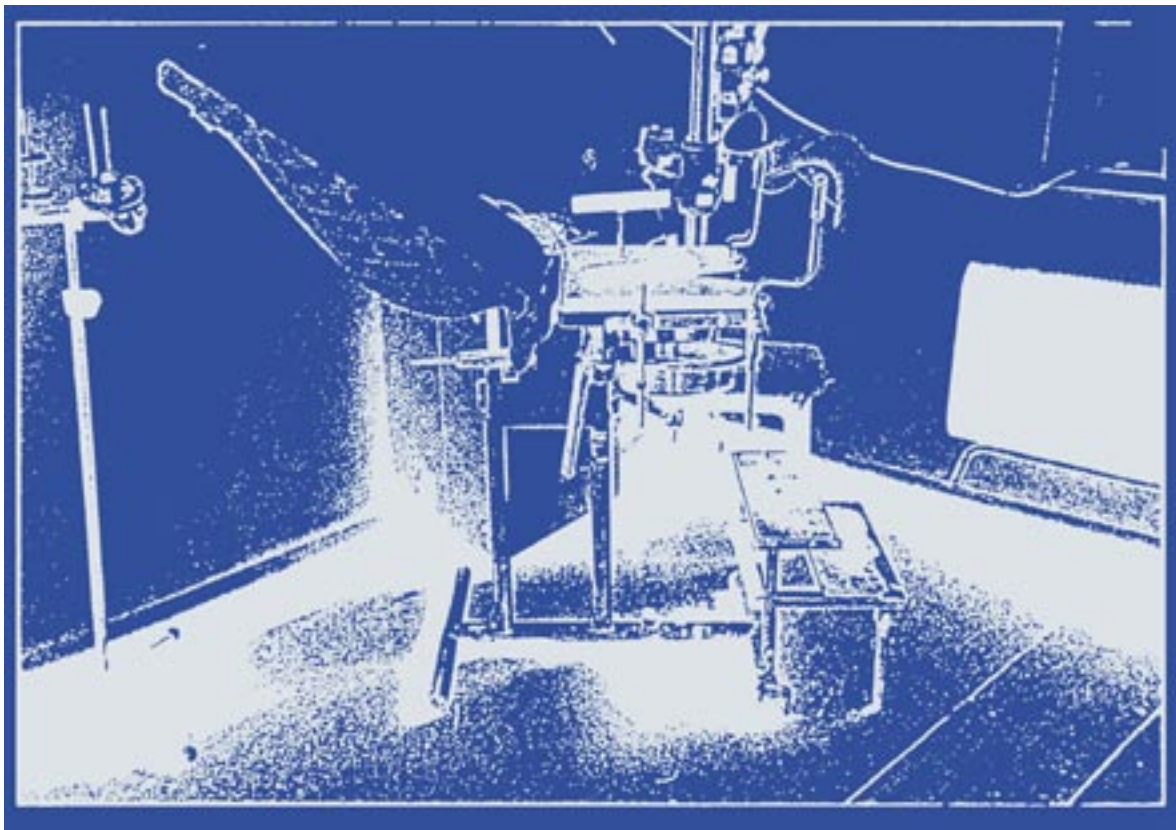




Public Services International  
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# FAILING HEALTH SYSTEMS IN EASTERN EUROPE



## DISCUSSION AND POLICY RECOMMENDATIONS

(An abridged version of *Corrosive Reform: Failing Health Systems in Eastern Europe* by Carl Warren Afford)

Edited by Ellen Roskam and Alan Leather  
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## **Acknowledgements**

All across Eastern Europe, health services plunged into crisis in the 1990s. Facilities may have been limited beforehand, and the system of healthcare in need of modernisation. But steep cuts in budgets, cuts in training and investment and, in some cases, official disinterest, created a pervasive system failure that has had terrible consequences, for patients and their families, for communities, and for those who have been required to work in the many parts of health services.

While it is hard to document all the changes that have taken place in the lives of healthcare workers themselves, there is sufficient evidence to be able to detect the main trends. This is the task undertaken in this book, drawing in part on research gained through interviews, visits to hospitals and clinics, and numerous meetings with health workers and health administrators in countries of the region.

This abridged monograph provides a vivid picture of the dedication and professionalism of health-care staff in worsening conditions, in which they have continued to work and have tried to maintain standards despite personal hardships. It has surely not been easy. The physical environment of many workplaces has been deplorable, often dangerous. One instance comes to mind. In the operating theatre in the cancer hospital in Kiev, nurses had to weave between buckets catching water from a leaking roof to carry out their duties, while having to work with out-dated equipment and a lack of drugs. Elsewhere, medical staff have continued to work through armed conflict, as in Bosnia, where 24-hour shifts were common and where improvised care was provided in shell-damaged buildings with an irregular supply of electricity.

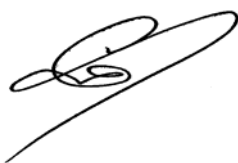
These may be depicted as isolated instances. But they are not. Providing healthcare has been an onerous burden, with salaries unpaid, training forgone, benefits neglected, leave cancelled. It is no wonder that morbidity and mortality rose in the 1990s in many parts of the region. However, while many have been forced to rely on secondary payments and secondary jobs, the vast majority of those working to keep the system going have retained a sense of duty and a pride in carrying out as good a job as possible.

This abridged monograph shows how health-care workers are being asked to make enormous changes, often without being consulted or even properly informed. International experts brought in to advise governments have often not spent enough time in analysing the situation, including listening to staff, before prescribing reforms. The studies contributing to this book show that the incessant pressure to cut budgets drastically has taken preference over planning the best way to provide health services for everybody in a fair way, on an efficient, accessible and sustainable basis. The consequences will not be forgotten. Yet now is the time to do better, and to ensure that the workers labouring to provide decent health services are treated with respect and dignity.

### **Failing Health Systems in Eastern Europe: Discussion and Policy Recommendations**

We would like to acknowledge the help and information provided by the many healthcare workers who participated in this project. Many showed a willingness to spend time, however long, explaining to inquisitive foreigners just what the daily situation is like. In several cases, hospital administrators were clearly embarrassed in revealing their problems. We appreciate their patience and forbearance, and wish them every success as they go about the lengthy process of rebuilding a vital component of a decent society.

Finally, this monograph owes a debt of gratitude to the authors of the “Draft Report to the Joint Meeting on the Social Dialogue in Health Services: Institutions, Capacity and Effectiveness”, who provided important insights into current thinking in this field.



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## BACKGROUND

# 1

The study, “Failing Health Systems: Failing Health Workers”, used empirical evidence in an attempt to quantify and assess the impact of a decade of reforms on health sector staff in Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS). The study drew heavily on data provided by fifteen PSI affiliates who completed the Basic Security Survey (ILO/PSI Survey)<sup>1</sup> for the years 1990-1999, specifically Armenia, Belarus, Bulgaria, Croatia, Czech Republic, Kyrgyzstan, Georgia, Latvia, Lithuania, the Republic of Moldova, Poland, Romania, the Russian Federation, Slovakia, and Ukraine. The aim of the research was to assess the insecurities of health workers in light of the seven socio-economic security dimensions as defined by the ILO’s Socio-Economic Security Programme (IFP/SES) (see below). The socio-economic position of the region at large and the sweeping health sector reforms that had taken place during the decade long reference period were also examined, providing some background to the study and an explanation of the context in which the technical evidence was gathered.

The second, simultaneous study examined in-depth, four countries seen to be representative of the region: the Czech Republic, Lithuania, Romania, and Ukraine. It sought to “gauge how restructuring has affected the working conditions of individual health care workers” by exploring workers’ experiences linked to working hours, physical conditions, changes in tasks performed, union representation and income (including non-payment of wages). The study applied a two-pronged approach, combining interviews and surveys of management, government representatives, union officials and worker representatives as well as individual employees.<sup>2</sup> A strategic sample of institutions regarded as “typical of the sector”<sup>3</sup> was investigated in each of the four countries, with the co-operation of trade union representatives and, wherever possible, hospital management.<sup>4</sup> The results of the survey (in graphic form) identify common

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1 This questionnaire was developed by IFP-SES and PSI and was originally sent to 35 PSI trade union affiliates across the region.

