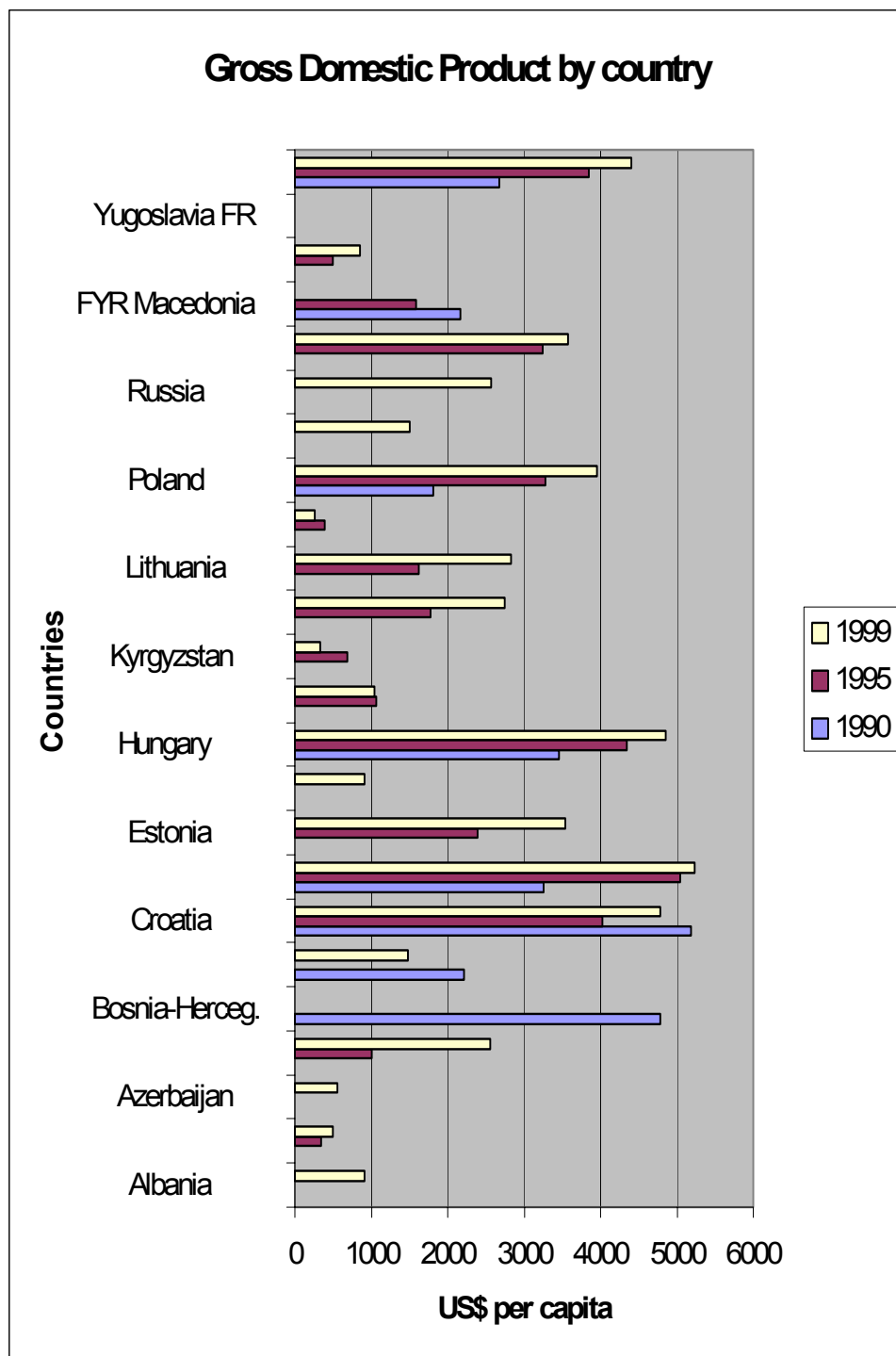
- ownership of the means of production was public and agriculture was largely collectivised with only limited experimentation in private ownership and trade;
- command economies operated through highly centralised planning and with a degree of inherent inefficiency associated with the planning model in use, (although there were variations most 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 and there was 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 too was profoundly affected with pressures to return collectively held 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 affect the CEE and CIS. There was overwhelming disruption in employment with widespread reliance on administrative leave, which saw staff sent home often without pay yet never formally registered as unemployed. It was also typical of much of CEE and CIS that workers were paid late, often as much as 3 months in arrears.

Responses to the disruption, as might be expected, varied considerably, depending on a range of factors not least 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 realised 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, Latvia and Croatia, have also gone a long way towards achieving a structural adjustment model as promoted by institutions like the World Bank and the IMF. The war in Croatia notwithstanding, all these countries had considerable infrastructure development and strong geographic or historical access to Western

capital. Armenia, Belarus, Kyrgyzstan, Moldova, Romania, and Ukraine, 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.



Source: WHO Regional Office for Europe health for all database 2001.

2.2 The Health Context

Despite this economic diversity amongst the countries of CEE and CIS, they had an extraordinary degree of commonality in their health care systems prior to 1989; a direct result of the political commitment to providing ‘free’ health care, with guaranteed, universal access and comprehensive cover. The changes that have taken place since, and in particular the impact on the workforces within the health sector, 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 both 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 highly detailed norms based on population levels, leaving a legacy of highly centralised management and planning and little decision-making capacity at local level;
- numbers of beds, institutions and indeed staff were set out by the respective national Ministry of Health and implemented by regional/local government;
- there was a traditional emphasis on communicable disease and the creation of sufficient hospitals beds to deal with epidemics which, together with a funding system (global budgets increased on the basis of historical incrementalism) that favoured institutions with large bed numbers, led to considerable over-provision;
- crucially, the health sector was defined as ‘non-productive’ and workers were therefore remunerated on pay scales significantly lower than 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 on average than men;
- there were no incentives for efficiency and staff costs were low so CEE and CIS countries tended towards labour rather than capital intensive approaches to provision and high bed to population and staff to population ratios⁴.

Health care systems, like the wider environment in Central and Eastern Europe, experienced a huge dislocation on the collapse of the centrally planned economies. The early 1990s saw little if any maintenance of health care facilities and very little capital investment in equipment. Heating, cleaning and maintenance services were often inadequate and supplies of pharmaceuticals and other goods were erratic. Health sector staff were frequently 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 ‘other’ pressures for change were in part about the wider restructuring of CEE and CIS societies and moves to rationalise public services like health, which made such a huge call on

⁴ Saltman R. & Figueras J. European Health Care Reform: Analysis of Current Strategies. WHO Regional Publications, European Series, No 72, World Health Organization (Copenhagen 1997).

resources. They were also about a desire to decentralise as a conscious rejection of central planning and as a means of responding more to patients needs and demands for quality and of promoting efficiency. Not least among these additional 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. Health status across CEE and CIS suffered a significant collapse that coincided with the years of independence. Life expectancy in Armenia, Belarus, Croatia, Czech Republic, Kyrgyzstan, Latvia, Lithuania, Moldova, Poland, Romania and Ukraine all fell dramatically although there has been some recovery subsequently. 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 dislocation⁵, which is often accompanied by the patterns of alcohol use and increases in violence witnessed in the region. This health crisis might reasonably be expected to have placed additional pressure on health sector workforces, creating additional demand and putting workers in proximity to relatively traumatic events. Health sector workers would also be expected to suffer the patterns of stress and other behavioural 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 however, that health expenditure fell at a time of increasing need amongst populations.

This impetus to change in the health sector then was the result of a number of pressures, not least the consequences of the economic collapse. It dovetailed with the focus on public sector reform and the pressures to cut public expenditure and led to a wide range of initiatives across CEE and CIS.

The initiatives chosen and the extent to which reforms were implemented vary across the countries responding to the questionnaire. Nonetheless, there are a number of common themes. They are discussed in more detail later in the Report but include, attempts to ‘downsize’ the health sector, decentralisation (all countries except Belarus and Ukraine); a shift from tax-based to social health insurance systems (Croatia, Czech Republic, Kyrgyzstan, Lithuania, Poland, Romania, Ukraine); and, the privatisation of elements of health services (Croatia, Czech Republic, Latvia, Lithuania, Moldova, Poland, Romania). They also include the introduction of formal out-of-pocket payments (co-payments, 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 impact 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 not be seen in isolation from the socio-economic security of all workers experiencing the transition of centrally planned economies towards market economies. Transition for many workers in CEE and CIS was accompanied by widespread hardship, typically including spiralling inflation, the closure of old heavy industries and an end to old certainties. The past decade has witnessed significant adjustments and consolidation of government structures yet political stability is far from region wide and slow economic recovery interspersed with periods of downturn have limited growth in many of the countries concerned.

⁵ Chenet L. & McKee M. et al. Changing life expectancy in central Europe: Is there a single reason? *Journal of Public Health Medicine*, 18 (1996)

The SES questionnaires reveal considerable diversity in conditions vis-à-vis socio-economic security by the end of 1999.

Clearly, with the ending of state guarantees of full employment, labour market security could only diminish yet it appears that the degree of security remaining varies considerably.

The economically active population (EAP) has declined in some of the countries surveyed (Armenia, Moldova, Ukraine) due to migration, demographic change 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 instances (Armenia, Croatia and 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 appears to be 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 having been placed on 'administrative' leave, are particularly prevalent in Moldova and Ukraine.

The SES questionnaires also suggest a striking decrease in the forms of employment that are associated with enhanced socio-economic security. In particular the category 'employees' fell as did work in the public sector, while overall part-time work which often provides less socio-economic security has been seen to increase (Armenia, Croatia). It appears then that changes in labour market security within the health care system are perhaps less striking than when seen in isolation.

Employment security has also shown signs of weakening. Non-regular employment has risen steeply (Armenia, Lithuania, Moldova) and is often associated with service sector work. Voluntary turn-over has often 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 suggest 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, 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 yet demands for new skills are arising.

Work security trends, (protection against accidents and illness at work), are complex with daily absenteeism rates and occupational death and injury rates falling on the whole (Lithuania, Ukraine) with some exceptions (Armenia has decreasing absenteeism and occupational deaths but increasing cases of work-related injury and 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) and legislation to prevent discrimination against workers with disabilities is in place.

Working time legislation remains robust with the protection 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 seems to have been a growth in the number of trade unions coupled with an overall fall in membership, although it is difficult to ascertain the true 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% to 41%) can be seen as 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. It appears that workers' wages are often increasing but it is much less clear how far these increases offset rises in living costs. There are suggestions that disparities between men and women are increasing and that inequality as measured by the Gini coefficient are woefully underreported (Armenia, Ukraine). It also seems that even where there is a statutory minimum wage workers may receive wages below this level (Lithuania, Moldova) and that the contributions based insurance schemes in place (Armenia, Croatia) do not always guarantee payment of benefits.

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 many countries over recent years there still persist significant socio-economic difficulties for the majority of workers in the region.

3. Human Resource Pressures in CEE and CIS Health Sectors

3.1 Health – A Distinctive Sector

The evidence of a general erosion of workers' socio-economic security across CEE and CIS is compelling and it is inevitable that workers in the health sector will face many of the pressures felt in the wider workforce. Health systems (and by association health sector staff) across the region have however faced additional reform imperatives both as public sector service providers at a time of structural adjustment and as part of a unique and peculiar market for health care. The 'rationalisation' 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 understanding of 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 seldom been driven by the socio-economic needs of the workforce⁶. Rather reforms have tended to focus on cost containment, decentralisation 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 2000⁷ emphasises 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.”

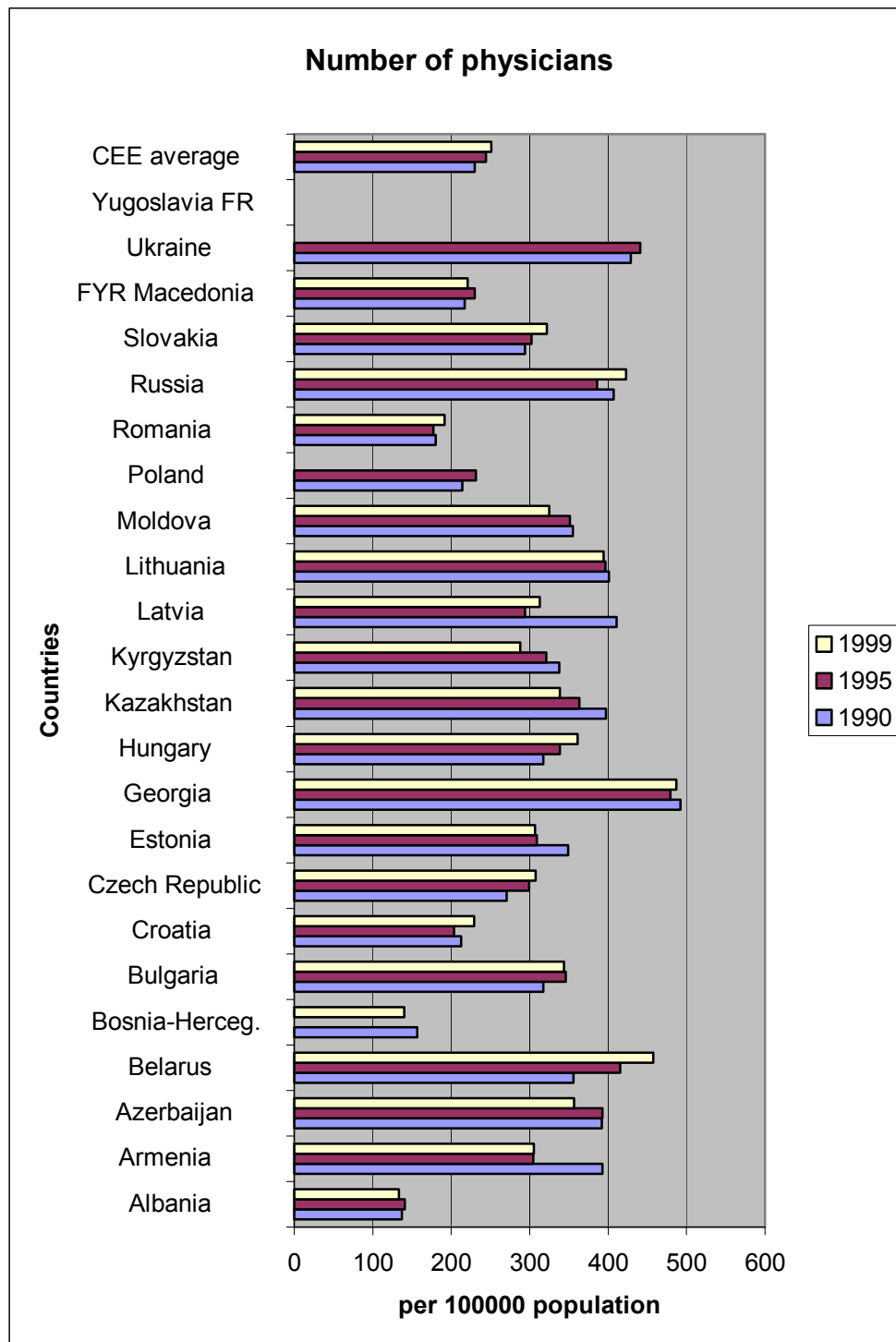
It would seem therefore that health system analysts in recognising the role of 'motivation' tacitly acknowledge the importance of the socio-economic security of staff. It follows then that the security of workers will have profound implications for policy making in terms of improving the care for patients 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 their salaries alone but because physicians are regarded as contributing 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 numbers of physicians per 1000 population in Latvia, Lithuania and Ukraine were 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 4.6, 4.3 and 4.2 physicians per 1000 population respectively, compared to levels of 3.1, 2.5 and 2.3 in Finland, Luxembourg and Ireland.

⁶ DSE. Public Service Reforms and their Impact on Health Sector Personnel. German Foundation for International Development (DSE). (Berlin 2000).

⁷ WHO. The World Health Report 2000. Health Systems: Improving Performance. WHO (Geneva 2001).