2 In total the authors received 2,215 individual responses to the questionnaire from health care workers, 466 from the Czech Republic, 834 from Lithuania, 735 from Ukraine, and 180 from Romania.

3 The institutions sampled included polyclinics, and a secondary care hospital or a specialist tertiary institution. See report for full details and weighting.

4 Although union support was provided, both union and non-union staff were surveyed.

## Background

themes in the working lives of health care workers and the differences between staff in the four countries.

Finally, a third component was commissioned by IFP/SES to investigate evidence on the health care sector in the Russian Federation. It aimed to assess the socio-economic situation of the country's health care workers and to set that in the wider context of the problems besetting the health care sector. The report examined the working conditions, income and skill security of staff in detail and examined the gap between official data and workers' experience.<sup>5</sup> Evidence was drawn from official documents and statistics provided by the Ministry of Health Care and the National Statistics Committee and interviewed health care staff and their representatives, illustrating vividly the challenges that Russian workers face.

The findings from these three research initiatives as well as a comprehensive iterative review provided the material for the book *Corrosive Reform: Failing health systems in Eastern Europe* by Carl Warren Afford. This annotated version of that book provides a summary of key findings of the overall picture of health sector reforms in CEE and CIS, and a summary of key conclusions and policy recommendations from the findings related to each of the seven forms of workers' security investigated.

The seven forms of socio-economic security examined in the ILO/PSI Basic Security Survey are:

- labour market security: adequate employment opportunities, through state-guaranteed full employment, or at least high levels of employment ensured by macro-economic policy;
- employment security: protection against arbitrary dismissal, regulations on hiring and firing, imposition of costs on employers, etc.;
- job security: a niche designated as an occupation or "career", plus tolerance of demarcation practices, barriers to skill dilution, craft boundaries, job qualifications, restrictive practices, craft unions, etc.;
- skill reproduction security: widespread opportunities to gain and retain skills, through apprenticeships, employment training, etc.;
- work security: protection against accidents and illness at work, through safety and health regulations, limits on working time, limits on night work for women, limits on working time, provision of paid sick leave, paid vacation time, maternity protection, etc.;

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<sup>5</sup> The authors explicitly preface their analysis with the recognition that "official statistics do not provide complete information, especially on issues of employment in the health care sector". The authors also point out that "information about the private sector (and, with few exceptions, about the departmental medical institutions) is not available".



### **Background**

- representation security: protection of collective voice in the labour market, through independent trade unions and employer associations incorporated economically and politically into the state, with the right to strike, etc.;
- income security: protection of income through minimum wage, wage indexation, comprehensive social security, progressive taxation, etc.

The way workers are regarded and treated will also depend on factors that vary across the region. The role allowed for trade unions and attitudes to solidarity will be shaped by national politics, recent history and perhaps a need to draw a line under what has gone before. Some countries may seek to establish a new identity by rejecting the past and asserting their membership in market economies. Some may pursue credibility with the west by adopting policies favoured by international financial institutions.

All generalizations about socio-economic security must therefore be understood in light of these caveats, and not as a denial of the differences between the countries of the region.

## **Failing Health Systems in Eastern Europe: Discussion and Policy Recommendations**

## THE HUMAN IMPACT OF TRANSITION

# 2

Eastern Europe is not an amorphous mass. It is an immensely diverse region. Yet every single country in it has suffered enormously going through “transition”. The collapse of the economies of CEE and CIS in the early 1990s is common knowledge. The extent of that collapse and the severity of its impact on the workers of the region are however more difficult to comprehend. Stagflation, restructuring, and burgeoning unemployment contributed to a devastating rise in poverty, growing disparities between rich and poor and falling life expectancy. By the end of the 1990s only Poland, Hungary and Slovakia had achieved or almost achieved their 1989 level of GDP (Dunford and Smith, 2000). Employment across the region declined by some 9 per cent for men and by 13 per cent for women between 1989 and 1996. Behind these statistics were 11.7 million people who lost their jobs, 7.2 million of them women (ILO, 1997). The reduction in labour force participation was even more marked and even harder to grasp, with vast numbers of workers “disappearing”. (Table 1) Many of the Czech, Hungarian and Lithuanian workers who lost their jobs in the early 1990s became non-participants in the labour market. They may have retired early or been pushed into early retirement. Many will have engaged in some precarious informal activity. Whatever the explanation they dropped out of the formal economy and were no longer captured by employment and unemployment statistics. This pattern was repeated again and again. While not all those withdrawing or “being withdrawn” from the labour market necessarily fall into poverty, the evidence of increased ill health, premature death, homelessness, destitution, emigration, forced work in the sex industry and the abandonment of children speak volumes about the extent of impoverishment in the region.

For many, transition translated to a collapse in life expectancy. Middle-aged men in particular died prematurely and in vast numbers. The precise causes are debated but the immense stress associated with job losses and poverty, falling nutritional status and problematic coping mechanisms including misuse of alcohol and tobacco have all contributed to increased accidents, violence and excess morbidity and mortality. Rising rates of tuberculosis (TB) which are associated with worsening living conditions, the appearance of multi-drug resistant TB and the emergence and re-emergence of sexually transmitted infections, including the spread of AIDS, have all taken a toll, particularly in parts of the former Soviet Union (Chenet *et al.*, 1996; Stepantchikova *et al.*, 2001). While the worst of the initial reaction has passed and life expectancy has started to recover, the stressors and dislocation that prompted damaging behaviours and contributed to appalling health outcomes are still in place.

### **The Human Impact of Transition**

The position of health care workers in CEE and CIS over the last dozen years must be seen in this context. Like everyone else those workers have experienced the impact of economic collapse, the pressures on the public sector and the uncertainties of restructuring. On top of this they have faced the strains of tending to a population in distress. They treat the men who die young in the face of social upheaval and the children with diseases of poverty. In the midst of this they must cope as best they can with scarce resources and monumental insecurities.

### **Economic and employment impacts; devastating transitions**

The economic advisers, the international community and above all international financial institutions who sought to guide transition fostered a particular approach to market reforms, an approach that was often enthusiastically taken up by post-communist governments. The presumption underpinning the economic policy they advocated was that price liberalization would be a key motor for change. It was to create market relations, prompt the tightening of fiscal policy and depress demand and public spending. These reforms, coupled with privatization, were to force enterprises to pursue efficiency. Enterprises were expected to respond by reforming employment and revitalizing production thus delivering economic regeneration. Price liberalization was advocated as a first step, which would lead on via stabilization and privatization to restructuring.

This sequencing of reforms proved wholly inappropriate (Standing, 1997). Price liberalization in what were highly monopolistic economies (and in advance of restructuring) led to spiralling inflation, the indebtedness of enterprises and a widespread collapse in production and labour markets. While manufacturing industries and utilities were the most obvious focus of market reforms and were the initial targets for privatization, the public sector was also profoundly affected. Governments were under enormous pressure to reduce budget deficits and in the face of falling production and dwindling tax revenues<sup>6</sup> they responded (as prompted) by cutting public expenditure and investment in the social infrastructure, in what has been termed “state desertion”. The effects of liberalization combined with these draconian attempts at stabilization caused havoc in societies, which did not have social security systems able to deal with mass unemployment. The expectation that it would do otherwise was optimistic if not foolhardy.

In some respects the international agencies and financial institutions that advised on the restructuring of Eastern Europe had tacitly recognized the

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<sup>6</sup> Tax revenues fell not only as a consequence of the collapse of manufacturing but also because of wide spread tax avoidance.

### The Human Impact of Transition

devastation that would be wreaked by reducing job numbers in that they advocated the establishment of social support systems as a adjunct to “shock therapies” (Standing, 2002). Their commitment to the market model of transition however, meant this support was envisaged as a safety net only. The IMF and World Bank in particular made minimizing the cost of such social provision a key objective, and through conditions attached to lending programmes, insisted on liberal and neo-liberal approaches to social and employment policy that inserted fundamental inadequacies into the systems developed.<sup>7</sup> The benefits put in place have therefore tended to be selective and to depend on means testing in order to “target” those deemed worthy of support. This has been highly problematic because the lack of established infrastructure for delivering benefits, the legacy of stigmatization and hostility to those not in work and the sheer unfamiliarity of people with the paraphernalia of benefit systems have made it particularly hard for people in need to secure their entitlements.

The “social safety net” promoted by the international community may have proved woefully inadequate and led to deprivation and poverty, in large part because of the flaws designed in the system as a result of neo-liberal beliefs. However, there are additional and very substantial problems that stem from the crumbling of social transfers.

Enterprises responded to the growing call for cash transfers to the state by seeking to evade the payment of insurance contributions and taxes. They routinely underdeclared revenues and, what is worse began to “casualize” labour, removing workers from “the books” and treating them as self-employed sub-contractors, since the nominally self-employed do not trigger the same insurance contributions. Staff colluded with this because of pressures from employers and because they had little confidence that the system would be able to deliver their entitlement to benefits in the future. It made sense therefore for them to opt for short-term cash payments instead of deferred entitlement (Standing, 1997). Irregular forms of employment and remuneration were also encouraged by the perverse incentives created by many tax-based income policies. These policies were promoted by international agencies and severely penalised enterprises for allowing average wage bills to rise. While this might have kept wages at levels that were attractive to international investors, it also prompted a shift from money wages into tax-free benefits,<sup>8</sup> cash-in-hand and under-the-table payments that further reduced the formal revenue base and the

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7 Role of international financial institutions (IFIs) in Gowan (1995) and Wedle (2000), cited by Rainnie et al., 2002.

8 A minority of enterprises, often the more successful and autarchic, have bucked the trend of replacing in-kind benefits with “monetarized” remuneration. They have maintained and enhanced enterprise-based service provision as a more tax efficient way of remunerating workers. This reduces transfers to the state as surely as casualizing labour and also polarizes the position of workers, increasing inequity.

### **The Human Impact of Transition**

level of social transfers (Standing, 1996). In the absence of adequate transfers local government declined to take on the service provision role vacated by so many enterprises, thus leading to shortfalls in services.

A final striking feature of the transformation of the centrally planned economies has been the recasting of the relationships between employers, management, employees and trade unions. Generalizations about an entire region obviously have their limitations but it is fair to say that in the communist era government was the all but universal owner-employer while unions (with a few notable exceptions) worked with government to promote productivity and as transmission belts for benefits. The labour process was based, in formal terms, on top down control but it consistently failed to achieve efficient coordination.<sup>9</sup> Instead there was unevenness of work and technology and considerable space for individual influence and negotiation. It is clear that workers were heavily dependent on the enterprise, and they may often have been alienated from their work and dominated by management as some commentators suggest. However, the notion that despotic and arbitrary factory regimes used piece rates and norms beyond the workers' control to impose oppressive discipline is less compelling when the actual powerlessness of supervisors to secure supplies or influence how work was done is acknowledged. Rainnie, Smith and Swain suggest there was a feeling of mutual interest between managers and workers with alliances established to achieve basic production norms in the face of the "shortage economy".

The international community, its financial institutions, the IMF, World Bank and investors, must all bear considerable responsibility for advocating an approach to economic transformation which exposed the people of CEE to such extremes of dislocation. Vast numbers were made unemployed, and even more were discouraged from participating in or forced out of the formal labour market. The sequencing of reforms and restructuring created a much greater need for the state to provide a "social safety net" than had ever been the case before, at precisely the time that revenues and social transfers were collapsing and governments were facing the most intense international pressures to cut public expenditure. Benefits systems have singularly failed to cope. Workers also have seen an entirely new set of industrial relations emerge while often the newly separated government and employers turn their back on trade unions. Those in work have no guarantees of adequate representation while those without work are voiceless. People welcomed the fall of communism and the opportunities market mechanisms were seen to represent, but the price they have paid during transition has been immense.

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9 The analysis of communist, and particularly Soviet, labour relations by Bahro, Burawoy, Mandel, Stark and others is described in more detail by Rainnie et al. (2002), pp.13-18.

## The impact of transition on the health sector

Change in the health sector must be seen both in the context of the wider economy and in light of its historical position in communist societies. The health sector before transition was regarded as “unproductive” and it was valued less than manufacturing or trade. Nonetheless, health services were regarded as a benefit that all workers were entitled to and as a cornerstone of efforts to produce the “next generation” of healthy workers. Staff may have been undervalued and relatively poorly paid<sup>10</sup> but the provision of care, particularly curative, occupational and rehabilitative health services, was an important component of the package of social transfers provided to workers. Provision was labour rather than capital intensive<sup>11</sup> and funded from global, tax-based budgets. It was normally organized in line with the Soviet Semashko model<sup>12</sup> and combined mainstream health service structures with parallel health systems linked to a range of Ministries and often to individual enterprises, which allowed workers to obtain health care in and through the work place.<sup>13</sup> There was a heavy reliance on centrally determined norms (of beds to head of population, and physicians and nurses to beds) with a quota of hospitals (in-patient care) and polyclinics (primary and specialist ambulatory care) per neighbourhood, district and region with tertiary, specialist hospitals concentrated at the apex of the system. Primary care was relatively undeveloped with a range of health posts and polyclinics offering first contact care but little in terms of health promotion and with only a limited capacity to refer upwards to secondary care and almost no gate keeping function. Typically facility budgets were increased on the basis of historical incrementalism and in line with numbers of beds, staff and patient stays or visits. This created few incentives for efficiency or patient turnover and helped to sustain high staffing levels (Saltman and Figueras, 1997). This did not attract the attention of governments because health service unit costs were relatively cheap and because before transition public sector support to health services was unquestioned.

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10 The low pay in health care may be explained by the fact that the majority of staff including doctors were female, despite which men held the most senior medical positions.

11 The numbers of physician and nurses per 1,000 population were high relative to norms in EU member states (for more details see Afford {2001} but total health sector employment was not as widely at odds with western European figures as is sometimes believed (see Section 3).

12 There were exceptions, notably self-management in Yugoslavia, but the model was otherwise widespread (and was of course applied without exception in the Soviet republics).

13 Before transition the Ministries like Defence, the Interior, or Railways and most major enterprises ran networks of clinics and sometimes hospitals. Since transition much of this provision has been cut along with other benefits in-kind. However, some services continue without being included in health sector reforms and without full accountability to Ministries of Health. There is startlingly little information about their staff, their likely future or their socio-economic or long-term security.

### **The Human Impact of Transition**

When the economies of CEE and CIS collapsed however, governments did little if anything to protect the value of their spending on health and some (perhaps in response to international pressure to reduce public expenditure) even cut the percentage of GDP devoted to health care. Data are incomplete but a comparison of spending in some European Union and transition countries gives a sense of the differences in norms. It does not however, reflect the relative value of the respective investment in health care or convey the tiny dollar sums per person being spent in most CEE and CIS countries. The assault on health spending was extreme, particularly in the face of price liberalization and stagflation, and it was translated into a chronic lack of public funds for investment and health sector pay.

Underinvestment in facilities and technology was not a new thing. Health sector conditions had been indifferent in much of the former Soviet Union and CEE and the focus on providing a high volume of beds (which was a misguided attempt to ensure sufficient capacity to respond to epidemics) consumed resources that might have otherwise been more effectively targeted. Nor was there a serious understanding of, or commitment to, quality services that would respond to individual patients' needs.<sup>14</sup> Health sector infrastructure was simply not a priority before transition. However, since transition there has been a further and often stark decline in conditions and a startling increase in inequity between regions. Low and falling health expenditures at a time when price liberalization sent the cost of medical supplies and pharmaceuticals soaring have created real, and sometimes insurmountable, difficulties in meeting even the most basic health needs. In the early 1990s many health authorities found it impossible to maintain the fabric of hospitals and clinics. Hospital equipment suffered too and became increasingly outmoded or even obsolete. There were also insufficient resources to purchase the basics like bandages and syringes. Increasingly patients were expected to pay out-of-pocket for the consumables required to provide day-to-day care and there was a proliferation of under-the-table payments.<sup>15</sup> These inevitably created barriers to access to care undermining the principles of solidarity and equity, which underpin public health provision. These problems persist across much of the region and although there are exceptions with donor programmes making significant contributions to some institutions and others (often the formerly closed or elite hospitals) investing in facilities and equipment, conditions overall are still widely held to be inadequate and to contribute to poor staff morale (McKee and Healy, 2002).