Source: WHO Regional Office for Europe health for all database 2001.

The high employment ratio for physicians in CEE and CIS is often explained in terms of the norms established in the 1970s and a conception of health care that allowed for higher levels of hospitalisation and longer lengths of stay than now regarded as desirable. Furthermore, doctors as ‘non-productive’ labour were an affordable substitute for more capital-intensive approaches to care. There was also under-development of nursing roles and in much of CEE and CIS physicians were

used to carry out relatively low-tech interventions and services. The position was exacerbated by the laxity of medical resource planning, and the late introduction of limits on medical school places. Reforming policy-makers were therefore minded 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 have been achieved but certainly the data suggest that attempts to reduce physician numbers have had limited success⁸.

Notwithstanding the focus on physicians, nurses were and continue to be the single most numerous group of health care professionals in the region 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) 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 was therefore 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 higher cost physician services. This has major implications for job security, in particular for increases in tasks and skill reproduction security mostly 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 were felt to be excessive⁹.

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 nurse education appear to be ruling out the model in favour of increasing hospital-based technical skills. The job and general socio-economic security of this particular group of nurses must therefore, be severely compromised.

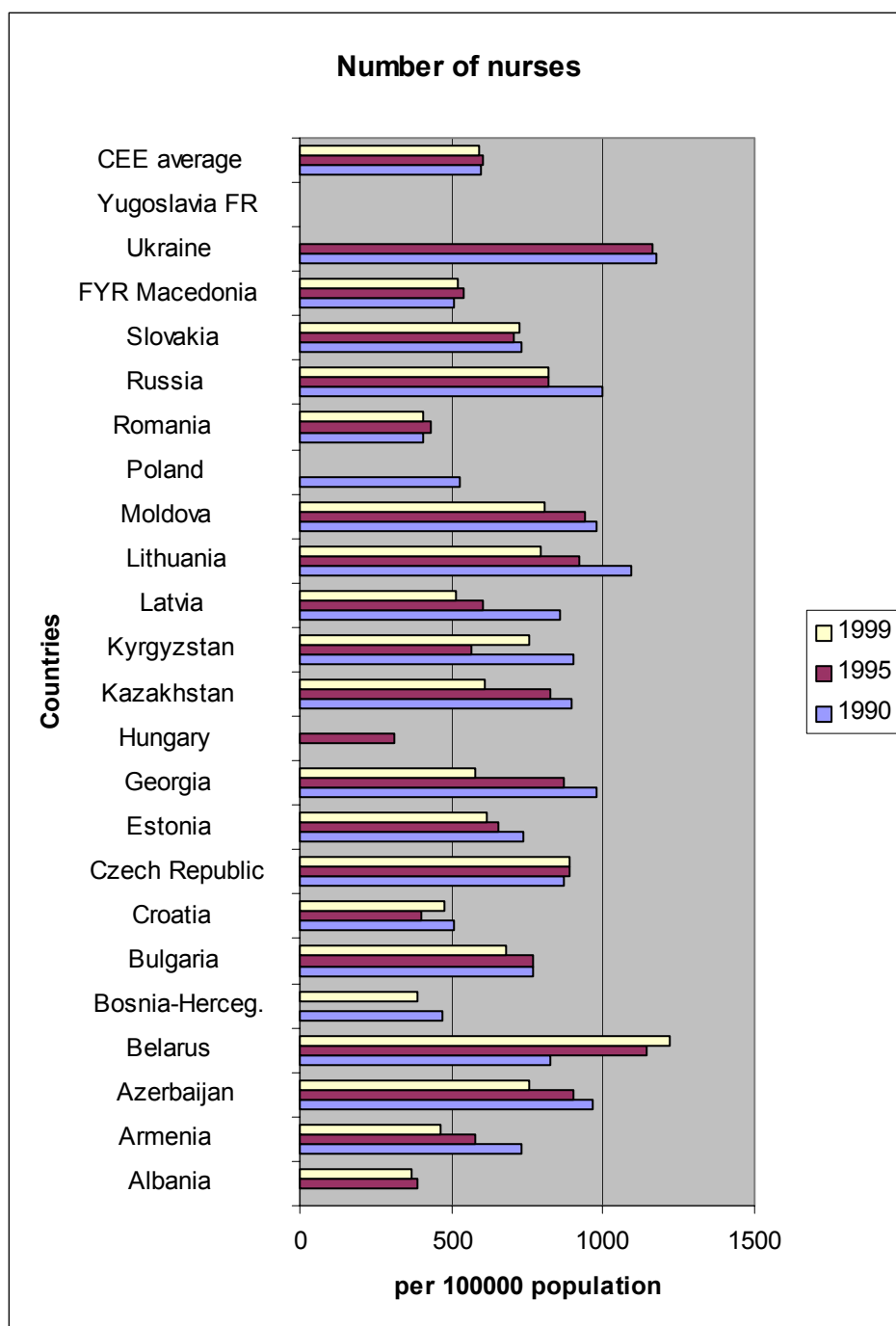
Interestingly, the health systems literature contains little reference to professions allied to medicine. This may be in part because there has been a generalised move of dentists and pharmacists into the private sector meaning they therefore have a diminishing impact on public sector budgets. It may 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 and nurses however, are regarded as important in terms of health systems 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

⁸ Kanavos P. & McKee M. Macroeconomic constraints and health challenges facing European Health Systems, in Saltman R., Figueras J. & Sakellarides C. Critical Challenges for Health Care Reform in Europe. WHO. Open University Press. (Buckingham 1998).

⁹ Salvage J. & Heijnen S. ed. Nursing in Europe; a resource for better health, WHO, 74, (Copenhagen 1997)

decreases in numbers of personnel is patchy and in some areas there have been increases perhaps because of freer access to training raising numbers qualifying (see below) and perhaps because data are complicated by retired staff remaining on professional registers.



Source: WHO Regional Office for Europe health for all database 2001.

3.3 Skills

The health sector has significant barriers to access for new entrants associated with the lengthy training involved. This affects the market for skills and skill reproduction security. It is also seen by health system policy-makers as an opportunity to limit staff numbers and to address issues of quality and the mix of specialities provided, with implications therefore, for labour market and job security. Control over access to training places has been used successfully to restrict physician (and nurse) numbers in many countries around the world, 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, 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 in terms of health planning not only because of the impact on total staff numbers but also because of the associated lack of influence over the aspirations of new graduates and entrants to the professions. Indeed an oversupply of professionals may also 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 standardised 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 and 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 and Poland) 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 which both enhance skill-reproduction security in that they create opportunities for gaining and retaining skills, whilst undermining it in that they imply 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 specialist and demand upgraded skills and qualification levels in the remaining specialities in order to meet EU requirements, which 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 responsibilities and delegate more medical (if clinically 'undemanding' 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 and it will be essential 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 enhanced¹⁰.

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,

“Globalisation 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.”

It is clearly the case that in Europe the combination of difficulties in recruiting qualified staff in Western Europe, 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 appears to be affected already with nurses moving to richer CEE and Western European countries (especially Germany) in search of better wages and working conditions. Some Western European hospitals are reported to be actively recruiting nurses from Eastern Europe, even when locally qualified staff are unemployed. This can only exacerbate existing difficulties in recruiting and retaining nursing staff within the CEE and CIS where there are 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 standardised 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, and 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 packages in CEE and CIS, especially in physician's pay, have come about as part of reform packages attempting to address efficiency in health care provision, along with 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 labour economics 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

¹⁰ Scrivens E. Accreditation: Protecting the Professional or the Consumer, OUP, (Buckingham 1997)

contracted hours are delivered. Payment by results relates pay to output and typically would revolve around a uniform price for each piece of output and the number of pieces produced¹¹.

It is possible to apply these concepts directly to the health care field particularly with staff 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 then 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 payments 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 systems¹². It also introduces the concept of 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. This is capitation.

The 'health sector perspective' means that reforms will be designed to address dimensions of health system performance. 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 and its users.

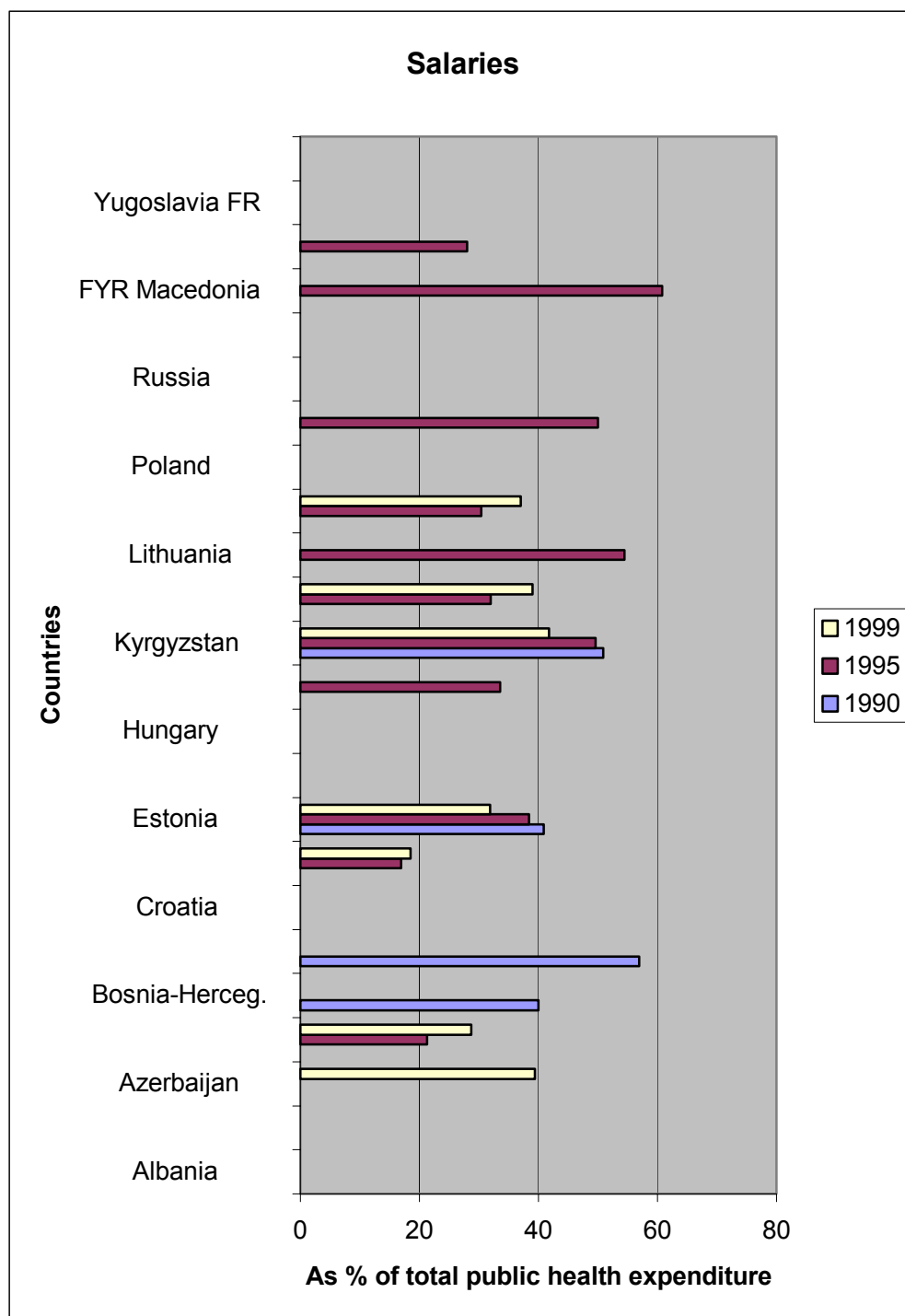
Remuneration for physicians tends to be the most complex and to include a combination of three main elements salary, fee-for-service, and capitation, which may be supplemented by 'allowances' to 'reward' good practice. Salary equates to physician time and thus remunerates the actual resource. It allows physicians to combine different duties (medical, administrative, research), gives them the security of knowing what their earnings will be and does not create incentives for them to treat unnecessarily or for longer than needed. It is typical of hospital or health centre employment but has been criticised since it does not create incentives for efficiency or differentiate between productive and unproductive staff. Fee-for-service remunerates the services that the resource (physician time) produces. Fee-for-service systems revolve around well defined fee schedules and are closely linked with moral hazard, over provision and cost escalation¹³. The system seems to work against doctors delegating to other care providers like nurses. Capitation remunerates the responsibility the physician

¹¹ Elliot R. *Labour Economics: A Comparative Analysis*, London McGraw Hill 1991 cited in *Critical Challenges for Health Care Reform in Europe*, *op cit*.

¹² Contandriopoulos A.P. et al. *Systèmes de soins et modalités de rémunération*. *Sociologie du travail*, 1, 1990 cited in *European Health Care Reform, Analysis of Current Strategies*, *op cit*.

¹³ Normand C. cited in ILO. *Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe*. (ILO/PSI Report). International Labour Organization (Geneva 1998).

takes 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 provider¹⁴. However, it may also prompt under-treatment and/or undermine the security of salaried staff such as nurses or support staff.



Source: WHO Regional Office for Europe health for all database 2001.

¹⁴ Rochaix L. Performance-tied Payment Systems for Physicians, in Critical Challenges for Health Care Reform in Europe, *op cit*.

The introduction of capitation in primary health care has sometimes included the suggestion 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). This will make 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 the incentives being used to enhance health system performance potentially undermining the position of health sector workers.

Despite discussion of these reforms, nurses and allied health service professionals are still most commonly 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.

In addressing payment systems, it should not be forgotten that large amounts of health care expenditure in CEE and CIS are out-of-pocket and informal. Health systems literature stresses the importance of who pays and 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 (although difficult to quantify). This must surely compound the difficulties of addressing income security. It must also impact on pay negotiations with employers. For example, informal payments are estimated to add 30% to the national care bill of Kazakhstan (World Health Report 2000) a figure consistent with anecdotal reports on Armenia, Belarus, Kyrgyzstan and Moldova and one that suggest employers negotiating wages must be aware of the magnitude of informal income when making pay offers.

Evidence from health systems suggests that no single payment mechanism can meet all the needs of a health care reform initiative or deliver all possible performance objectives. Nonetheless, efforts to reformulate payment systems have been a key part of reform trends. While the literature on incentives bears out the suggestion that health has a particularly complex labour market and may therefore require a complex set of remuneration packages, it is also important that reference be made to socio-economic security. Health system literature tends not to address this 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 the motivation of staff). As such, evidence from the Basic Security Survey represents an important step forward.

4. Health System Restructuring and the Impact of Privatisation

Reforms to health care systems have been prompted by a range of concerns including the wish on the part of policy-makers to contain costs and/or to enhance performance. The speed, scope and consistency of the reforms strongly suggest that while they may have utilised models developed and evaluated in other parts of the world, they have not been genuinely evidence-based. Rather, policy-makers seem to have been prompted by ideological commitments to particular approaches not least decentralisation, the shift from tax-based to insurance models, the introduction of market and quasi-market elements and more specifically, privatisation. 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. This section of the Report seeks to address these reforms, with specific attention to those areas with particular ramifications for socio-economic security.

4.1 Decentralisation

Decentralisation 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 decentralisation 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 which are seen as key areas of delegation of authority (Czech Republic, Lithuania, Romania) and with privatisation, the ultimate model of decentralisation (Czech Republic). Health system literature suggests that decentralisation was not matched by a growth in capacity to generate or manage resources at a local level and several countries have seen some re-centralisation/re-concentration of authority¹⁵ (Latvia, Lithuania and Poland). There are also suggestions that reforms have led to regional inequities as wealthier regions offer better services.

In terms of impact on socio-economic security, decentralisation 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 decentralisation 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 (Moldova, Poland). Professional bodies too have often taken responsibility for professional standards and exercise some regulatory powers (Czech Republic, Romania) and this may have implications in the longer-term for skill reproduction security. There are also suggestions that decentralisation, and in particular the 'regionalisation' of training may introduce inequalities of access (Kyrgyzstan).