Staff morale has also been undermined by significant erosion in the value of health sector pay. Even allowing for relatively low salary levels before

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14 This is a comment on responsiveness to users and not on the technical quality of health services.

15 It was commonplace in communist systems for an extensive informal economy to run in parallel with the formal economy. Health was not exempt and "gratitude payments" were widespread.



### **The Human Impact of Transition**

transition, comparisons with other sectors and with national average pay provide little comfort for nurses, auxiliaries and administrators and not much more reassurance for doctors. For many health workers wages have been severely devalued, and in some cases continue to fall behind the national average. In the immediate aftermath of transition health sector staff were often paid late, sometimes as much as three months in arrears, and although in most countries this is increasingly rare, examples persist of delayed payment and of the use of administrative leave. This has exacerbated the culture of gratitude payments and of parallel economic activity that existed before transition and there is evidence that an enormous amount of health expenditure is private, out-of-pocket and unregulated,<sup>16</sup> although this does not imply that a large proportion of any individual's pay is "informal". Under-the-table payments may be problematic in terms of ensuring access to health care services but they also have serious implications for staff security. Informal pay is by definition difficult to measure or to regulate and is not amenable to distribution in line with transparent or agreed objectives. Occupational groups having direct contact with patients will inevitably have greater opportunities to supplement their income, and the most powerful, i.e. doctors, will be far better placed to control resources and therefore to command gratuities. Administrative staff, auxiliaries and cleaners are likely to have the lowest pay and the least access to supplementary sources of income, exacerbating inequities.

The "context for health" is a problematic one. The operating environment has changed radically, with health now in competition with other social needs. The way health systems have been configured is not sustainable, particularly given the rising costs of pharmaceuticals and new technology, the investment needed to counter the results of years of neglect, relatively high staffing levels and the wider economic pressures that exist. There is clearly a perceived and a real need for reform. There is however, little understanding of how best to translate reform models into practice and less recognition still of the importance of including in policy-makers' thinking the impact of any change on health sector staff.

Those attempting to reform health care systems (or advising on their reform) occasionally may have been entirely market-oriented but most often have worked from the assumption that health is a special and value-rich commodity that cannot be treated like any other entitlement or benefit. There is obviously considerable justification for this. Health and ill health are powerful determinants of quality of life. Societies often regard equity and solidarity in health care services provision in a way they do not when other services and utilities are considered. Similarly, demand for health care, and the nature of supply as described in health economics are somewhat special. There is a clear

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16 Household expenditure surveys for Bulgaria suggest that about half of health sector revenue is from informal sources while the World Bank suggests that in Moldova only a fraction of costs are covered by the government (cited in Afford, 2001).

### **The Human Impact of Transition**

public good associated with investment in public health, at the very least in terms of controlling communicable diseases. There is also a clear mismatch between the time when people can afford to pay for health care (in the middle of life when they are working) and when they actually need health care provision (at the beginning and end of life when they are not working) (Normand, 1998). Solidarity is seen not just as an ethical issue but also as the only rational means of spreading the cost of health care across a lifetime, allowing for the risk element, and providing for the potentially catastrophic costs of some health interventions. There is also a body of evidence showing that health is a precursor of development, and that without efforts to ameliorate ill health individuals affected will be trapped in poverty and will not be able to benefit optimally from economic development opportunities (WHO, 2002a).

Nonetheless, the unique elements of health care and its role in well being are not necessarily more significant than those wider determinants of health like housing, diet, and employment. It is regrettable that the experts advising on how best to structure and restructure health care systems focus so exclusively on the importance of health care services and overlook the significance of health care systems as employers. The concentration on mechanisms that are consistent with a health economist's reading of the world often have led to reform strategies which overlook the needs of the workforce.

Payment mechanisms for staff are a case in point.<sup>17</sup> There is an immense literature on how to combine elements of pay for physicians. These are regarded as crucial because they are seen as levers to control physician behaviour, which will ensure their work is consistent with system objectives and within affordable limits (rather than being an engine for greater expenditure). This consideration overlooks entirely what it is that a doctor needs to live on or how much they may be paid relative to professionals in other sectors. Most strikingly of all, the literature focus on physicians reveals the lack of thinking about other groups of staff even though they make up the bulk of health sector staff. Nurses' pay and conditions occasionally receive some attention, (often in the context of encouraging them to "substitute" for physicians), but analysts routinely ignore the importance of the socio-economic security of technicians, administrators and other support staff to how health systems actually work. They may not determine overall expenditure on health but must make an enormous difference to the efficiency, effectiveness and quality of care and therefore to the population's health.

It is typical that the focus on mechanisms and structures that might enhance performance should crowd out proper consideration of the people working in health. Decentralization, perhaps the most widespread (and most frequently cited) reform, provides another compelling example of this. It was almost a

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<sup>17</sup> Consideration of pay does not include discussion of informal payments.

### The Human Impact of Transition

truism of health policy advice in the 1990s that to be closer to the patient, i.e. to decentralize, was to be “better”. The Ljubljana Charter signed by the Member States of the WHO European Region promotes the beliefs that health care systems should be of the highest quality; that quality implies responsiveness to patients; and that being able to adapt services to local needs is part and parcel of responsiveness.<sup>18</sup> It was held that efficiency, effectiveness, and quality could best be delivered locally. Therefore post-communist societies were encouraged to break up the monolithic structures of their centrally planned economies and allow local management, devolution of decision-making and a mixture of ownership and organizational forms. Advice to decentralize from external theorists chimed with a strong desire on the part of many national policy-makers to reject the overly dogmatic, command and control approach of the years before transition. Opting to devolve authority was a means of asserting a new identity. Some Ministries were reluctant to lose their grip and resisted, but only in exceptional cases were they able to halt the roll out of power to local government. Decentralization was widespread and was intertwined with a number of other reforms. It was carried out however, with surprisingly little thought for how it would work in practice. This is not to suggest that centralization is preferable to decentralization. It is rather that it had huge and unintended consequences for employment, which do not seem to have figured at all in the deliberations of planners.

Decentralization has fragmented employment. It has seen employment contracts pass from a single employer to the level of the institution (hospital, polyclinic or single-handed practice), transforming the rights and employment, income and voice representation security of workers. It has raised general problems of inequity within countries and between urban and rural areas in particular. The Russian Federation for example has seen disparities in pay between regions widen into an enormous gulf (Stepantchikova *et al.*, 2001). It also undermines the concept of equal pay for equal work (in comparable circumstances). Poland has cases of workers in the same hospital, doing the same jobs but receiving different salaries because they are employed by different levels of government (Karski *et al.*, 1999). Decentralization also threatens union membership and the right of staff to access collective bargaining since small employment units are not easy environments for unions to operate in. Crucially, it has also seen a transfer of responsibilities to local government (neighbourhood, district, regional) for which those authorities were wholly unprepared. There are enormous, and now acknowledged, gaps in the training and capacity of staff to take on new responsibilities and most importantly a huge lack of financial reserves and resources at local level. This has meant institutions

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18 The World Health Report 2000 (WHO, 2001b) confirms the sense that responsiveness is a key dimension for measuring the performance of health systems, but is less prescriptive in suggesting how that should be achieved.

### The Human Impact of Transition

and local government have frequently failed as employers with indebtedness, payment in arrears and underinvestment, all decentralized efforts to sustain reasonable security for staff.

Another common reform strategy has been the shift to social health insurance. It is distinct from decentralization but is linked to it in that it implies the passing of government authority to an insurance fund, often with a set of regional structures, which further de-concentrate authority. Decentralization was intended to introduce mechanisms to control output and efficiency and was expected to enhance quality by linking payment and performance. There was also a desire to achieve three further objectives: 1) protect plummeting health care expenditure: 2) to be seen to empower consumers: 3) to create a mechanism whereby patients could make a clear connection between the care they consumed and what they paid for it. Payroll deductions were expected to bring home to people what they put into the health care system, which in turn was expected to make them value the services they received. The move to insurance was not as universally advocated as decentralization and many analysts warned that health care financing based on general taxation was actually the most cost-effective and appropriate way to meet societal objectives where these include the provision of universal health care, free at the point of use. However, there was support in countries for any reform that was seen to emphasize the shift away from the past, to establish ties with a Bismarckian heritage and to align the country with Germany. The World Bank tended to support any mechanism that would allow for private elements to be included, paving the way for clear constraints on what would be provided. Insurance is such a mechanism and invites the creation of a minimum, universal package supplemented by private and voluntary schemes.

Primary care is another area of reform, logical in terms of effective health care delivery but has not fully addressed the implications for staff. Both WHO and the World Bank agree that primary care and in particular family medicine or general practice, is the most appropriate way of ensuring cost-effective treatment, continuity of care, and an appropriate gate keeping function to prevent overuse of secondary and tertiary services. They recognize that doctors taking on new responsibilities require new skills and have, therefore, helped support the design and delivery of training. There has been less investment in retraining for nurses however, and a tendency to assume that *feldshers* (an Eastern European model of independent nurse-practitioner) would move within the new physician-led structures. There is also evidence from Poland that general practitioners given the opportunity to become fund-holders and manage their own budgets tend to reduce staff levels, evade tax and insurance payments, recruit retired staff in order to avoid making pension contributions, and generally follow poor employment practices (ILO, 1998, pg. 20). Health care reformers have not adequately considered the implications of this kind of behaviour for the new primary care model and for the employees of general or family practices.

### **The Human Impact of Transition**

A final tranche of reforms has been that of privatization.<sup>19</sup> There was, and is, considerable ambivalence amongst health policy advisers on this issue. Privatization (in the wider economy) is part and parcel of the restructuring and the shock therapy insisted upon by the IMF and certainly antipathy to state monopolies is inherent to much of the support given by the World Bank. Yet the risks to universal health care provision of allowing a fundamental rupture of solidarity (in the form of opting out by the well and wealthy) is seen as an immense threat by many including WHO. There is a clear distinction made between privatization of funding and privatization of provision, and again policy advisers tend not to concern themselves with the implications for staff of this explicitly health market oriented debate. So far privatization of funding has been widely regarded as overly precarious and countries are encouraged to retain a public collection and pooling of resources to cover the costs of (at least) a comprehensive if basic package of care. Privatization of provision or of service delivery is however, much more widely accepted as is private ownership of facilities. The ways in which countries wish to contract with providers of care both public and private are seen as tools for achieving cost control, meeting quality criteria and so on. All of the countries of CEE and CIS have sanctioned private sector pharmacies and dental care, and many have extended privatization to primary care, outpatient care and diagnostic services. Hospitals because of the cost and complexity of running them are still largely in the public sector and still employ the bulk of staff. In some cases the acceptance of private practice was ideological, in others it recognized the fact that services were being paid for out-of-pocket anyway but without any form of regulation and in others it was an attempt to capture additional funds that were just not available to the health system through public channels. The position of staff scarcely ever featured in the discussions taking place.

Although most staff are still public employees, the introduction of privatized employment is a significant milestone. Like decentralization, it fragments employment, only more so, and it creates enormous threats to security. Doctors who become self-employed may work exclusively as contractors to the public sector, and so can be regarded as “not truly privatized” but their pension arrangements, working conditions and so on will no longer be secured by the state. Most importantly, the staff they employ directly will be dependent on their continued success for their own income security and will be far more vulnerable as regards employment and work security than in

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19 Privatization can be analysed in a number of ways. According to Afford (2001), its dimensions are given as privatization of funding; private ownership of facilities; privatization of service delivery whether profit making or not-for-profit; privatization of employment and contracting out or the sale of functions. A fuller (if slightly different) analysis, which addresses privatization of pharmaceuticals and the public-private mix, is given by Hunter (1998).

### **The Human Impact of Transition**

mainstream health services. The evidence emerging from Eastern Europe also suggests that private employers are more antagonistic to trade unions than those in the public sector, which bodes ill for voice representation security. There are also a few, worrying reports of the contracting-out of functions like cleaning, catering or computer services in the Czech Republic, Hungary, Poland and Slovenia (Hall, 1998). The experience of contracting-out in the United Kingdom was that the conditions for staff and the degree of trust between employer and employee were severely compromised by this form of privatization. Many health policy experts regard the introduction of for-profit services with scepticism and suggest that the “owners” of health facilities or medical practices can only generate a profit through savings that threaten patient services. This must also raise fears that the security of the weakest employees will be jeopardized by the cuts needed to fuel profit making.

Many of the key reforms (decentralization, the shift to insurance, the introduction of primary care and privatization) have taken place as the result of rather inward looking consultations between health system experts (national and international) and health authorities, chiefly Ministries of Health. Health policy-makers place great emphasis on the way in which health systems are to handle patients and on how different reforms will affect citizens’ rights. There is little evidence though that they have ever fully engaged with the issues of workers despite the oft-repeated mantra that staff are the backbone of the health system (and its largest expense). A telling example of this focus on health rather than employment considerations is the way that negotiations with trade unions have tended to be supplanted by discussions with professional associations, or rather physicians’ associations. Governments have increasingly co-opted them (or been co-opted by them) so that doctors now formally manage elements of standard setting and regulation in almost half the countries of the region. It is not inappropriate for professional bodies to play a part in accreditation or for doctors to champion their own perspectives (although there is the potential for conflicts of interest). It is inappropriate however, for governments to sideline unions and deal with representatives of only one professional group (the most powerful) as if they could reflect the interests of other health service occupations. Governments and their international advisers have yet to do enough to understand the socio-economic security needs of all health workers, including auxiliaries, cleaners and cooks, or to genuinely involve them in planning and implementing reforms that work. Governments and their international advisers have yet to do enough to understand the socio-economic security needs of all health workers, including auxiliaries, cleaners and cooks, or to genuinely involve them in planning and implementing reforms that work.

## LABOUR MARKET SECURITY <sup>20</sup>:

# 3

### Conclusions and Policy Recommendations

Full employment was a key feature of the centrally planned economies of CEE and CIS until the transition of the early 1990s. All citizens were held to have a duty to work and the state provided them with employment opportunities. Since the shift to the market however, state guaranteed employment has ceased to exist. The ending of guaranteed jobs combined with widespread macroeconomic failure, has seen labour market security across the region collapse in sector after sector. The health sector has been affected along with the rest of society and has witnessed significant challenges to employment levels. This does not mean that all the CEE and CIS countries have seen cuts in jobs in health. (In fact trends as regards numbers of jobs are very mixed). However, it is clear that the old certainty that workers experienced no longer exists.

Numbers of workers employed, levels of unemployment in the sector and the hours worked can actually mask labour market insecurity. The data often under represent the scale of the problems faced not least because severance packages and welfare provision available to staff leaving the health sector are so inadequate. Statistics must therefore be interpreted with care and in the context of wider issues, including the use of administrative leave, attitudes of staff and the stated aims of health system reforms, if the actual insecurity that exists is to be understood.

No clear, measurable, regional pattern of labour market security has emerged from the studies. Job numbers have fallen in some countries and increased in others and while unemployment seems not to be numerically significant, vacancies may be on the decline. Many staff work long hours and take on more than one job but others are placed on administrative leave or are paid in arrears. The whole area of labour market security is obscured by lack of data, uncertainty about what is happening in parallel health systems and the inadequacies of so many CEE/CIS welfare systems which make registering as unemployed all but pointless and help trap staff in unpaid, “nominal” jobs.