¹⁵ Croatia is exceptional in having moved from self-managed socialism to a decentralised 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.

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 demonstrate 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 haven't have often taken steps to pave the way for future insurance led development (Armenia and Latvia have created an agency/fund as third-party payer, and Moldova has passed preparatory legislation). Only Belarus has no plans to introduce social health insurance. The models they have established 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 pay roll deductions (Lithuania). There are countries with a number of funds (Czech Republic, Poland) but competition has proved problematic. 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 imply that the third-party payer (the insurance fund) will negotiate explicit contracts with the health care institutions or professionals delivering services. This separation of functions and purchasing role is not unique to insurance systems but it does suggest that resource allocation will be linked more closely to quantity and/or quality of care delivered 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 services will seek to maximise 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 formalisation of user-fees has been a significant change and was cited by the responding unions as such (Armenia, Croatia, 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. They were also seen as a way of reducing under-the-table, or gratitude payments, which have a long tradition in the region and were often expected. The formalisation 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 (Moldova), 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 by the institution/individual concerned (Latvia) thus reducing expected income and undermining income security. Staff relying on informal or gratitude payments clearly have less

security than those with a formal entitlement and their pension contributions will also be based on an artificially low income.

4.4 Privatisation

Privatisation or the transfer of government functions to a nongovernmental organization, whether a private profit-making company or a non-profit voluntary agency, is seen as the ultimate form of decentralisation¹⁶ and has been introduced in varying degrees across much of the region (Croatia, Czech Republic, Latvia, Lithuania, Moldova, Poland and Romania). Despite some variations there is a striking degree of consistency with significant privatisation of pharmacies and dental practices (which often pass into private ownership) and limited introduction of private mechanisms in primary health care. However, hospitals and funding remain, to a large extent, in the public sector not least because hospitals, which occupy a dominant position within CEE and CIS health systems, do not lend themselves to private, for-profit management. Privatisation and its impact on socio-economic security can be considered from the following perspectives¹⁷,

- Privatisation 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)
- Privatisation of service delivery¹⁸
- Privatisation 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

Privatisation of pharmaceutical manufacturing and drug market liberalisation, 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.

Privatisation 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 privatised funding mechanisms. 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, Kyrgyzstan, Lithuania, 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 for private care 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.

¹⁶ Saltman R. & Figueras, J. ed. European Health Care Reform 1997 *op.cit.*

¹⁷ Hall D. cited in ILO. Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe. (ILO/PSI Report). International Labour Organization (Geneva 1998).

¹⁸ Private service provision in the form of profit-making and charitable enterprises is part of the privatisation typology in Scheil-Adlung X. Social Security: The Challenge of Privatisation. ISSA (2001), and is added to that of David Hall.

Private ownership of facilities: There has been extensive privatisation of certain facilities, most notably pharmacies (were even Belarus and Kyrgyzstan have allowed some pharmacists to operate as small, private businesses) and dental clinics (some 79% of Lithuanian and 90% of Polish dentists work privately). A few spas and rehabilitative facilities (Czech Republic) and specialist diagnostic clinics (Armenia) have also been privatised but by and large these have a minimal impact on the health care system as a whole. The picture with regard to primary care is more complex with many facilities still publicly owned, some owned by state or county government and leased to private practitioners (Croatia, Czech Republic) and some centres privately owned (Croatia, Latvia).

Hospitals overwhelmingly remain in the public sector although small numbers belong to the Church or community or nongovernmental 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 providers may be self-employed sole practitioners (perhaps leasing facilities) or part of a group practice that acts as the employer (although many do continue to be state employees). Practice nurses and support staff in all of these settings will tend to be employed by the individual or group and therefore lose contact with others in the sector. It seems likely that employment, job, work, representation and income security for the self-employed or employees of a small undertaking would be more precarious than for employees of the health sector but there is insufficient evidence to demonstrate this. It is also the case that while hospital sector staff have been little affected by privatisation 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 3.4 above).

Privatisation 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 many of the countries 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 (Croatia, Czech Republic, Latvia). In others there are small markets for private services paid out-of-pocket (Poland, Romania). The affect of privatisation of service delivery on the socio-economic security of workers overlaps with the other issues discussed here and in 3.4 and will be 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. Similarly when private services are paid for out-of-pocket the provider might be expected to experience relative income insecurity.

Privatisation of employment: In essence, privatisation of employment refers to whether or not individual staff employment contracts continue to be held 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 very small experiments with private sector development privatisation 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 (private) institution in which the individual works (Latvia) and as has already been

discussed, privatisation of pharmacies, dental practices and in some instances primary and ambulatory care has increased self-employment (Croatia, Czech Republic, Poland) with all the attendant implications for socio-economic security. Despite these instances of employment being privatised however, it seems that most staff in the health sectors of CEE and CIS continue to work for the public sector with their contracts held by public sector institutions, often hospitals, local or national government (Latvia, Lithuania, Moldova, Poland, Romania). The Basic Security Survey of the Czech Republic suggests that where staff work for private hospitals, pay is in line with that in the public sector and that other private facilities (out-patient clinics, spas) while they have their own regulations pay “average wages (which) usually do not differ very much from the general average.”

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 privatisation of employment. Nevertheless, redundancies and diminished working conditions seen elsewhere in the region post-privatisation and anecdotal evidence from the health sector itself would suggest that fears around privatisation are not unfounded.

Contracting out: The use of private contractors to deliver functions like cleaning, catering or computer services has immense implications for the privatisation 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 workforce¹⁹.”

However, the existing sample has not provided evidence of contracting out making significant inroads into service provision in CEE or CIS.

It seems that privatisation has had a similar impact on the socio-economic security of the workforce to decentralisation and to a lesser extent the shift to insurance. 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 encouraging of unions) and possibly job, skill and work security which may all suffer as a result of losses in representation security.

It has also been suggested that introducing markets into health care and contract culture with its high transaction costs may lead to wider problems for staff as high trust relations are replaced with low trust ones and accountability is undermined. Privatisation is explicitly linked with instability and fragmentation and employers are portrayed as relying increasingly on short-term contracts, demanding changes in skill-mix, and applying downward pressure on pay. Concerns have also been raised as to the impact of privatisation on professionalism and its tendency to erode a caring ethos²⁰.

¹⁹ Saltman R. & Figueras J. ed. European Health Care Reform 1997 *op.cit.*

²⁰ Hunter D. ILO. Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe. (ILO/PSI Report). International Labour Organization (Geneva 1998).

4.5 Other Structural Issues

There are a number of other issues that can also be seen to affect health systems structures and that will have consequences for socio-economic security. Key amongst these are

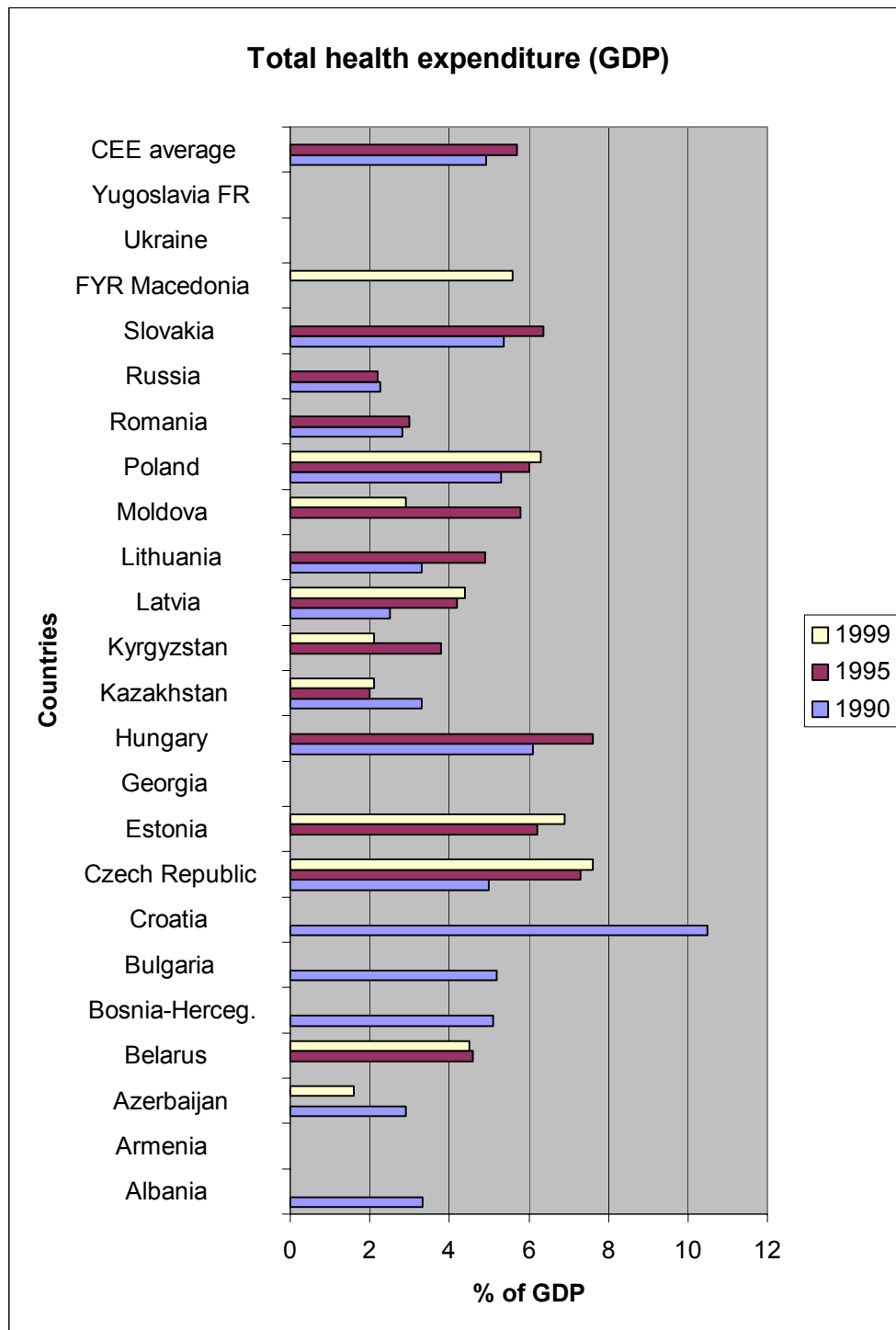
- Primary health care reforms
- Restructuring or management changes
- Budget cuts or expenditure below a given GDP threshold
- World Bank intervention.

Primary health care reforms: Considerable emphasis has been placed by health system reformers on the development of primary care and all the countries concerned have initiatives in this area. There has been particular emphasis on developing a primary care ‘gate keeping’ function, which implies that primary care will be a patient’s first point of contact 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/families. In terms of socio-economic security of staff it implies a need for retraining, the redefinition of nurse and physician roles and the likelihood of 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 management within health care institutions, prompting a renewed focus on public health and health promotion and instituting a revised approach to financial management and accounting practice across the region. All these are likely to 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 all had their own dedicated health service). Large enterprises too were important health care providers in the past and also employed medical and nursing staff who possessed a great deal of accumulated and specialised knowledge of hazards within their own industries. Policy-makers across CEE and CIS have typically called for rationalisation of parallel systems and for them to be brought within the main stream. Staff within the parallel system are likely to experience considerable socio-economic insecurity as the continued role, or even the existence, of their services are debated and 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 services²¹. Some of the countries covered by this Report appear to enjoy levels of public expenditure that compare well with other CEE countries and are not far below Western European averages (Croatia 7%, Czech Republic 7.36%). Others have lower expenditure (Latvia 3.9%, Lithuania, 4.9%, Poland, 5.2%) yet remain within a manageable range, although notably private sources of funds are identified as making an important

²¹ The World Health Report 2000. *op cit.*



Source: WHO Regional Office for Europe health for all database 2001.

contribution to expenditure in each case^{22,23,24}. Five, however, appear to experience real difficulties in terms of overall budget and cuts in spending and these have a direct impact on the socio-economic security of staff.

²² Karaskevica J. et al. Health Care Systems in Transition: Latvia. European Observatory on Health Care Systems, WHO, (Copenhagen 2001).

Armenia for example, has no definitive information on health expenditure but is believed to spend in the region of 1.4% of GDP on health, and has structured health care system payments with the explicit recognition that it can fund only about 25% of health care provision. Only 'vulnerable groups' or particular conditions are covered and providers are obliged to treat them but are reimbursed for less than the cost of treatment. Hospitals therefore have to generate sufficient fee income to subsidize the basic package and to pay their staff²⁵. Public health expenditure in Moldova has dropped dramatically as a share of GDP (to 2.4% in the 2000 budget) and in real terms per capita. The lack of funding is described as severe and the World Bank Project Application Document suggest that 70% of public spending goes on electricity, heating and other aspects of running the 55 regional and tertiary hospitals. Salaries, pharmaceuticals and treatment costs are not included and again informal, under-the-table payments seem to play a major part in financing health care staff²⁶. This picture of low expenditure with an ill-defined contribution from formal and informal out-of-pocket payments also applies in Kyrgyzstan, (2.9% of GDP, 1998), Romania (2.6%, 1998) and Ukraine (2.9%, 2001). 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 supporting the restructuring of funding and the separation of provider and purchaser functions (Armenia), 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). Latvia has also received IMF credits as part of its economic policy implementation which includes streamlining state administration, structural reform and privatisation. 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, Moldova, Ukraine²⁷) treat staff differently. It is clear however, that the restructuring and reforms promoted by the World Bank do imply changed working circumstances and therefore disruption to workforce socio-economic security.

²³ Cerniauskas G. & Murauskiene, L. et al. Health Care Systems in Transition: Lithuania. European Observatory on Health Care Systems, WHO, (Copenhagen 2000).

²⁴ Karski J.& Koronkiewicz A. Health Care Systems in Transition: Poland. European Observatory on Health Care Systems, WHO, (Copenhagen 1999).

²⁵ Hovhannisyanyan S. et al. Health Care Systems in Transition: Armenia. European Observatory on Health Care Systems, WHO, (Copenhagen 2001).

²⁶ Monchiaga A. et al. Health Care Systems in Transition: Moldova. European Observatory on Health Care Systems, WHO, (Copenhagen - in press).

²⁷ Belarus and the Ukraine have received loans to address TB/AIDS only and the loan to Moldova for health care reform and structural adjustment has only been disbursed from mid-2001 (Source: <http://www.worldbank.org>)

5. Socio-economic Security in Countries

National health systems throughout the region have been affected by reform. These changes have often been necessary, and perhaps desirable in terms of achieving better health system performance for the populations of CEE and CIS. They have also, inevitably, had consequences for the socio-economic security of health sector staff. It is the purpose of this chapter to examine the country evidence generated by the IFP-SES/PSI Basic Security Survey. It provides a descriptive analysis of issues around each of the seven security dimensions following the format of the original questionnaire. It also draws parallels between countries through a statistical (SPSS derived) analysis. Finally, it gives some very preliminary consideration to whether there are discernable correlations between the various approaches to reform or to privatisation (of financing, ownership, service delivery or employment) 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 might therefore be expected to have been adversely affected by the focus of many reform initiatives on what were perceived as excessive staff numbers and the over provision of beds and hospitals.

Health policy literature suggests that evidence of over-provision and under-utilisation (particularly relative to western European norms) was valid. It is the case however that in CEE and CIS, some facilities and beds are included in health care system totals that might in western European be seen as part of the social care network or some other non-health sector service. Nevertheless the closure of facilities seems to have been limited in scale and has often focussed on very small in-patient clinics. It also seems that many threatened institutions have not closed down altogether but have changed affiliation and now provide social care. Evidence from the Basic Security Surveys indicates that there is no uniform pattern. It suggests that in Kyrgyzstan the number of hospitals and clinics has actually increased slightly over the last decade while there were significant closures programmes in Armenia (1999) and Moldova (1998). It should be noted, however, that despite the cuts in Moldova World Bank analysis suggests that it still has higher levels of provision than anywhere else in Europe.