Labour market insecurity is not easily measured but is nonetheless a very real phenomenon as demonstrated by the fears of workers and their trade union representatives. International agencies promote cuts in physician numbers and in medical school places, and inadvertently generate a sense of uncertainty in all occupational groups. Many other health sector reforms are perceived as

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20 The IFP/SES defines Labour Market Security as adequate employment opportunities, through state-guaranteed full employment, or at least high levels of employment ensured by macro-economic policy.

### Labour Market Security

challenging labour market security although this is not their intention. Central governments for example, are increasingly withdrawing from health care provision, abandoning their role in favour of local authorities and insurance bodies. These “local” bodies may be better placed to respond to patients needs but they often do not have the well being of the labour market as an objective and do not inspire confidence in workers.

There are real issues about determining the optimum level of employment within the health sector, in the contexts of Eastern Europe. Shedding enormous numbers of jobs makes little sense if employment levels are not as high as is widely believed, if the cost of employing staff is relatively low and if the staff in place are shown not to generate significant additional costs. However, if low levels of investment are combined with efforts to maintain high staff to population ratios this will keep workers in jobs with poor pay, conditions and equipment and produce a permanent and vast working poor. The peculiar market for health reinforces these dilemmas not least because the greatest demands on the sector are often made by the poorest in society who can be forced into poverty by health system failures and because many in the health sector are already part of the “working poor” (WHO, 2002a).

The recent WHO commission on macroeconomics and health and its work with the World Bank have prompted an acknowledgment that employment contributes significantly to well being and health. It is surely time to go beyond this and recognize that the interests of well being and health cannot be best served by insisting on low state expenditures which can only result in low paid public sector workers. This is of particular relevance given how much of health service provision remains in the public sector in CEE and CIS and how important the motivation of health service staff is seen to be. There needs to be a re-evaluation of approaches to job numbers in the health sector and an active shift of focus away from employment cuts towards ensuring a labour market security that will maximize health system outputs and ensure that the health services play a positive part as employers. The following recommendations, if acted on by the international/donor communities, national governments, employers and unions, would help address these concerns.

International agencies and bilateral assistance programmes should explicitly (and actively):

- recognize the macro-economic importance of the labour market in health;
- acknowledge the influence of employment on the health and well being of health sector workers;
- subscribe to the policy statement that job cuts should not be the initial, knee-jerk response to enhancing efficiency in CEE and CIS;
- promote research into the labour market in health with a view to analysing the cost benefits of different staffing levels and models of health care delivery;



### **Labour Market Security**

- promote research into other areas of the labour market, and in particular, that of parallel health systems to establish employment patterns;
- initiate a dialogue with trade unions and associations on the structure of the labour force;
- sponsor and promote a code of practice for governments engaging in health sector reform (see below); and
- support the development of legal frameworks within the CEE and CIS that will facilitate protection of labour markets in line with the code of practice.

Governments should be asked to subscribe to a code of practice, which commits them to:

- introducing “employment impact assessment” on all proposed health system reforms (drawing on the approaches of environmental, health and human impact assessments), to map the likely consequences for jobs and staff of all structural changes before they are implemented;
- discussing all proposed changes with trade unions and associations;
- carrying out a financial and skill audit of all local authorities, health sector institutions and insurance agencies prior to devolving employment responsibilities to them with a view to establishing guarantees that the bodies concerned will be able to fulfil their obligations to pay and otherwise maintain staff;
- introducing legislation to protect job numbers and staff where jobs are transferred to the private sector (using the model of the transfer of undertakings/engagements protection afforded to EU staff);
- legislating against the use of administrative leave and the manipulation of severance entitlement by employers;
- addressing the welfare provision available and taking such steps as are feasible to enhance benefits, encourage the unemployed to register and prevent discouragement from the labour market;
- investigating the creation of incentives for rural employment;
- improving the quality of the recording and use of employment and unemployment data.

Trade unions should work with members and, where appropriate with employers and/or government to:

- collect and verify data on administrative leave;

### **Labour Market Security**

- explore the causes and extent of unpaid overtime and its consequences for staff;
- seek to eliminate administrative leave and unpaid overtime;
- assess the impact on the labour market of pensioners' involvement in health services and lobby to ensure a dovetailing of benefits and employment policy that will protect staff whether they are entering or exiting the labour force;
- develop information campaigns to address members' fears about job cuts;
- identify and establish links with trade unions that represent staff working for other Ministries or enterprises in the 'parallel' health services and those that might best represent health care workers who are to move into social care provision or the administration of health insurance. Together agree joint mechanisms for reviewing the impact of reforms on the labour market, job numbers and employment rights;
- network across the region and with Western European counterparts to identify strategies to ensure labour market security in the face of privatization;
- engage in a series of debates, both internal and public, about the preferred balance between job numbers and health service costs in order to move towards a system that provides efficient, cost-effective and responsive care and decent, sustainable and rewarding employment.

# EMPLOYMENT SECURITY <sup>21</sup>:

# 4

## Conclusions and Policy Recommendations

The health sectors of the entire region were almost exclusively state operated until 1991, where all staff were state employees entitled to a full range of traditional employment protection. Health sector staff were a single entity, but were hired in line with clear criteria, could expect long-term employment, had rights that prevented them from being dismissed arbitrarily and were entitled to maternity pay and other benefits. There was a degree of uniformity stemming from the active use of norms in planning and management. As workers in the health sector they tended to enjoy a degree of employment protection simply by virtue of the nature of work in health services. The barriers to access to careers in health (for example the lengthy training needed to carry out medical, nursing or other technical tasks), the limited number of health care providers and the sheer difficulties governments face closing hospitals or health centres promoted long term, continuous employment with the same employer. Whether employees worked in highly specialized hospitals, the vertical structures of the Sanitary Epidemiological system or in small, rural health posts they shared a basic employment security. As the transition to the market has taken place this overarching protection has crumbled.

In some respects CEE and CIS countries have maintained employment security. The majority of staff have long-term links with the health service and are committed to a public service ethos. Their formal entitlement to maternity leave, advance notice of redundancy and severance pay is good, at least on paper. In reality however duration of employment is as much a marker of the lack of alternative employment choices as of security, and many of the benefits to which staff are entitled are simply not accessible in practice. Indeed some are actively manipulated to prevent uptake, tacit barriers to severance pay being a case in point. As important, the value of those benefits has plummeted, undermining their whole meaning.

Security has diminished not simply as a result of economic pressures but largely due to health system restructuring. This has undermined the highly centralized organization of employment that was typical of command economies, and seen the growth of a decentralized and poorly regulated employment environment. Smaller establishments have been established, the directors of larger institutions have been given greater autonomy and local authorities have acquired more responsibility for staff (by default). None have a

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21 The IFP-SES defines Employment Security as protection against arbitrary dismissal, regulations on hiring and firing, imposition of costs on employers, etc.

### Employment security

primary concern with the security of the workforce and most have few financial reserves with which to ensure that contractual commitments to staff are honoured. Increasingly staff must depend for the exercise of their employment rights on individual institutions and individual decision-makers, inevitably resulting in real threats to their security.

Health systems staff across CEE and CIS fear losing their jobs and clearly feel that the legislation in place will not actually protect them. They are pessimistic about the alternatives open to them and surely know that most welfare systems fail to provide unemployment benefits. Their employment security is severely compromised, further challenged by the spectre of changing contract type and of contracting-out. Both are poorly understood and difficult to map accurately but pose an enormous threat to workers. The shift to temporary employment, commercial contracts and contract labour (compounded by the poor regulation of privatized providers) will inevitably lead to the casualization of labour and will undermine entitlement to employment protection. The sub-contracting of hotel (cleaning, laundry and catering), information management or other functions will push staff out of the health sector itself and away from such protection as they now enjoy. It may particularly disadvantage women workers. Given the stated importance of staff in health and the emphasis reformers place on quality and responsiveness, it makes little sense to promote contract types that deny staff a secure future. It is surely more appropriate for planners and policy-makers to try to guarantee employment security in the changing health system context. The following recommendations may help address this issue.