Survey data also illustrate shifts in staff numbers. However, in a sector which has often been accused of over staffing, it is perhaps surprising that not all countries surveyed have instituted job cuts. Four of the countries concerned do report falls in job numbers (Armenia, Czech Republic, Moldova and Ukraine), but in Croatia and Latvia²⁸ staff levels have remained more or less stable, although there has been some movement between public and private sectors. Belarus, Kyrgyzstan, Lithuania²⁹ and Poland all report some increases in numbers. Accurate data for the private sector were not always available while the parallel health systems remain a largely unknown factor so it is not possible to make firm assertions about overall trends.

²⁸ The WHO Regional Office for Europe health for all database indicates a 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.

²⁹ Staff levels in Lithuania have risen since 1990, but have nevertheless slid back from the high levels of 1996.

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, and the Czech Republic, along with Poland are prominent amongst countries which, at least superficially, seem to have phased out certain public sector jobs and to have substituted them with similar numbers of private sector staff. However, there is not enough information on the types of jobs lost or the private sector roles 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) as reported fell by just over 1,000 between 1990 and 1999 with a slight rise in numbers of female staff. The WHO health for all database 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) and the responding union records that the commercialisation of services, the privatisation of services and restructuring all increased jobs over the reference period. The total figures then, on balance, seem relatively stable. However, this masks a pronounced shift in jobs from the public to the private sector. In 1990 just 2.2% of health sector staff worked in the private sector compared to a little over 14.5% in 1999.

It has been difficult to obtain unemployment data for the sector as a whole. It seems that in many countries it is not numerically significant (Belarus, Czech Republic, Kyrgyzstan, Latvia, Lithuania) but may nonetheless be perceived as a problem (even as in Kyrgyzstan where job numbers have risen significantly) or give rise to stress (Czech Republic, Lithuania). Unemployment has increased significantly in recent years in Armenia, Moldova and Ukraine (attributed by responding unions to budget cuts) and also features in Poland despite rising staff numbers. Interestingly, privatisation, changes in management systems and restructuring were sometimes cited as having contributed to rising unemployment in the sector, even where the unemployment levels themselves were low and there was little evidence of extensive privatisation. 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 privatisation, commercialisation 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. It seems that 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 out-patient visits and anticipated vacancies rather than being made redundant³⁰.

³⁰ Karnitski G. et al. Health Care Systems in Transition: Belarus. European Observatory on Health Care Systems, WHO, (Copenhagen – 2001 in press).

The picture as regards part-time work is also incomplete and there are no data for many countries (Armenia, Belarus, Kyrgyzstan, Lithuania, Ukraine). It seems that 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 that this may be in no small part, because of the traditional strength of childcare provision. The Czech Republic experience is interesting as it emerges, in explaining the pronounced drop in numbers of part-time staff over the last decade, that part-timers in 1990 were almost exclusively pensioners. The data available indicate that Croatia, Latvia and Moldova also have relatively low levels of part-time employment (although this rises to 5.3% in Latvia), whereas Poland has a very high dependence on part-time staff (40%), most of whom are women. It would be well worth examining this area more closely in future studies.

There are similar problems with the statistics on short time working. 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% in 1990 to 20% in 1999, whilst in Latvia 5.3% of staff worked less than their contracted hours. The use of 'administrative leave' is also a common feature in many health systems. 12% of the Kyrgyzstan workforce had been placed on administrative leave, whilst in Armenia and Moldova figures of 5% and 7.5% respectively were reported. Latvia and Lithuania by contrast report the incidence of administrative leave as being significantly lower (0.4% and 0.5-3% respectively). 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 trend across the globe 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 numbers of staff combining their formal roles with additional work. In Moldova for example, the percentage of health staff combining formal roles with other work stood at 32% in 1999, whilst in Belarus the figure was 30%. High rates were also recorded in Kyrgyzstan, Poland and the Czech Republic where rates reached 24%, 20% and 13% respectively. It is not always clear to what extent workers rely on additional wage packets but it is suggested that it is often a significant component of income, with as much of 50% of doctors' wages coming from secondary roles (Poland). The reliance on second jobs is not universal however as only 0.7% 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 two instances with actual hours worked rising in the Czech Republic and the opposite occurring in Lithuania which has seen actual hours fall in line with contractual hours. This seemingly secure picture however hides consistently long hours for many workers. In Poland doctors work the longest hours with some 90% of them completing between 66 and 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 and Moldova support staff work for around 52 and 58 hours per week respectively. These figures contrast with Lithuania where average hours are now only 30-40 hours per week.

As is suggested above, much of the overtime worked is performed by doctors and this may suggest that overtime is a structural part of their professional arrangements. In the Czech Republic for example, 93% of doctors work overtime and in Latvia 60% worked extended hours. Certainly the examples of Armenia and Croatia suggest a consistent pattern with 30% of Armenian doctors routinely working approximately 15 hours overtime a week 'watching in the hospitals' while in Croatia 70% of all doctors and specialists work 8 hours overtime a week as standard. This tends to

suggest a formal reliance on overtime to cover night or on-call duties. The prominence of doctors should not however, detract attention from others in the sector who work overtime. In Kyrgyzstan for example, almost half of all administrative staff and a quarter of support staff work overtime compared to only 1.5% of doctors and 5.5% of nurses. In Latvia approximately, 65% of nurses, along with 60% of allied health workers, work overtime hours, and in Belarus 54% of doctors, 35% of nurses and 58% of support staff work beyond their set weekly hours.

Pensioners still play a significant role within the health systems of CEE and CIS countries, no doubt due in no small part to the low levels of benefit paid to retirees. In Belarus approximately, 15% of health sector employees were pensioners in 1999, whilst in Poland pensioners made up 6.1% of employees, both figures constituting a rise on 1990 figures. This trend does not extend across the whole region however. In the Czech Republic, Kyrgyzstan and Lithuania numbers of pensioners working have reduced (although in Kyrgyzstan numbers remain high at 18% of health sector staff).

With the lack of funds in many countries it is no surprise that early retirement schemes have not been used extensively to reduce the overall workforce. Only in Kyrgyzstan and Poland do such schemes exist at a formal level, whilst in Lithuania early retirement is available through bi-lateral agreements.

Globalisation has been blamed for much over recent years although it remains to be seen whether the phenomenon will in the long run benefit transitional economies or hinder their development. It is certain however that the emigration of health care professionals has detrimental effects on health care systems, not least by exploiting national investments in training. Details on the number of health care staff who have left CEE and CIS are scarce but in Moldova over 6,900 health workers left for neighbouring countries, while in Croatia 30% of redundant trained health sector employees left their home country (due perhaps largely to the war). It is too early to identify a trend as regards 'brain drain' but there is clearly a potential threat, particularly to accession countries.

5.2 Employment Security

Employment security touches on a range of issues including, protection against arbitrary dismissal, regulation of hiring and firing and placing the burden of costs on employers. Command economy systems were characterised by secure employment with highly centralised regulation of employment issues. The decentralisation of authority for hiring, particularly to small institutions may be expected to have undermined this. Evidence suggests however, that employment security remains relatively good in CEE and CIS, although there are some worrying trends in regard to contractual status.

The Basic Security Surveys 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 tended to be in the region of two months.

Details of the contractual status of workers and any shift from labour to commercial contracts are limited. Data available however, do suggest a weakening of employment security in respect of contract type. In Kyrgyzstan and Poland around a quarter of staff worked on temporary contracts, placing many of the benefits enjoyed by permanent employees out of reach. In Latvia the reported situation is even worse, with 90% of health sector staff on temporary contracts. The situation is not universal though, and only 0.5% in Moldova are on temporary contracts while the number affected in the Czech Republic has fallen from 14.5% in 1990 to 6.35% in 1999 an improvement in employment

security. It is reported that 100% of health sector workers in Belarus and Lithuania operate as contract labour or on commercial contracts rather than on labour contracts. It is not entirely clear what the status of contract labour is in either country (particularly as privatisation in Belarus is limited) but the position merits further examination as it indicates a potentially major blow to employment security³¹. Women are entitled to maternity pay in all countries surveyed and in addition are sanctioned to return to their posts after the leave period. Again, there appear to be no problems with receiving these benefits. The duration of maternity benefits is often relatively generous and may be up to 12 months (Croatia, Lithuania) and seems if anything to have improved over recent years with only Kyrgyzstan reporting a reduction in duration of benefits (to 3 months). More details are given below.

Maternity leave: Examples of entitlement given in the Basic Security Surveys include:

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).
Croatia:	12 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:	112 days or approximately four months. (A decrease over the last decade).
Latvia:	112 days or approximately four months. (An increase over the last decade).
Moldova:	4.2 months.
Poland:	26-39 weeks (An increase over the last decade).

5.3 Work Security

Work Security addresses protection against accidents and illness at work, through safety and health regulations, limits on working time, unsociable hours and night work for women. Work security, might have been expected to suffer as centrally planned economies with an emphasis on workers’ entitlement have given way to more market oriented economies and as regulatory frameworks have fallen into abeyance. However, as with employment security it appears that in broad terms the legislative protection in place remains relatively good regardless of system changes and that some aspects of health and safety may have improved, albeit that workers face considerable stresses.

Where data are available there appears to have been a decrease in the numbers of work related injuries between 1990 and 1999. In many instances this reduction has been significant (Armenia, Kyrgyzstan, Latvia, Moldova, Ukraine). In parallel, absence due to injuries has reduced in many of the reporting countries (Armenia, Belarus, Kyrgyzstan, Moldova, Ukraine) sometimes by as much as

³¹ 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’ (Source: R. Hussmans, STAT, ILO) so their application in the health sector is likely to be relatively constrained.

80% (Latvia). There are less data on work-related disease although days lost when reported seem to 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 Moldova the reverse was true and 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 Moldova, the number of work-related diseases rose, albeit by a smaller number. It is also the case that falls in reported injuries and disease may 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 and Kyrgyzstan for example, average disability/ invalidity benefits amount to 100% of wages, comparing favourably with Croatia where benefits stand at 10% of the average wage. The most frequently cited range however, is from 80-100% 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).

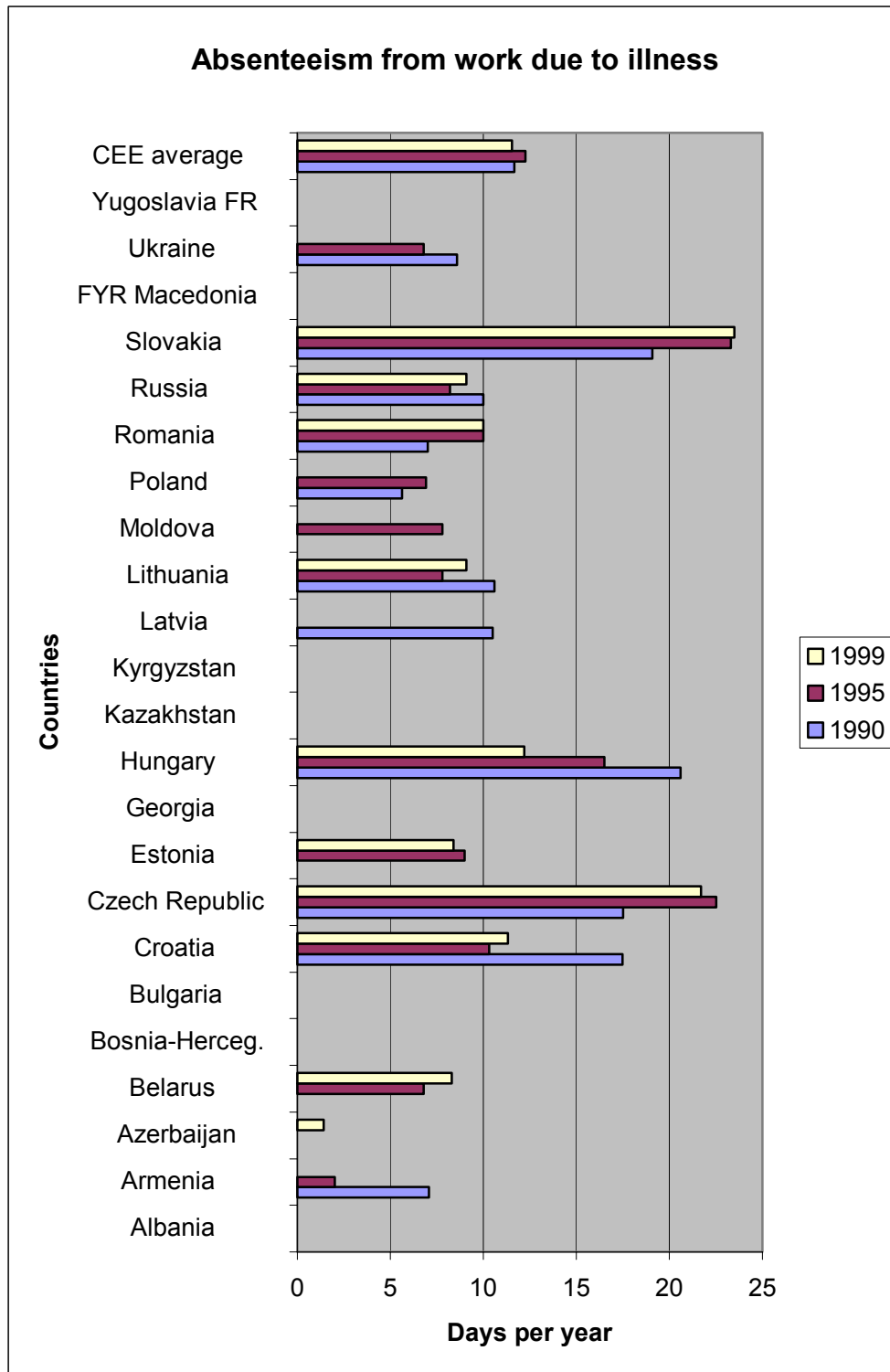
Precise details of absenteeism across CEE and NIS are sketchy with few statistics being available. However, existing data suggest that absenteeism is falling. There are however, quite a considerable amount of qualitative data capturing the reasons that lie behind absence. Key reasons continue to be sickness/illness or sickness/illness of a child or family member. It may be however that the decline in absenteeism is less positive than might be first imagined. Evidence from almost all affiliates suggests that the incidence of employees attending work despite being ill is increasing (only the Czech Republic and Ukraine are exempt from this phenomenon). This is explained as the result of “fear of dismissal” (Belarus, Croatia), and to loss of earnings, or a combination of the two (Latvia, Lithuania, Poland). In Armenia’s case there is a suggestion that reluctance to take days off even when unwell is directly related to the fact that staff rely heavily on direct payments from patients. Certainly, it follows that where workers depend on informal out-of-pocket payments from patients they will be particularly disadvantaged if they are absent from work.

Absenteeism and ‘presenteeism’: The Basic Security Survey suggests absenteeism is falling in part because,

- Armenia “The interest to have higher earnings has been increased.”
- Latvia “A fear to lose job, and disability benefits rate is lower than wage rate.”
- Moldova “Due to necessity to gain a living.”
- Poland “Sick leave is paid only 80% of your salary and in fear of dismissal.”

The reasons for increases in those attending work when they might have been absent are similarly,

- Armenia “Real income derives only on the account of payments by patients, absence from work prevents from getting earnings.”
- Kyrgyzstan “Financial motivation”
- Lithuania “Employees are afraid to loose job and to get lower wage.”
- Moldova “Financial needs.”



Source: WHO Regional Office for Europe health for all database 2001.