International agencies and bilateral assistance programmes should:

- promote long term and secure employment contracts as the most appropriate for health sector staff;
- support a mapping exercise of the types of employment contract being used across the region;
- sponsor an overarching review of the legal underpinnings of employment protection on a country by country basis with particular reference to the implications of decentralization for security and to the actual costs of making staff redundant;
- encourage the involvement of trade unions and professional associations in social dialogue on contract issues;
- develop a glossary of contract related terms used in CEE and CIS, and in Western Europe and translate it for use across the region;
- produce and disseminate case studies and analysis of Western European experiences of the contracting-out of health services functions; and
- recommend the indexation of benefits.

### **Employment security**

Governments should be asked to:

- survey the extent to which employment contracts have been passed to individual provider units;
- review (or participate in a review of) the legal status of decentralized institutions as employers;
- legislate to reinforce the obligations of employers to honour employment guarantees at least to the levels of those prevailing in 1990;
- address the status of those staff employed in small establishments ('single-handed' practices) by self-employed physicians and by the private sector and ensure the extension of employment protection to them;
- ensure legislation on contract type prevents the use of temporary contracts or commercial contracts as a means of undermining entitlement to benefit;
- commit as a matter of policy to allow the contracting-out of services only where a full costing of the options has been completed and where the protection of staff working as sub-contractors is guaranteed;
- map changes in contract type by gender, to ensure that women are not disproportionately affected by measures which diminish security;
- re-examine the levels of severance pay and maternity benefit with specific reference to the actual income of staff (where under-the-table gratuities are commonplace) and the value of in-kind benefits in 1990, and to index benefits accordingly; and
- take action to enforce the provision of benefit entitlement and to remove the loopholes that allow employers to withhold severance pay, trapping workers in poverty.

Trade unions should:

- track the numbers of staff being "fired" or made redundant from different health care institutions to identify whether particular organizational models (private practices, limited liability or joint-stock companies) or particular employers (local authorities, self-employed physicians) provide consistently less employment security;
- monitor the payment (and non-payment) of redundancy and severance pay;
- work with civil society to develop para-legal and civil structures through which workers can pursue their employment rights;

### **Employment security**

- advocate the payment of insurance contributions by members and employers and campaign against opting out of the systems that create entitlement to benefit;
- develop information packs, and provide support and legal services to those denied entitlement to unemployment and other benefits;
- present employers and employees with the evidence generated through experience in Western Europe on the importance of trust in the work place, highlighting the negative impact of new contract types on cooperative strategies within the workplace and on the security of the female workforce;
- carry out exit interviews with workers quitting the union to identify how many of them continue to work within the sector but are discouraged from union membership by the conditions attached to new contract types.

## JOB SECURITY <sup>22</sup>:

# 5

### Conclusions and Policy Recommendations

Attempts to reduce total job numbers and to move employment contracts to smaller, decentralized employers make the health sector environment increasingly precarious for workers across CEE and CIS, with few guarantees remaining. Even the way different professions are defined, the content of particular jobs and the boundaries between them are being questioned. The technical skills and qualifications demanded in medical, paramedical and nursing work still afford staff some job security and protect career niches, but despite the specialization of different occupational groups they face a re-thinking of demarcation and in some cases of working practice. This has created a degree of job insecurity, unheard of before transition. It does not mean that all change is necessarily negative. The reform of the region's health care systems has created the potential for new skill areas and career niches and should offer a range of workers the opportunity to move out of the shadow of physicians and take on innovative and challenging roles.

There is scope for development as health sector reorganization and reengineering of the workplace are implemented and as EU influence prompts a review of job boundaries, including job expansion, recognising when the role of one group of staff grows this may be at the expense of the job security of other occupations. Job security can only be achieved in combination with other forms of protection, not least access to training, but also with protection of voice representation and skill reproduction security.

Health service staff maintain a relatively high degree of job security because many occupations are distinct by virtue of their technical content. A hospital pharmacist or a physiotherapist cannot simply switch jobs and neither one can be replaced by a new recruit without specialist training. Nevertheless, the relative protection inherent in the career niche they occupy does not protect against change.

All occupational groups in health are faced with challenges resulting from the reform of the health care systems of CEE and CIS. New management, accounting and clinical standards are being introduced, along with new norms for numbers and types of specialties. There is pressure throughout the region for staff to deliver efficacious treatments cost-effectively and in line with EU practice. Inevitably this means individual staff having to adapt what they do,

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22 The IFP-SES defines Job Security as a niche designated as an occupation on "career", plus tolerance of demarcation practices, barriers to skill dilution, craft boundaries, job qualifications, restrictive practices, craft unions, etc.

## Job Security

abandoning outmoded or discredited procedures and taking on new work practices.

Staff see their qualifications devalued by developments in clinical and management practice and feel disadvantaged relative to new graduates. They fear seeing their skill area downgraded, and in the case of *feldshers* and other very specialised occupations face being phased out altogether. Poor management can quickly turn opportunities for change into the grounds for stress, creating tensions between and within occupational groups. Training, continuous professional development, consultation and sensitivity to gender issues can all counterbalance these insecurities but only if they genuinely prepare all staff for new job tasks and provide on-going support in meeting the demands of a health care system in transition. In their absence all the change taking place can and does create a sense of insecurity.

There is a distinct role for unions and professional associations in negotiating an approach to reform that does not wholly compromise job security. They are obvious partners for social dialogue in any effort to ensure that staff in all health care institutions, (whatever their relationship to central government or form of ownership), benefit from change rather than being crushed by it. It is regrettable that at a time when all workers require collective voice, doctors' associations should be seen to be pulling away from the trade union movement and addressing more sectional interests. Doctors are the least vulnerable staff group. They are also the closest to government with their professional bodies accepting increasing statutory responsibilities for licensing and accreditation. It is natural that their mandate should not include the needs of other occupations but it is worrying if concern for their own career niches should distract from the needs of the system as a whole. The following recommendations seek to suggest some policy directions, which would best serve the interests of all occupational groups and promote overarching job security.

International agencies and bilateral assistance programmes should:

- acknowledge that one single model of job categories and tasks will not 'fit all' health systems at all stages of their development;
- advise countries not in rapid transition (non-accession countries) against seeking to meet EU standards in the short-term and as a primary concern;
- advocate for comprehensive regulation and control of numbers entering medical and nursing training;
- promote a commitment to retraining of staff to take on new roles, rather than replacing experienced staff with new entrants to the health sector;
- work with national governments to develop and refine training programmes for new job tasks and categories, including in primary care, public health, management and information technology;



### Job Security

- advocate for all proposed change to be discussed with trade unions and associations and to be gender sensitive;
- encourage links between Western European and CEE/CIS associations for nursing, midwifery and other professions allied to medicine as well as between trade unions, and otherwise support the development of a professional voice for a full range of occupational groups; and
- support research into the role of professional groups in licensing and accreditation, generating case studies and guidelines on best practice.

Governments should consider:

- enforcing a *numerus clausus* approach to restrict numbers entering the health professions through private and public routes;
- formally committing themselves to retrain staff required to change the content of their job and legislating to ensure that local government and private sector employers extend similar guarantees to staff;
- working with international agencies to develop and refine training programmes for new job tasks and categories, including in primary care, public health, management and information technology;
- revising in-service training and continuing professional development programmes so that they best support staff in new roles;
- reviewing the role of *feldshers*, midwives and/or public health nurses with a view to maintaining the existing job structure for autonomous nurse practitioners;
- protecting occupational groups other than doctors by mandating employers and insurance companies that negotiate directly with doctors' associations to include representatives of all professional groups in these discussions;
- involving a full range of trade unions and professional associations in changing working practices and determining standards, and in accreditation and licensing activities;
- setting out a clear road map illustrating the scope and extent of the reforms, so that trade unions are in a position to negotiate on behalf of staff, and so that staff can understand the full implications of the changes that are being made to job content and boundaries; and
- legislating to ensure that job enlargement or enrichment leading to increased responsibility (whether clinical or management) be matched by increased remuneration, fully funding appropriate pay increases for staff directly employed by central government, and mandating such increases in decentralized employment settings.