Stress levels and conceptions of what is stressful vary across national boundaries, however it is true to say that many Basic Security Survey responses share a sense of the seriousness of this issue for staff. Nonetheless, stress has not risen universally throughout the period concerned, having remained constant in some places (Czech Republic) and indeed fallen in others (notably Croatia and Latvia). It is noteworthy however, that even where stress is not as severe as it has been (or might be) it is

consistently associated with economic hardship (sometimes linked to wage arrears), threats of job losses and the inherent strains of working in a medical environment. Even where unemployment is in fact low the Basic Security Survey still identifies fear of job losses as being stressful for workers (Czech Republic, Lithuania). In addition to these ‘common’ concerns there are also nationally specific reasons for stress. In Ukraine for example deception is cited as being an important source of stress whilst in Poland privatisation is seen to cause anxiety and in Latvia the “increasing number of those having serious illness” is problematic. It is also possible to draw direct parallels between how health systems operate and the causes of stress. In Armenia a system of out-of-pocket, fee-for-service payments creates anxiety in staff as they become dependent on patients paying them (or their institutions) directly and therefore suffer the consequences when patients cannot afford fees.

Stress: Causes of stress cited in the Basic Security Survey include

Armenia	<ol style="list-style-type: none"> 1. Threat to be laid off, transition to a contract system (conclusion of fix-term labour contracts) 2. Arrears in wages 3. Insolvency of the majority of patients.
Croatia	<ol style="list-style-type: none"> 1. War situation (1990-1995) 2. Fear from dismissal.
Lithuania	<ol style="list-style-type: none"> 1. A fear to lose job 2. A fear to get lower and untimely paid wage 3. Economic situation in the country and anxiety caused by willingness to provide services of good quality
Moldova	<ol style="list-style-type: none"> 1. No guarantees on a work place 2. Poverty and impossibility to support a family 3. Uncertainty in tomorrow
Ukraine	<ol style="list-style-type: none"> 1. Sudden death of a patient 2. Unexpected dismissal due to staff reduction 3. Deception.

Stress was not often associated directly with occupational health but there were areas of overlap and certainly health and safety must be considered an important dimension of work security and an area 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. It would seem however that this degree of participation does not guarantee an improvement in conditions. So, conditions are felt to have improved in the Czech Republic (with no formal union role), Croatia, Latvia and Lithuania with changes including new equipment and stronger health and safety measures improving the situation for workers. In contrast conditions are worsening in Armenia, Kyrgyzstan, Moldova and Poland despite a statutory role for unions in all except Kyrgyzstan. In the case of Armenia this slide in conditions may be attributed to the fact that despite the official involvement of both management and unions in health and safety committees, only 10% of hospitals do involve both parties in practice. Indeed in Armenia

the negative situation seems to be compounded by a lack of compulsory inspections in any facilities, a situation which is mirrored in Kyrgyzstan despite the fact that “public inspectors on occupational health and safety are elected in each structural unit”. By contrast in the Czech Republic where unions lack involvement in health and safety it is incumbent upon management to inspect all facilities.

It is clear that even where there are falling numbers of injuries at work, conditions may be seen to be unchanged or deteriorating (Belarus, Moldova, Poland). It would seem therefore that the formal involvement of trade unions in this area is not enough to ensure work security and that further steps need to be taken to ensure the adherence of health care establishments to the principle of union cooperation if necessary with reinforced regulation through inspection by government.

5.4 Skill Reproduction security

Skill reproduction security entails the provision of widespread opportunities to gain and retain skills, through apprenticeships, employment training and so on. For the health sector such security is essential. 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, the high staffing norms in place meant that in practice CEE and CIS health systems had few restrictions over numbers entering training. There was a long tradition of ongoing or continuing, professional education for doctors but less corresponding investment in consistent access to in-service training for nurses and little evidence of any coherent attempt to 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, Moldova) and to increase standards (Latvia). However, at the same time private medical and nursing schools have opened (Armenia, Moldova) albeit without formal sanction and with considerable uncertainty about their graduates’ status and indeed, whether or not they will be allowed to practice.

Ongoing training has also been through a number of changes with some indication that as the previous approach to in-service education has been eroded it has not always been replaced with adequate provision for all staff. So, although the majority of employees are reported by the Basic Security Survey as being able to use and maintain their skills (Armenia, Belarus, Croatia, Czech Republic, Kyrgyzstan, Latvia, Ukraine) there are a number of outstanding problems in the area.

One area for major concern is the ‘universal’ ability to maintain skills and to access ongoing training or more particularly the ability of the health system to respond to the needs of all staff regardless of occupation. In Poland, whilst doctors and nurses are reported as being able to use and maintain their skills, allied health services, administrative staff and support staff are not. In Lithuania staff are only “partially” able to maintain skills and in Moldova only administrative staff are able to do so. In the Polish instance the cause is given as a shortfall in training for these occupational groups. Their skill erosion is identified directly with a lack of opportunity to specialise and to obtain computer skills. It seems then that certain occupational groups are being excluded.

There are also concerns arising from the way that health care systems respond to the need for retraining brought about by the creation of new roles within the sector. Many of these new roles including family doctors/general practitioners and public health nurses, arise from the increased

emphasis on primary care. Computer, accounting, administrative and financial skills are also demanded by the management reforms taking place. To a lesser extent there are also retraining needs associated with new technologies and pharmaceuticals. The two key skill reproduction issues here seem to be the availability of appropriate training and the role of unions and associations in ensuring access and appropriateness.

Training is provided to a greater or lesser degree in all the countries surveyed. It has increased in some cases to meet new legal requirements (Croatia, Kyrgyzstan) or may be prompted by the need to conform to EU standards (Czech Republic). This does not mean though that access is assured to all in the sector and the amount of training available is reported to have declined in some cases (Armenia, Moldova, Poland). Barriers to access also exist and are often linked with shortages of time and money (see also the case of Latvia and Lithuania below) and in the case of Kyrgyzstan to regional variations. Worryingly, the Basic Security Survey for Moldova suggests that training is also hampered by a lack of enthusiasm on the part of staff suggesting considerable demotivation.

Unions and associations frequently regard training as an important area of concern and include in their list of responsibilities work to ensure that staff have access to training and can maintain their professional status. However, despite extensive provision across the region, many national unions are excluded from the design of training and retraining (Croatia, the Czech Republic, Lithuania and Poland), so undermining 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, it seems that not all costs are being covered by the employer. 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 Latvia and Lithuania there appear to be difficulties for those wishing to retrain, or complete training, in finding opportunities to apply their new skills^{32,33}.

5.5 Job Security

Job security covers protection of occupation, skill area or “career”, protection against de-skilling, down-skilling, and restrictive work practices, protection of job qualifications and tolerance for craft unions. As such 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 government. There is then immense scope for change across CEE and CIS and so great potential for disruption to workers.

Broadly speaking the region’s health care provision remains labour rather than capital intensive but there is already a shift of more complex tasks from medical to nursing staff in some countries (Czech

³² Karaskevica J. et al. Health Care Systems in Transition: Latvia. *op. cit.*

³³ Cerniauskas G.& Murauskiene L. et al. Health Care Systems in Transition: Lithuania. *op. cit.*

Republic, Poland). There is certainly a strong regional trend for the number of job tasks undertaken by all categories of staff to increase (Belarus, Czech Republic, Kyrgyzstan, Latvia, Moldova, Ukraine) and this further emphasises 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 communautaire*), and this is reflected in Basic Security Survey responses from affiliates. Overall however, there is a tendency for countries to attempt to upgrade job categories (Belarus, Czech Republic, Kyrgyzstan, Ukraine) and for the number of job categories to be left unchanged (Armenia, Croatia, Latvia) or to rise (Belarus, Kyrgyzstan, Lithuania). Moldova and Poland report differing trends in the public and private sectors with job categories in the Polish private sector remaining stable and those in the public sector rising, while in Moldova the reverse is true.

In some countries there may also be added pressures as graduates of private medical and nursing schools, come on to the market potentially threatening skill areas by diluting the professions, involved. However, the fact that so many professional associations are being established and are taking on the regulation of standards should go some way to protecting job security.

5.6 Representation Security

Representation Security relates to the 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. For the CEE and CIS the past decade has been of critical importance with the ending of automatic trade union membership and the undermining of the unions role in employment issues. There has also been the birth of new type of professional association.

As might be expected the near 100% union membership that was typical of the former centrally planned economies has not proved sustainable and unionisation in the health sector has not been spared often dramatic falls. Significant decreases in membership were witnessed between 1990 and 1999 in Lithuania (100% to 20%), the Czech Republic (93.5% to 32.5%), Latvia (99% to 50.2%) and in Armenia (80% to 30%), whilst in Poland the already low 1990 membership level of 40% has halved to 20%. Only in Kyrgyzstan and Ukraine has membership retained the high rates (above 95%) previously associated with the region.

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 towards membership. 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. It is the case though that in each of these countries the private sector is felt to discourage union membership. Nonetheless, private sector antipathy towards unionisation, while worrying in itself, cannot account for the steep falls in members, as private sector employment is still relatively limited in most of the region. In countries with the least significant decreases in union membership, (Kyrgyzstan, Ukraine) unions were felt to be encouraged in most establishments although there is some uncertainty around the data.

In many countries reporting, the number of unions operating in the sector had remained unchanged, with often a single union representing the workforce (Armenia, Belarus, Kyrgyzstan, 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 organisation. As such they are sometimes seen as fragmenting the workforce and allowing the interests of small groups or individual professions to be promoted at the expense of others, on occasion hindering general agreement and wider representation (Czech Republic).

New unions - Lithuania and Poland: In Lithuania the bodies now in place are given 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 Specialist on Taking Care for Sick, Association under Health Department of Lithuania.

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

Data on associations are incomplete but they also seem to have increased in some countries (Croatia, Czech Republic, Lithuania). Membership numbers are missing in some instances where associations exist (Armenia, Croatia, Kyrgyzstan), but they appear very high in many countries that have data (Latvia 60%, Lithuania 85%, Moldova 79%). There is also some significant overlap with union membership in particular countries (in Latvia 26-50% of staff are members of both and in Moldova 76-100%). Only Poland has experienced a recent decline in membership levels to 40%. It appears that associations together with professional medical societies, play an increasing role in standards and licensing for medicine, dentistry and pharmacy (Croatia, Czech Republic, Latvia, Lithuania, Poland, Romania) although they are not always seen as influential (Armenia, Kyrgyzstan³⁴).

The role of trade unions appears to have evolved in some countries in the last ten years but to retain a set of common activities. Certainly, in most national systems trade unions focus on the core areas of negotiating wages, benefits and training (Armenia, Kyrgyzstan, Latvia, Moldova), wages and benefits (Czech Republic, Poland, Ukraine) or primarily wages (Belarus, Croatia, Lithuania). Negotiating powers of unions seem to vary however, depending on the sector in which they operate. For example, in the Czech Republic and Poland the unions’ role in determining public sector wages and benefits was felt to be very significant or decisive whilst in the private sector it was believed to be small or uncertain. In addition to these core activities several countries report union involvement in hospital management, particularly as it touches on workers’ rights, (Armenia, Lithuania, Poland). In Lithuania this involves unions designating representatives to County Councils. In Belarus, Latvia and Ukraine unions also directly disburse benefits carrying out the “provision of needy employees with financial aid on different occasions”, while in Latvia unions also give “financial support in covering the costs of training courses and certification”.

The reported role of associations is somewhat sketchy, however it would seem that they too are involved in consultations on wages and training, at least 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 (as is the case in the private sector in Moldova). The associations listed for

³⁴ Health Care in Transition series, as cited.

the Czech Republic however, seem to address institutional needs and may be targeted at organizations rather than at individual members.

Unions then, are involved in collective bargaining more frequently than associations. In the bulk of countries this takes place at three levels, the national, provincial and hospital (Armenia, Belarus, Kyrgyzstan, Lithuania, Moldova, Poland). To some extent the number of negotiating levels calls into question how binding national agreements can be on the institutions employing staff. Key exceptions are Croatia which has collective bargaining at the national level only (and where collective agreements have been breached by government), Latvia which has negotiations at national and hospital level only and the Czech Republic where only hospital level negotiations take place.

Collective bargaining in the Czech Republic: Although consultations in the Czech Republic take place with national level partners on wage policy/remuneration, labour claims/conditions, and the network of health care facilities and its funding as needed, discussions are held to be useful no more than 10% of the time. The major problems listed in the Basic Security Survey are

- Limited opportunities for the range of collective bargaining in the public sector
- There is no partner for collective bargaining on a higher (regional, national level). Collective bargaining is possible only on the level of individual enterprises.
- Fragmentation of trade unions.

Most trade unions surveyed, in addition to undertaking collective bargaining, 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 the discussions are successful. It seems that in some cases consultations are formalised 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, Moldova ‘as needed’). 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 and legislation (Armenia, Kyrgyzstan, Latvia, Poland). Basic Security Survey responses indicated huge differences in perception about the usefulness of such meetings with the percentage of occasions on which consultations were considered helpful ranging from 6% (Lithuania) to 60% (Moldova) and 40-70% (Poland), with no clear pattern emerging as to whether these had tended to be more or less useful over recent years.

Agreed bargaining powers and consultation procedures do not however guarantee a voice as has been found in Croatia where the 1999 round of talks, broke down resulting in the collapse of previous arrangements and a unilateral declaration by government of a round of pay cuts, in breach of ILO convention 98. The Basic Security Survey records that “government is not prepared to conduct genuine social dialogue” and that the usefulness of consultations is “currently very low”, having diminished in value over the recent years.

Traditionally health sector workers have avoided strike action, although the right to strike remains unrestricted for most occupations across most of the region. However, there are constraints on strike action for doctors (Poland) doctors working on essential functions (Moldova) and on both doctors and nurses (Armenia). Furthermore widespread restrictions have been introduced in Lithuania, although the extent of these is still unclear. Notwithstanding their rights health sector workers have

tended to not to strike and only in Moldova and Poland was strike action used in the reference period. A simple interpretation of these data might lead to an assumption that good industrial relations prevail. However, demonstrations took place in almost all countries surveyed, and work slowdowns were reported in 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

Income security covers protection of income through minimum wage, wage indexation, comprehensive social security and progressive taxation. 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, many Basic Security Surveys suggest firmly that health sector workers have witnessed a fall in the real value of their wages over recent years.

Data are not complete but 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 (Moldova) 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 doctors and nurses relative pay is seen to have fallen while administrative and allied staff wages increased compared to national averages. Even where wages are seen to have risen problems persist as in Croatia where recent rises have been undermined by cuts imposed by government in 2000 and 2001 or in Kyrgyzstan where despite reported increases for all occupations wages are said to be “lower than subsistence minimum” (although interestingly they seem not to fall below the nation legal minimum). 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 and Poland reports a 20-30% increase for doctors nurses and administrative staff from 1989 (despite which salaries of support staff and allied professions have fallen and minimum wages are commonplace³⁵). Few data are available on differences between public and private sector pay but the Czech Republic reports similar wages applying while in Latvia lower pay is reported in the private sector. It also seems that doctors in private practice or in more ‘entrepreneurial’ organizations in the Czech Republic can generate substantial additional income.

The percentage of the workforce receiving pay at or below the minimum wage is not available in all countries. Where data are available numbers working for such low wages range from the relatively positive 2.3% in the Latvian public sector, rising to 13.9% in the Latvian private sector and 30% in Armenia to the worrying 70% in Poland.

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 to pay it is not easy to identify a clear pattern. It is certainly typical that tariff elements play a part (Armenia, Belarus, Poland) often in

³⁵ The Basic Security Survey emphasises the importance of secondary jobs (with 50% of doctors’ income and 40% of that of administrative staff derived from secondary roles) and the extent of minimum wages within the health sector must be understood in this context.

combination with payments by results and time rates (Croatia, Latvia). 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 in determining pay and incentives at the expense of national, collective agreements.

Anomalies in pay – challenges to income security: The Basic Security Survey 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 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.

Interestingly, doctors' pay has often risen relative to nurses pay (Belarus, Croatia, Czech Republic). The Basic Security 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). Affiliates do though seem to broadly support the conception that there should be modest differentiation of individual pay to reflect work rate and effort (Czech Republic, Latvia, Poland) and to create incentives increasing "workers' interest in the intensiveness and quality of their work and get a guaranteed and additional wage"(Kyrgyzstan).

It seems that secondary income is of enormous importance in many of the countries surveyed. Data on secondary payments made by patients are limited but are shown by the wider literature to be significant. Total income from secondary jobs contributes roughly one-third of wages for doctors, administrative staff and those in allied health services in Belarus, 12% of nurses wages and 35% of doctors pay in Armenia, and 30% of wages for staff in all categories in Kyrgyzstan (where a further 20% of pay comes from payments made by patients). In Poland secondary jobs play a particularly dominant role providing doctors with around 50% of their wages, nurses with approximately 30%, allied professions with 20%, administrative staff 40% and support staff 15%. This phenomenon can only challenge income security.

The fact that health sector wages are widely regarded as inadequate and, in addition, are falling in many countries makes delays in wage payments particularly worrying. The Basic Security Survey reveals that staff in Armenia and Moldova are especially at risk of wage arrears and so to acute income insecurity. In Armenia 100% of the workforce received at least some of their wages late in the 3 months leading up to the survey and in Moldova late payment affected 75.95% of public sector health workers, an increase on earlier years. The picture is a little more positive in Kyrgyzstan where delays in wage payments were decreasing, nevertheless delays still affected 40% of the workforce. The situation is also reported to be worsening in Lithuania and Poland but the extent of the problem does not compare to that in the countries with particularly low levels of GDP.

Data on the payment of benefits, by both government and enterprise, are imprecise. Where details are given, entitlement seems dependent 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, Moldova) and to private sector staff in others (Poland). Enterprise benefits were often not available to staff (Belarus, Croatia, Kyrgyzstan, Moldova) or the existing levels of enterprise benefits were felt to be decreasing (Lithuania, Poland).

The picture as regards pensions was also mixed with no clear pattern emerging. 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% of all occupations covered by a 'pay as you go' pension scheme. In Moldova and Poland by contrast pension provision, while available, is not universal. In Poland's case this means only around 20% of all occupations within the health sector are covered by the pension scheme. Similarly, contribution rates vary across national boundaries with both increasing contributions (Kyrgyzstan) and decreasing contributions (Lithuania) making it difficult to determine a trend across the region.

Income insecurity across the CEE and CIS appears to be relatively high although not to be linked to 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 (where the affiliate cites low fee-for-service and the indebtedness of sickness funds to hospitals as having negative consequences for staff). Similarly, privatisation 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 Moldova but to have undermined income security in Latvia. It does seem though that where health expenditure is low, workers often experience considerable insecurity.

6. Conclusions: Linking Security and Structural Change

The CEE and CIS have faced enormous economic upheaval and structural transformation over the last decade as they have undertaken the transition from centrally planned to market economies. Workers' socio-economic security has been compromised throughout the region as demonstrated by the work of IFP-SES³⁶. It is in this context that health care systems have experienced pressures to reshape themselves. This impetus for reform stems from concerns about how health care systems respond to patients' needs, but also from the implications of the significant cost of public health care provision. Health care workforces have been under pressure therefore, in terms of numbers (since staffing levels were felt to be high), skill mix and levels (as new types of care were promoted) and changing payment systems (as different mechanisms to promote efficiency were tested)³⁷.

The Basic Security Survey has collected evidence of how this period of upheaval has impacted on the people working in health care. PSI affiliates identified key changes which they felt played an important role in shaping their sector³⁸. The details of each reform effort are inevitably particular to individual countries, nonetheless, it does seem that there are some common trends across the region. Certainly, the Basic Security Survey provides a compelling picture of the precarious socio-economic security conditions that many CEE and CIS health care workers have to contend with³⁹.

It is difficult to make overarching statements about workers' experience, particularly given the small sample size, and there is certainly no clear regional pattern with regard to Labour Market security. Four countries witnessed an overall reduction in jobs, and four noted an increase. Unemployment appeared not to be numerically significant but there was no consistent explanation of its causes (with privatisation sometimes cited as decreasing job numbers and sometimes increasing them). Part-time work was not particularly prevalent, but was in Poland, and data on short time working were also uneven. Contracted hours did seem to remain constant across the region, and long hours and the practice of combining formal roles with a secondary job were common place but not universal.

Employment and Work security provided 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, there appears to be a region wide shift as regards injuries at work and absenteeism which are both in decline (although falls in absence from work seem often to reflect insecurity on the part of staff). There was however, no clear trend in levels of stress and more importantly it seems that contract types are beginning to change in some countries with temporary contracts playing an important and increased role in Kyrgyzstan, Latvia and Poland, if not elsewhere.

Skill reproduction security and Job security are both 'patchy' with the ability to maintain skills varying between countries, and perhaps as importantly, between occupations. Training provision is also uneven with increases reported in some countries (Croatia, Czech Republic) and a decline in others (Moldova, Poland) and barriers to access emerging in others still (Latvia, Lithuania). There are also differences in regional trends as regards job category numbers and job category upgrading although there is a clear tendency for numbers of job tasks to increase.

³⁶ Chapter 2: The CEE and CIS Context, looks at the environment in which change has taken place.

³⁷ Chapter 3: Human Resource Pressures in CEE and CIS Health Sectors addresses the health system analyst's conception of staffing issues.

³⁸ Chapter 4: Health System Restructuring and the Impact of Privatization: covers key reform issues.

³⁹ Chapter 5: Socio-economic Security in Countries reviews the survey findings by socio-economic security type as defined by the IFP-SES programme.

Representation security has changed extensively although clear region wide trends are not always discernable. Trade union membership has fallen in most countries (sometimes to a fifth of previous levels as in Lithuania) but has been fairly stable in Kyrgyzstan and Ukraine. The number of unions is unchanged in four countries but has increased in others, while associations appear to have emerged in some 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 however, considerable divergence in the extent to which negotiations are seen to be effective with the Lithuanian affiliate regarding consultations with national partners as helpful only 6% of the time in contrast to the Polish experience that negotiations help in 40-70% of instances.

Income security does allow some generalisation as to trends across the region but again the detailed position varies from country to country. Overall the Basic Security Surveys 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 between reports for the Latvian public sector (2.3%) and Poland (70%), although wage levels in Poland are complicated by an extensive reliance on secondary jobs. It is interesting also that while the numbers on a minimum wage in the Latvian private sector are higher than in the public sector (13.9%), privatisation has in some circumstances been seen to enhance income levels and income security (Czech Republic, 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 the CIS.

Just as the sample under analysis is also too small to make authoritative statements about socio-economic security trends across countries it also rules out definitive or statistically significant judgements on the links between different approaches to reform and dimensions of socio-economic security. Notwithstanding, some qualitative consideration of themes does allow an understanding of the range of issues involved and highlights areas for further research.

Decentralisation 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 (considered separately below) and the empowerment of hospitals and more particularly hospital directors in hiring and negotiating pay and incentives. The evidence to date suggests that decentralisation 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 thus creating income insecurity for staff (for example in Lithuania where fund indebtedness to hospitals is linked with low pay settlements) and also where sub-national disparities bring about differences in access to training (Kyrgyzstan). The key concern though must be that decentralisation tends to give rise to the fragmentation of employment with myriad institutions directly employing staff (Armenia, Croatia, Poland). This has implications for all socio-economic types 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 level of the institution relative to at national level?
- Is there evidence of emerging inequalities between staff (between and within institutions)?

A shift from tax to social insurance has taken place in all the countries surveyed except Armenia, Belarus, Latvia⁴⁰ and Moldova. It is in many respects a form of decentralisation, and as with decentralisation 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 should necessarily prejudice staff security but it does seem that the shift has prompted lots of 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. Certainly, it is possible that insurance funds will negotiate coverage and reimbursement with reference to 'professional associations' but will overlook trade unions (Czech Republic) undermining representation security, or that anomalies like payment fluctuations for staff (Croatia) will prove to be more than teething problems. Further work might address the 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 of negotiated contracts (between insurance funds and hospitals) for trade unions 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?

Some privatisation has taken place in most of the countries surveyed, but it has often been restricted to pharmacies, dentistry and spas. There is now private primary care in the Czech Republic, Croatia, and Latvia, but private provision remains most unusual in the hospital sector and governments are still the major employers of health system staff. Privatisation might have been expected to have had the most adverse impact on workers' security of all the reforms to date. However, the Basic Security Survey findings suggest a rather more mixed picture, perhaps because privatisation 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 experience in the Czech Republic. Nor is there a clear picture as regards Work or Job security where public sector standards may be compromised by public spending constraints and under-investment in facilities and equipment (Moldova). It certainly seems likely that Representation security will be affected in the long-run although there is still only preliminary 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 'privatised' and if, when they become self-employed, they cease to be included in the health system union movement. There is then a need for further research and not least for work on the 'contracting out' of 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 pay levels necessarily 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?

40 Although Latvia uses insurance terminology to describe its third party payer, its system is in fact tax based.

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. Armenia records public expenditure on health as 1.4% of GDP in 1999, whilst in Belarus, Kyrgyzstan, Moldova, Romania and Ukraine the figures are between 2.1% and 2.9%. Although data are incomplete these same countries figure repeatedly amongst Basic Security Survey respondents where salaries are paid late (Armenia, Kyrgyzstan, Moldova), where administrative leave is extensive (Armenia, Kyrgyzstan, Moldova) and where wages are paid at or below minimum levels (Armenia, Belarus, Moldova, Ukraine). 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 (Kyrgyzstan, Ukraine). 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?

This Report provides part of the background story of the events that are shaping the working lives of health sector staff. An analysis of the Basic Security Survey has helped identify key pressures on health systems and has highlighted their implications for workers' socio-economic security. It has been difficult though, because of sample size, to make definitive statements about correlations between reforms and security. This 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 and will surely allow for such essential correlations to be made. More importantly still, further research will help trade unionists identify how regulatory and organizational structures affect the security of their members and will signal both 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.

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8. Annex: Country profiles

8.1 Armenia

Structural changes: The Basic Security Survey identifies a range of reforms that have affected the socio-economic security of the health sector workforce since independence. The decentralisation of management and the launch of paid services in 1997 are singled out as being of influence together with the introduction of state enterprise joint-stock company status for all health care institutions in 1999. There has also been a programme of hospital closures with the number of hospitals and clinics decreasing over the last decade, from 176 in 1990 to 143 in 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 decentralisation has been extensive. Some responsibility for regulation and for ensuring provision has been 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/polyclinic directors are responsible for managing their own financial resources, setting prices for services paid out-of-pocket, determining staffing levels and negotiating contracts with staff covering pay and terms and conditions of service. There has been little real movement towards social insurance although the State Health Agency (SHA) was established as the first step away from a tax based system. Although it acts as third party payer its funding is from tax revenues and it does not have insurance functions. It did however, recentralise some of the functions that had been passed to local government.

Privatisation has been limited but has affected pharmaceutical retail and dentistry. Most pharmacies now operate as private-for-profit enterprises and there has been a shift towards free-standing dental practices increasing levels of self-employment. There are also a very few examples of private or partially private diagnostic or tertiary facilities (a proctology centre, an institute of surgery, an obstetrics centre and the not-for-profit Arabkir Medical Centre) which are highly specialist. They 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 exams.

Public expenditure on health is very low, the Basic Security Survey suggests as low as 1.4% of GDP. It is estimated that only 25% of health care expenditure is covered by the state, 15% by humanitarian aid and 60% 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 sufficient funds to cross-subsidise the treatment of the 'protected' population. The World Bank has played an active role in health system reform, assisting with the establishment of the SHA and working with regional governments on 'optimisation plans' for restructuring. It has also provided funds for pilot work and guideline development for primary health care and financing reform.

Labour market security: Staff levels in the public sector fell between 1990 and 1999 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 Survey attributes decreases in the level of employment to privatisation of services despite the fact that it appears relatively restricted and to budget cuts of more than 20%. 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% in 1990 to 20% in 1999, whilst administrative leave in 1999 was believed to stand at around 5%. 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, whilst no data are provided on the actual number of hours worked. There are no details of overtime for most occupations, but 30% 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. There is no early retirement scheme provided for under existing legislation.

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 cases 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 again 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.

Work security: Work related injuries have dropped significantly, and it seems that only women take days off as a result of work-related injuries (the total days lost equals female days lost in D1b) yet working conditions and health and safety are described as having deteriorated. There are no data provided on the number of work related diseases. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. On average disability/ invalidity benefits pay recipients 100% of their wage, for up to 6 months.

There is no trend for absenteeism given but the main (and only) cause listed is "sickness". It is suspected by the affiliate 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 now 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". The three major problems unions face in 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". Management are required to involve trade unions as members of Health and Safety committees, however with only 10% 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.

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 3 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.

Representation security: The percentage of employees in the sector who are members of unions has decreased sharply from 80% in 1990 to approximately 30% 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 3 years. Secondary data suggest that different doctors, nurses and various medical specialities including cardiology, surgery, gynaecology and neurology, have separate associations

There was only one day 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 employing staff 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.

Income security: As we have no data as yet on price inflation within Armenia 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 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 3 years delays in wage payments have increased and over the past 3 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 be paid a percentage of out-of-pocket payments and a percentage of the third-party payments for each case treated, where these apply, only. Hospital directors will calculate the 'revenue' each doctor and nurse generates and so their pay entitlement. On this basis from 20-40% 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% 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.

8.2 Belarus

Structural changes: The affiliate identifies a range of reforms with changes to the financing of state health institutions (from 2002) and the transition of primary health to a general practice model as key. 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 (as a percentage of Gross Domestic Product) on health care has increased to 4.9% from a low of 2.6% in 1990.

Secondary data suggest that legislation has been passed paving the way for private sector development but to date it has been negligible with the exception of pharmaceuticals. Pharmacies 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 1800 did so only a small number are believed to be offering private consultations and operating on a fee-for-service basis and these work almost exclusively at the low technology end of medicine. There are also a very few pilot examples of quasi-private dental and cosmetic polyclinics. These 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 central government to decentralisation but the system is still highly centralised. 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 decentralisation 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 is very much supplementary and has 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 bed numbers, expected out-patient 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% in 1999 and was thought to affect all staff other than those in administration.

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 lasting 52 hours in 1999. Administrative and support staff are recorded as being contracted for 40 hours a week on average, compared with 35-38.5 hours a week for doctors/specialists.

The actual average hours worked per week demonstrate differences in contracted and actual hours for doctors and support staff but not for administrative staff. Administrative staff actually work the hours contracted with only 2% doing overtime while doctors/specialists work an additional 10 hours a week and support staff an additional 12 hours a week. 54% of doctors work overtime, 35% of nurses and 58% of support staff.

Approximately, 15% of employees in the health sector were also pensioners in 1999, which constitutes a rise on 1990 figures (10%), whilst there exists no early retirement scheme provided for under existing legislation.

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 3 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 4 months of compensated maternity, with an additional allowance in the zone affected by the Chernobyl disaster.

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

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 2000 days per year. No details exist on work-related diseases.

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

No statistics are available on absenteeism, however the affiliate believes that the level has remained constant. Management are 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. There are regular inspections of all primary, secondary and tertiary facilities.

Skill reproduction security: Employees are reported as being 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 3 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.

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% in 1990 the number of doctors who are union members has fallen to 89%. This decline cannot be blamed on hostility of management in the public sector however, since they were felt to be neutral in their feelings towards union membership. There remains just one union operating within the sector. There were no reported days 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 3 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 that "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, however highly skilled employees are provided with performance payments. There is also reported use of bonus payments as "highly skilled employees (specialists) are provided extra payments rating to 50% of wage rate", and "workers' to 32% 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). Fixed rates are laid down by the Ministry and increments based on years of service and level of qualification are also set centrally. It is suggested that under-the-table payments play a substantial role.

8.3 Croatia

The response is a joint submission by two PSI affiliates.

Structural changes: The responding unions do not have access to complete data but stress that, just after the reference period wages in health care were reduced by 5% 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% (and in some cases of 35%). The PSI affiliates have notified the ILO of the breach of ILO Convention 98.

The affiliate identifies the key reforms of the 1990 - 1999 period as the privatisation 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% of GDP is on a par with the Czech Republic for 1999 (no 1990 data is given).

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 privatised. There are also private polyclinics operating from private premises.

The previous system was highly decentralised and based on self-management which had poorly defined ownership and a lack of management accountability. The current system has seen some recentralisation 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 decentralisation, did not have a singly, major third-party payer. The establishment of the Croatian Health Insurance Fund has consolidated the system and standardised 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% of revenue in 1995 and 1% in 1997.

Labour market security: The total number of staff (for public and private sectors combined) as reported fell by only just over 1,000 between 1990 and 1999 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 significant falls amongst administrative staff or that redundancies were more prevalent outside this particular period. The affiliate reports that there was a marked shift in employment from the public to the private sector with just over 14.5% of person employed in the private sector in 1999 compared to 2.2% in 1990. The commercialisation of services, the privatisation of services and restructuring are all seen by the affiliate as having increased jobs.

Unemployment was reported as 5,039 (1999 figures only). Significantly, the average period of unemployment after redundancy was 18 months. Part-time staff numbers appear to be low at only 723. The majority of part time employees are women. Only 0.7% of all employees are reported as combining their formal role with other work (and only doctors and nurses are affected). 30% 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, which is likely to have been significant. Despite privatisation, contracted hours have remained roughly the same and the actual number of hours worked have reduced slightly. Only doctors are reported as working any overtime and this appears to be a standard contractual arrangement in Croatia, with 70% of all doctors/specialists working 8 hours overtime a week.

Employment security: All health employees regardless of whether they are employed in the private or 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 appears to be no difficulties associated with receiving benefits.

5% of the workforce were reported to be on temporary contracts in 1999 although this was a new phenomena and did not exist at all in 1996. The concepts of contract labour or working on commercial contracts rather than on labour contracts are listed as not applicable. Secondary data describe how both public and private providers can contract with the Insurance Fund, private insurers or employers and reports Ministry estimates that up to 30% of doctors may be working in private practice. This suggests there may have been considerable fragmentation in employment.

Work security: There are no available data on work related injuries or absence from work due to injury, although the affiliate reports that conditions have been improving with new equipment and stronger health and safety measures and that employees are entitled to disability benefits. Benefits appear low however, at 10% 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 that stress is serious (1999) an improvement relative to 1990 when it is listed as very serious. There are only two causes given: "war situation (1990-1995) 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 over time.

Skill reproduction security: All occupations report being able to use and maintain their skills and retraining is provided although unions have not been involved in the design of training. The number of job categories has remained the same and no change is reported in the number of tasks carried out.

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% in 1999 (from 100% 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, the numbers of the workforce who belong to associations was felt to have increased.

The affiliate lists as the main occupations or professions protected by specific unions or associations as: "nurses; medical radiology engineers and; biochemists" Secondary data suggest that Croatia has statutory

‘professional chambers’ for physicians, dentists, pharmacists and biochemists and that the 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. There are no laws restricting the right to strike although as is typical within the sector the right to strike 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” and becoming less useful over the last 3 years. The main problems faced by the union are: “lack of social dialogue and; slow operation of judiciary”.

Income security: As we have no data as yet on price inflation within Croatia it is not possible to quantify the rise or fall in salaries in real terms. Nonetheless, it is felt by the affiliate 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% and nurses salaries by 10% between June 1998 and June 2001 while administrative and support staff salaries appear to be unchanged. Doctors’ salaries were equivalent to 170% of nurses’ salaries in 1998 and to 190% in 2001. Nurses pay fell from 59% of doctors’ pay to 52% over the 3 year reference period (although their salaries did nonetheless increase), while for administrative staff the drop was from 44% to 35% and for support staff from 35% to 29%. Subsequently the affiliate states 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 affiliate explaining that “in 2000 wages in health care were reduced by 5%. 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% and in some cases by 30%.”

Payment structures have remained unchanged between 1996 and the present, the public sector maintaining a tariff whilst the private sector seems to combine a time rate with payment by results. The affiliate suggests that 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 the national collective agreements stipulated in F3b. 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 and 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 were not usually entitled to enterprise paid benefits, and all benefits are “stipulated by the law and collective agreement”.

8.4 Czech Republic

Structural changes: The responding union identifies a range of reforms with decentralisation of management and privatisation as key. Notwithstanding the reforms it is perceived that the situation is now relatively stable compared to 1996 with slight improvements in socio-economic security. Expenditure on health care has risen as have the numbers of hospitals reported.

Secondary data suggest that most health care provision is private, that is, the bulk of services are delivered through private providers (general practitioners, dentists, ambulatory specialists, home care services) under contract to the insurance funds (which are publicly funded). Ownership of facilities is either 'state-owned' (Ministry or district authority run) or nongovernmental (belonging to private, church, community or nongovernmental organisations). Most hospitals are owned by the state and are contracted to provide services to the insured. Only 9% 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 they rent facilities to the private practitioners who operate from them.

The previous health system in the Czech Republic was tax based and centralised. A key delegation of authority has been shifting the task of financing health care to the insurance funds and in addition, some regulation has been devolved to the district level or to professional chambers. Privatisation has been a major route to decentralisation with primary care and dentistry delivered by private practitioners renting space in community-owned buildings and spas, pharmaceuticals and pharmacies now privately owned.

The compulsory health insurance that replaced the tax-based system is now administered by nine, independent insurance funds. There was originally competition between a much larger number of funds on the basis of the supplementary services offered but this proved untenable and there were financial difficulties for the funds some of which 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 fund. Weak regulation is being reviewed and it is hoped that cherry picking can be prevented, risks pooled more effectively and the funds strengthened financially.

The affiliate records health expenditure at 7.36% 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 but more marked is the shift from public to private sector employment. Unemployment is low with 1,058 reported as seeking work within the sector. Part-time work decreased significantly between 1990 and 1999 from 8,700 to 1,970 – the majority of those now working part time are women. 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".

Some 13% of all staff are reported as combining their formal role with other work with all staff groups except nurses affected. 6% of redundant health sector employees are reported as having emigrated but there is no total figure given to set this in context. Despite privatisation, hours contracted have remained roughly the same although the actual number of hours worked have risen slightly across all occupations with the most significant rise being for doctors. Furthermore, some 93% of doctors work overtime.

There continue to be high levels of pensioners working in the sector although this has fallen slightly (as

detailed above) and the affiliate gives a positive review of pension arrangements (noting that 100% 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% in 1990 to 6.35% in 1999.

Work security: The number of injuries to employees has decreased slightly, although the average length of an absence from work for injury has risen. There were no fatal injuries reported in 2000. There is no law requiring management to involve trade unions as members of Health and Safety committees, nevertheless conditions in hospitals and clinics are reported to be improving over time, due perhaps in part to the compulsory inspections of all facilities.

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” and that “the Government is trying to look for some ways to improving their situation or at least employability” although it is noted they are often not union members.

Absenteeism is attributed to illness and; non-occupational injury and is believed to have remained at similar levels over recent years. There is no perceived change in the numbers attending work who could be absent. Stress is seen as somewhat serious and not to have increased over recent years. The main causes of stress are given as: unemployment; social insecurity and; low income level.

Skill reproduction security: Employees are reported as being able to use and maintain their skills and retraining is provided although unions have not been involved in the design of training. The number of job categories has decreased, but the categories have tended to be upgraded, no doubt due to the *acquis communautaire*. The range of job tasks has increased for all staff in all sectors.

Representation security: The percentage of employees in the sector who are members of unions has decreased sharply from 93.5% in 1990 to 32.5% 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 and 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 case.”

The union is reported as having consultations with national level partners based on need with 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% 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 is 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 very significant whilst in the private sector the role was felt to be small. The affiliate also reports the role of unions in pushing for greater differentiation of wages to reflect the different work carried out by different staff and its part in addressing the current system of graded pay scales with defined steps or increments per scale all linked to a Catalogue of Work Tasks agreed legally with government. These are due to change to 16 grades with 12 steps each at the start of 2002. Private sector grades are also set out although these are slightly simplified.

There are no laws restricting the right to strike.

Income security: As we have no data as yet on price inflation within the Czech Republic it is not possible to quantify the rise or fall in salaries in real terms. Nonetheless, the affiliate feels that over the last three years the trend generally has been for wages to rise 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. Health policy literature attributes much of the impetus of 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.

Both the public and private sectors include 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 they tend to be replaced by lump sums to counteract incentives to over treat and escalate costs.

The affiliate suggests that decentralisation contributed to a marked increase in salaries and greater differences between groups. Specialists are reported to have done well and those “workers performing the up till then undervalued tasks, e.g. accountants, programmers etc.” Differences are recorded between “entrepreneur” and “non-entrepreneur organisations” with more wage differentiation in entrepreneurial organisations with foreign company involvement and a slower growth in wages in non-entrepreneurial organisations.

The affiliate suggests private hospitals pay like the public sector but that other private facilities (out-patient clinics, spas etc.) have their own regulations but that nonetheless, “average wages usually do not differ very much from the general average.”

8.5 Kyrgyzstan

Structural changes: The affiliate identifies a range of reforms with the “MANAS” programme of health sector reform (1996) and the continuation of health reform, 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 beds numbers overall have declined according to secondary data, which might suggest ward or bed closures within large institutions. Public expenditure (as a percentage of Gross Domestic Product) on health care has decreased to 2.1% in 1999, constituting a steady decline from its level in 1990 (3.9%).

Secondary data suggest that the MANAS health sector reform 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 a health insurance element to health system funding with the establishment of the Mandatory Health Insurance Fund. Reforms have also included the formal recognition and organisation 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. It is confined mainly to urban areas and concentrated in ambulatory care and pharmaceutical retail. Privatisation of employment contracts is negligible as is private ownership of facilities. This is borne out by the Survey which does not list anyone as working in the private sector or give answers on the impact of commercialisation or privatisation or any other private dimension except in the answer to (F1f) where it states 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 reforms. 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 6000. Interestingly, 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 was believed to stand at around 12% while in 1990, only 4% of employees had been placed on administrative leave. The percentage of staff combining their formal role with other work stood at 24% in 1999, with nurses and support staff mainly affected. 30% of ‘total income comes from secondary jobs’ for all categories. 0.5% of redundant trained health sector employees have emigrated or 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 hours.

Approximately, 18% of employees in the health sector were also pensioners in 1999, which constitutes a significant fall on 1990 figures (32%). An early retirement scheme has been introduced to the sector with 16% 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 3 months and advance notice in cases of redundancy stands at around 2 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 are reported to have decreased over the decade. Compensation during maternity presently stands at 3 months.

24% of workers in the health sector were recorded as working on temporary contracts in 1999, constituting a significant rise on 1990 levels (16%). 36% worked as contract labour or on commercial contracts.

Work security: The number of work related injuries have decreased over the last decade to roughly one quarter of 1990 levels. Consequently, working days lost have reduced to 680 in 1999. There are no data provided 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% 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” It is suspected that the reported 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 lack of financial resources.

Management are 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. Disturbingly, 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.”

Skill reproduction security: Employees are reported as being able to use and maintain their skills and retraining is provided, with unions being involved in the design of training. Access to training has increased although there still remain some restrictions due to insufficient funding and some concerns about equity of access in different regions. There has been a tendency to upgrade job categories over the past 3 years and in general the number of job tasks has increased across all occupations, although the number of job categories in hospitals is shown as both increasing and decreasing.

None of the changes in skill reproduction security were ascribed to the reforms listed in A2b, instead the main reasons for the developments were given as the “effect of International Conventions and Acts and the inceptive introduction of democratic components in the real life of the republic.”

Representation security: The percentage of employees in the sector who are members of unions has decreased albeit by a small amount. Union membership which stood at 100% in 1990, reduced to 95.5% in 1999. The continuing high level of union membership is perhaps due to the reported support for unions in the public sector. There were no reported days lost to strike action in 1999, nor any demonstrations.

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, and 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 however 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 are reported as having regular consultations with national level partners. The main topics of consultation with national level partners are listed as: “legal issues; socio-economic issues and; labour issues, which are seen as useful 40% of the time.” The most important problems facing unions are listed as: “issues of wage, because it is lower than subsistence minimum and; rate of resources allocated for health improvement, it is very low (no 3rd issue)”. There are no restrictions on the right to strike.

Income security: As we have no data as yet on price inflation within Kyrgyzstan it is not possible to quantify the rise or fall in salaries 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 (F6), albeit that no workers are receiving wages ‘at or below the minimum wage’ (G8).

All occupations are paid by tariff, and according to time and results albeit by a mixture of methods. Secondary data confirm this picture, suggesting 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 “increas(ing) workers’ interest in the intensiveness and quality of their work and get a guaranteed and additional wage”.

20% of wages are described as coming “from secondary payments made by patients” (G4a) for all categories except allied health services (i.e. including administrative and support staff) This suggests that this element of pay is derived from a formal payment system not informal or gratitude payments (since these typically do not reach all staff equally and might be expected not to reach administrative staff at all). Certainly 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 3 years delays in wage payments have decreased, although this still affects 40% of the workforce.

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

8.6 Latvia

The affiliate identifies a range of reforms with the introduction of mandatory state health insurance (in 1996) and the development of primary medical service (creation of family doctors) as key. The number of hospitals has decreased over the last decade, although as a percentage of Gross Domestic Product public expenditure on health care has risen, standing at 3.71% in 1999. WHO estimates of total public expenditure on health care are slightly higher at 4.4% of GDP in 1999.

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-centralisation in 1997 superseded this early and extensive decentralisation 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 privatisation 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 are intended to see a major shift to private provision but change is still patchy. There has been only minimal privatisation of hospitals. Despite the extent of privatisation 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 according to health policy literature.

There is considerable uncertainty as to the total contribution made out-of-pocket. The Ministry of Welfare itself suggests only 7-10% of expenditure is made up of out-of-pocket payments whereas WHO European Regional Office data gives a figure of 21% in 1998-9 and the World Health Report 2000, 39%. Some of the confusion may be due to difficulties estimating under-the-table payments, which are hard to measure and are believed to affect only some segments of the population/country (70% of respondents in a study on perceptions of corruption suggested they never made unofficial payments or gifts for medical care).

Latvia has been given IMF credits twice, first in a banking collapse and then to support economic policy implementation including streamlining state administration, structural reform and privatisation.

Labour market security: Overall staff levels in the public sector have fallen, with losses only partly offset by increases in private sector employment. This reported decrease is confirmed by secondary data, which 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. Figures for the numbers working part-time are unavailable for 1990, however 5.3% worked on this basis in 1998, the majority of whom were women. Some 5.8% of the workforce worked less than their contracted hours in 1998 and 0.4% had been placed on administrative leave. 6.8% of all staff (except administrative staff) are 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% of doctors and 65% of nurses, and 60% of allied health workers, work overtime.

12% of employees were pensioners in 1999, and 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 1 month's pay on redundancy. Women are entitled to maternity pay and to return to their posts after leave and again appear to receive their entitlements. Indeed maternity leave entitlements are reported to have increased over the decade, and now stand at 112 days or approximately four months. Worryingly however 90% of workers in the health sector were recorded as working as contract labour or on commercial contracts as opposed to labour contracts. This figure is a 10% fall on previous years.

Work security: The number of injuries to employees has decreased substantially since 1990. Reported incidents of workers missing work for 1 day or more as a result of a work-related injury fell from a high of 7002 in 1990 to 860 in 2000. Likewise, the number of days lost fell from 165,900 in 1990 to 26,000 (both numbers of workers injured and days lost by work-related disease are down by over 80%) in 2000. 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 "1. disease and 2. 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 the response to D5b. which explains that more staff are 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 are 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

Skill reproduction security: Employees are reported as being able to use and maintain their skills and retraining is provided with unions being involved in the design of training. Nevertheless, some difficulties are reported most notably that the employer is not covering all costs.

The number of job categories was felt to have remained the same over the past 3 years, however the tasks undertaken have increased for much of the workforce, especially in the public sector.

Representation security: The percentage of employees in the sector who are members of unions has decreased sharply from 99% in 1990 to 50.2% 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 2. 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 as well as training was felt to be very significant whilst associations in the field were limited to the organisation and upgrading of

training courses. 60% of the workforce belongs to an association, whilst 26-50% belong to both a trade union and an association.

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” and “financial support in covering the costs of training courses 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 are said to be “wages; financing of health sector and; draft laws and health sector reforming”. They are seen to be helpful only 30% of the time. The main problems listed by the affiliate 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”.

Secondary data suggest the Latvian Physicians’ Association was influential in pushing for reform and includes representatives of specialities and sub-specialities who elect certification committees to address professional standard setting/ licensing. The Association of Physicians organises postgraduate studies.

Income security: As we have no data as yet on price inflation within Latvia it is not possible to quantify the rise or fall in salaries in real terms. Nonetheless, 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 3 months 0.19% of the public sector and 0.08% of the private sector did not receive their wages on time, a decrease on earlier levels. 2.3% of the public sector workforce received remuneration at or below the minimum wage level, whilst this figure rose steeply to 13.9% 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. There was a move in most of the country towards a points systems linked to services delivered (for primary, ambulatory and secondary care) which is now seen as an error that created perverse incentives to over treat or treat more expensively. (There was also a contrasting pilot model combining 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 for the population covered 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 differentiation and of formula designed to ensure “equal remuneration of equal work” (i.e. one which includes incentives and rewards for those working harder). In this case 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% bonus for intellectual contribution (certification, responsibility, work intensity) and a 20% bonus for night work and hazardous working conditions. The aim is equal remuneration of equal work.”

8.7 Lithuania

The affiliate identifies a range of reforms with the introduction of mandatory state health insurance (in 1997) and the restructuring of the system via the division of institutions into levels (first, second, and third) as key. The number of hospitals and clinics has decreased over the last decade, albeit by a small amount, whilst public expenditure (as a percentage of Gross Domestic Product) on health care has remained steady at around 4.4%.

There was rapid decentralisation on independence, however there has been some subsequent recentralisation to offset the unintended fragmentation and loss of coordination that followed the move of responsibilities out to the regions and municipalities. The main responsibility for paying for health care in Lithuania has nonetheless been transferred to the State Sickness Fund and some 90% of finances came from statutory insurance in 1998 (as opposed to 15% in 1994). However, tax contributions have continued to play a major part in funding with only 20% of the Fund's revenues actually derived from pay roll deductions and the contributions of the self-employed. The balance is transferred to the fund from income taxes (by employers) and through state budget transfers. This mixed system is intended to minimise 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 privatisation in the Lithuanian health sector is confined to pharmaceuticals (accounting for 100% of wholesale and 73% of retail trade in 1995) and to a lesser extent dental care (79% of dentists work exclusively in the private sector), cosmetic surgery, psychotherapy and gynaecology. A few dental polyclinics had been privatised (by 1999) but no hospitals and ownership of facilities is largely unchanged. Guidelines on the privatisation of primary health care have been formulated and paving legislation passed 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 they are liable for 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, test or spa services may contribute as much as 23% of total health care expenditures.

Labour market security: Staff levels have risen since 1990 by around 5000, however this disguises a slight fall in employment since 1996. This recent fall in employment has occurred in both the private and public sectors. Correspondingly, unemployment has grown since 1996 to a level of 2416 in 1999. Existing unemployment was attributed to restructuring of the sector, whilst the privatisation of services, a shift to fee paying services and changes in management systems was thought to have had a positive effect on employment levels.

Health system literature suggests that staff numbers remain high for the region and those in training should sustain current trends. It cites labour force statistics of 1993 and 1998 in support of the view that the sector suffered little unemployment during the downturn and that female auxiliary staff in urban areas suffered most. This suggests the rising trends described by the affiliate 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 within the sector. Administrative leave in 1999 was believed to stand at around 0.5 - 3%. 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% of employees in the health sector were also pensioners in 1999, which constitutes a significant fall on 1990 figures (21.6%). 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 from 2-6 months. Women are entitled to maternity pay and to return to their posts after leave and again appear to receive their entitlements. Indeed maternity leave entitlements are reported to have increased over the decade and women are given a generous 12 months of compensated maternity leave.

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

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% of their wage, with 100% being paid to those whose disability lasts more than 30 days.

Again, no statistics are available on absenteeism, however it is felt that the two main reasons for absence from work were disease and care for the sick. The affiliate believes that 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; anticipated late payment and reductions in wages and: the general economic situation in the country.

Management are 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.

Skill reproduction security: Employees are reported as being “partially” able to use and maintain their skills. Retraining is provided, although unions are not involved in the design of training. The availability of training has increased especially in the area of specialist courses, but also in terms of comprehensive training. Nevertheless, staff are experiencing some difficulties of access, most notably over the availability of time and money.

The number of job categories has increased over the past 3 years, as has the number of tasks undertaken.

Representation security: The percentage of employees in the sector who are members of unions has decreased sharply from 100% in 1990 to approximately 20% in 1999. This fact does however hide a small rise in union membership since 1996. This decline cannot be blamed on hostility of management in the public sector however 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 1 in 1990 to 7 in 1999. There were no reported days lost to strike action in 1999, although some demonstrations have taken place over the reference period.

Representative organisations 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% 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 twice a year. The main topic of the consultations (which have no obstacles listed) are: “training and retraining; privatisation and restructuring and; exchange of information on normative documents”. They are seen to be helpful only 6% 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 are shown to have fallen since 1998 (in US dollar values), which is backed up by the affiliate who feels that wages have fallen relative to average wages over the past three years for nurses, those in allied health services and for support staff.

There are no clear data provided on the determination of wages, however secondary data suggest that physicians at least were paid a basic (minimum) salary, which was 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 services provided by hospitals and in 1999-2000 sick funds were recorded as being in debt to all institutions, which in turn will have had an impact on rates of pay. Over the last 3 years delays in wage payments have increased, as has the percentage of the workforce receiving wages at or below the minimum wage. There is also a reported decrease in the level of enterprise-paid benefits. 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 3 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”.

8.8 Moldova

The affiliate identifies a range of reforms affecting the health care system of Moldova. The most significant of these are identified as being the reduction of budgets, management decentralisation, privatisation 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 have suffered). Secondary data suggest however that there were few changes in numbers of beds and facilities until very recently and that despite cuts from 1998, on Moldova still has a higher level of provision than anywhere else in Europe. Public expenditure on health care in terms of the percentage of Gross Domestic Product has fallen from a high of 5.8% in 1990 to 2.9 in 2000-2001.

Health literature emphasises the economic crisis that has affected the health sector since independence. It suggests that the independent impact of the failing economy on society in Moldova 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.

There has been paving legislation since 1995 allowing for privatisation but the vast majority of facilities remain under the ownership of central or local government. Pharmacies and dental clinics however, have almost all been privatised although government remains a shareholder in a number of them.

Steps to decentralise 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 determine policy and standards overall. The lack of resources severely constrains scope for local government innovation, however. There has also been decentralisation to the hospital level with hospital directors being given the right to charge for services, retain 'profits' and take employment decisions although it is unclear to what extent these are exercised. Privatisation as a form of decentralisation has been limited.

The lack of funding is described as severe and exacerbated by an emphasis on tertiary care with the bulk of funds consumed by the physical infrastructure of hospital buildings. The World Bank Project application shows 70% 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, although they are difficult to quantify the World Bank believe 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 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 of the basic package have left informal, under-the-table payments as an important source of revenue and therefore, as an important source of income for health sector staff.

Secondary data also suggests that parts of the Moldovan health care 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: Staff levels have fallen significantly, with the total number of persons employed in the health sector reaching 82,210 in 1999. The sector had employed 115,236 in 1990. The number of people involved in the private sector was not available. Unemployment stood at 3217 within the sector in 1999, having risen from 1060 in 1996. Existing unemployment was attributed to the commercialisation of services, privatisation of services, 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. As indicated above health literature suggests that the bulk of staff losses have taken place recently and result from the financial crisis and major efforts to cut back on over-provision.

Data on the numbers working part-time are unavailable for 1990, however 1320 worked on this basis in 1999, the vast majority of whom were women. Some 7.5% of the workforce had been placed on administrative leave in 1999. A high proportion of staff (32%) are reported as combining their formal role with other work, this being especially true for nurses and support staff. Such conditions have surely contributed to the 8.5% 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).

8.2 per cent of employees in the health sector were also pensioners 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 and again appear to receive their entitlements.

Only a small percentage of staff within the sector were recorded as working as contract labour or on commercial contracts as oppose labour contracts at 0.5%.

Work security: The number of recorded work-injuries has decreased substantially since 1990. Days lost to work-related injuries fell from 2988 in 1990 to 1330 in 2000. However, work-related diseases rose, albeit by a smaller number. Interestingly, the clear majority of incidents affected women. The payment of disability and invalidity benefit has remained unchanged with no reported difficulties, however the period covered (12 days) is strikingly low compared to other countries. On average 85% of a workers' average wage is paid as benefit during the period of disability/ invalidity.

Statistics on absenteeism have improved since 1990 with a reduction of around 40%. Absenteeism in this instance is attributed to "annual leaves, maternity leaves (until the child is 3 years), temporarily disability leaves, unpaid leaves". 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" in Moldova, 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 are 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.

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 availability is felt to have decreased. Access has diminished due to "lack of money, and the unavailability of training".

Adding to these problems is a lack of enthusiasm on the part of staff. Secondary data describe radical cuts in medical school places 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 was felt to have remained the same over the past 3 years within the public sector and to have increased in the private, with increased tasks undertaken by all occupations.

Representation security: The percentage of employees who are union members has decreased less markedly than in many countries with membership falling from 98.5% in 1990 to 89.2% 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 1. 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. 79% of the workforce belong to associations, and 76-100% 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% of the time and to have become more useful over the last 3 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 of the right to strike are for doctors in cases of “medical aid for essential functions”.

Income security: As we have no data as yet on inflation within Moldova it is not possible to quantify the rise or fall in salaries in real terms. Nonetheless, the affiliate feels that average wages have fallen for all health sector staff. Remuneration is based on salary with extra payment made for night work, work intensity, hazardous work, qualifications, continuous work etc. Nevertheless, it is reported that “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 to supplement their income.

It is felt by the affiliate that the privatisation 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 3 months 75.95% 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% of funds needed) and violation of legislation on remuneration. Public sector employees were entitled neither to enterprise nor 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.

8.9 Poland

Structural Changes: The affiliate identifies a number of reforms, the most significant of which is seen to be the introduction of a new form of health insurance (sickness funds in 1999), with health service privatisation (1998) also being highlighted as important. 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 database 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 described expectations that bed numbers would be further reduced.

Privatisation has been relatively extensive and has affected pharmacies and dental practices and seen the introduction of private medical practice. Nearly 90% of dentists were working privately in 1999 and 66% 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 organisations) and the state continues to be the most significant employer.

There had been a longstanding role for regional administrations but the 1990s saw greater decentralisation with increased responsibility for planning, provision and funding at the level of the voivodship (region) and ownership of institutions passing to powiats (districts) and gminas (localities). Despite a reduction in the number of regional voivodships from 49 to 16 in 1999 which concentrated authority somewhat, significant decentralisation 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 stabilised 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 specialised services will remain part of the state budget.

Public health expenditure as a share of GDP is shown as 5.2% in 1998 and it is suggested that once adjusted for purchasing power parity this 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 23000, with a shift of around 10% of the workforce into the private sector. The rise in employment since 1990 has not however prevented an increase of unemployment within the sector, which has doubled to 2349,8 in 1999. This mixed picture is reflected by the respondent who believes that whilst the commercialisation of services and changes in managements systems have increased the number of jobs, privatisation of services, shifts to fee paying services, budget cuts and restructuring have brought about a decrease in employment. A large proportion of the Polish health sector works part-time (40%), the majority of whom are women. No data is provided on short-time employment within the sector or on administrative leave. 20% 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% 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. Nevertheless they are described as being adequate despite shortages in some areas.

Approximately, 6.1% of employees in the health sector were also pensioners in 1999, which constitutes a rise on 1990 figures (2.4%). Provision for early retirement exists, with 17.9% 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 public and private sectors amounts to 6 months pay (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.

30% of staff worked on temporary contracts in 1999, while 20% of workers were recorded as working as contract labour or on commercial contracts.

Work security: Work related injuries have decreased over time from a high of 5688 in 1990 to 4231 in 1999. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties. On average disability/ invalidity benefits provided recipients with 80-100% 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 “worker was on sick leave (ill) and employee got sick leave on his/her ill child”. The decrease is linked to insecurity as “sick leave is paid only 80% of your salary and in fear of dismissal”. There is also a perceived increase in the numbers 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 “1. lost the job 2. low salary and 3. new system of health care service and privatisation”.

Management are 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.

Skill reproduction security: Whilst doctors and nurses are reported as being able to use and maintain their skills, allied health services, administrative staff and support staff are not. The shortfall in training for these occupations seems to stem from a lack of opportunity to specialise and to obtain computer skills. The training that is provided does not involve unions. Over the past 3 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.

Representation security: The percentage of employees in the sector who are members of unions has decreased sharply from 40% (already comparatively low) in 1990 to approximately 20% 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 1 in 1990 to 8 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% 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 “1. wages 2. collective agreement and 3. acts”. They are seen to be helpful 40-70% of the time but to have become less useful over the last 3 years.

Income security: Data on average salaries are not provided for 1998, however the affiliate feels that they were around 20-30% lower than in 2001. Generally, wages are reported as having risen over the past 3 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 are dependent upon 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 though 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 privatisation 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% of their wages, and nurses with approximately 30%, allied services 20%, administrative staff 40% and support staff 15%.

Over the past 3 months around 20% 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% 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% of their monthly income to “the insurance office”, however only around 20% of all occupations within the health sector are reported as being covered by the pension scheme.

8.10 Romania

The responding union records a range of reforms with changes to health insurance systems and reforms to primary medicine 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. No details are provided on public expenditure on health care.

Limited privatisation 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 the 1990 was tax based and centralised and underwent a process of decentralisation. Considerable authority was passed 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 from 1998-9. This triggered some adjustments to the previous decentralisation 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.

Spending on health is very low in Romania with just 2.6% of GDP shown as devoted to health in the WHO Regional Office for Europe health for all database. Out-of-pocket payments (formal and informal) are inadequately recorded and so although it is known that total expenditure is higher it is unclear by how much. It would still appear that funding 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 Basic Security Survey data were available on the seven elements of security (labour market, employment, work, skill reproduction, representation and, income 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 capitation based with fee-for-service top ups, whereas it relies on fee-for-service in specialised ambulatory care and on a fixed payment per person hospitalised, 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.

8.11 Ukraine

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 Basic Security Survey highlights a range of reforms with the introduction of mandatory state health insurance (in 1996) 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 Gross Domestic Product devoted to public expenditure on health care rose in the mid-1990s but has more recently taken a downturn, standing at 2.9% 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 significance attached to discouragement from applying for work within the sector.

Figures on part-time, short-time working 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.

Work security: Injuries to employees have decreased substantially since 1990. Reported incidents of workers losing their ability to perform work for 1 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 28576 in 1990 to 16377 in 1999. The payment of disability and invalidity benefits has remained unchanged with no reported difficulties.

Absenteeism is attributed to “disease” and “family reason” and is believed to have stayed the same over recent years. Nor is there a perceived change in the numbers attending work who 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 are 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.

Skill reproduction security: All employees are reported as being able to use and maintain their skills and retraining is provided with unions being involved in the design of training. The number of job categories was felt to have remained the same over the past 3 years, however the tasks undertaken have increased for the entire workforce. There has also been a tendency to upgrade job categories.

Representation security: The percentage of employees in the sector who are members of unions has remained relatively unchanged, standing at 97.5% in 1999 (having been 99.8% 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 in the country, 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: As we have no data as yet on price inflation within Ukraine it is not possible to quantify the rise or fall in salaries in real terms. Both 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.