Trade unions should:

### **Job Security**

- lobby for appropriate restrictions to numbers entering training for medical, nursing and allied professions;
- insist on an active say in the introduction of change in working practices, and in the modernization of services to improve efficiency and effectiveness, including agreeing new job tasks and categories, contributing to the development of appropriate training, and deciding how it will be provided;
- act as a key route for providing information to the workforce, securing and communicating adequate and timely details of all proposed changes to working patterns, working conditions and job descriptions;
- ensure that all reforms that affect job security are discussed at a local level (through representatives of trade unions and associations) well in advance of the introduction of any change;
- identify and approach occupational groups at particular risk from changing clinical standards and definitions, including *feldshers*, therapists and rehabilitative staff, and develop tailored support and representation to directly address their job security concerns;
- monitor the impact of changes from a gender perspective to ensure that the shifting on job boundaries does not disadvantage women workers;
- establish links with professional bodies to discuss jointly the implications of standard setting and accreditation for staff in occupational groups outside medicine and nursing;
- liaise with the European trade union movement and the European Union to highlight the implications of international standard setting for the job security of staff at a local level; and
- review the job content of members on an occupation-by-occupation basis and work to ensure job enlargement and increased job tasks and responsibilities are linked with commensurate increases in pay.

## SKILL REPRODUCTION SECURITY <sup>23</sup>:

6

### Conclusions and Policy Recommendations

Creating widespread access to education and training was a significant achievement of the pre-transition societies of CEE and CIS. The region enjoyed almost universal access to basic education, enormously high literacy levels and an extensive post-secondary education infrastructure. The education and health sectors collaborated to produce (largely female) doctors, nurses, pharmacists, dentists and a range of other medical and paramedical professionals all of whom were absorbed by health care systems.<sup>24</sup> There were also structures in place to deliver in-service training as well as to allow staff to specialize or achieve post-graduate qualifications. Although not all the education and training was at a level that would be regarded as sufficient or desirable by today's standards it turned out qualified staff who are still able to apply their skills post-transition. These staff are now being called upon to adapt to changing circumstances and to take on new tasks and responsibilities. The pressure to gain new competences however, is unlike many of the pressures to change working practices. There often has been a focus on increasing quality and responsiveness and not just efficiency. Change is, therefore, more often perceived by staff as being about opportunities as well as threats.

New entrants to the health sector face their own issues, with impacts on existing staff. Barriers exist to access to continuing education and retraining. High human capital is a positive legacy of communism but without active lobbying by trade unions and associations these assets could be lost. Workers need to secure not only equal access to training but also the chance to apply that training in a safe and well-paid environment if they are not to end up moving to other sectors or other countries, or simply fall into despair.

Workers in most occupations in health have traditionally had high levels of both education and training. Nevertheless, a retrospective review of curricula and qualifications in place at the time of transition suggests that the region had fallen behind the West in terms of the content of medical and related courses and the teaching methodologies used. There was a tendency to focus on communicable disease and to undervalue responsiveness to patients.

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23 The IFP-SES defines Skill Reproduction Security as widespread opportunities to gain and retain skills, through apprenticeships, employment training, etc.

24 Some sense of the scale of production is given by the Russian Federation, where even today 10 per cent of all higher education establishments and some 15 per cent of all secondary vocational educational establishments train students to work in health (Stepanchikova et al., 2001).

### **Skill Reproduction Security**

Notwithstanding these shortcomings, there was a very extensive skill reproduction infrastructure in place which continues to function. This legacy of the past is enormously valuable and worth preserving. It is not however, sufficient to provide workers with the security they need in constantly changing health systems.

The existence of training infrastructures in all the countries of the region has not meant guaranteed access to training for all the groups of staff in the health sector, in practice. Some of this failure to deliver universal benefits stems from the fact that training is primarily designed for and targeted at occupations, like family physicians, that are intended to play a pivotal role in health sector reforms. This is often the case even where these groups represent only a tiny fraction of the health sector personnel and where no structures are in place to support them in applying their newly acquired skills. This preoccupation distracts attention from occupations like nursing the elderly or the mentally ill, which are almost without exception, regarded as unglamorous and are ignored in training terms.

Insecurity is also rooted in the barriers individual staff encounter in trying to access training. Some of these relate to the physical isolation of staff in rural areas, (although staff in towns and cities other than the capital also seem to have restricted options) and some to the lack of training for particular occupations mentioned above. One of the most significant barriers is money. Staff asked to cover the cost of training, or even its indirect costs are put in an impossible situation. Even when there is no charge, simply being away from work can mean an untenable drop in income for staff who depend on informal payments to supplement their earnings. Insecurity, however, is not just a matter of availability, distribution or access. There are also critical questions about how good the training on offer is and how well it enables staff to use their skills. Theoretical or academic courses cannot always give staff the opportunities they need to gain and retain practical competencies.

Getting the balance of education and training right is an essential element in producing a workforce motivated and able to deliver high quality and responsive health care within reformed health sectors. Getting it right though can be a double-edged sword as the more skilled workers become the more likely it is that they will be targeted for recruitment by West European employers. There is a danger implicit in raising skill and qualification levels at a time when the governments of CEE and CIS are unable to provide staff with pay and conditions, which compete with those in the West. The danger is that the investment involved will simply equip staff to move away and so will ultimately benefit richer health care systems. The following recommendations are intended to address some of the challenges of achieving skill reproduction security, despite these possible (negative) consequences of success.

International agencies and bilateral assistance programmes should:

### **Skill Reproduction Security**

- make a clear commitment to training for all occupational groups;
- prioritize (in their work with national governments) initiatives which address the training needs of staff other than doctors and nurses;
- advocate for national governments to secure formal trade union and association involvement in training design and delivery and insist that unions and associations are partners in any sponsored or joint training initiatives;
- lobby EU institutions to establish a levy to be paid by Western European institutions recruiting CEE or CIS trained staff, with the levy to be paid into a training and development fund in the country of origin of the recruit;
- support a survey of skills training provided to all occupational groups on a country-by-country basis with a view to identifying the provision for staff other than doctors and nurses and highlighting any regional or gender inequities; and
- sponsor a qualitative study of the impact of different training models/styles on working practices; drawing out obstacles that inhibit the application of lessons learned and factors that facilitate uptake; and generating case studies and guidelines on training design.

Governments should:

- formulate an explicit partnership agreement with national trade unions and associations to design, monitor and deliver training systems and for the development and implementation of all the recommendations below;
- provide guidelines and regulation to ensure that the standard-setting and accreditation functions of professional associations do not compromise, or are not compromised by, their role as advocates for sectional interests;
- regulate private sector medical and nursing schools appropriately and ensure that the production of staff by the private sector is factored into national human resource planning initiatives;
- establish quality criteria for training and a register of recognized training activities and/or providers for the full range of occupations in health;
- institute a certification or accreditation process for all health care institutions that includes explicit targets for the training of all staff i.e. all occupational groups, with the training to meet agreed quality criteria;
- ensure that all government and insurance bodies (where they exist) only deal or contract with institutions that meet the accreditation criteria with respect to training provision for all staff;
- legislate to ensure employers, whether they are private or public sector or from parallel health systems, are obliged either to provide training that

### **Skill Reproduction Security**

meets agreed quality criteria directly or to cover the cost of equivalent training;

- work with insurance bodies (where they exist) to address the training needs of staff in the social health insurance system and develop appropriate training, quality criteria etc.;
- monitor equity of access to training including between occupations, across regions/provinces, and in gender terms; and
- review training provision in light of the impact it has on working practices on the “shop floor”.

Trade unions, and where appropriate associations, should

- play a full part in the design and accreditation of training, exploring with government ways of ensuring that unions are represented in standard-setting;
- advocate on behalf of ancillary staff to ensure their training needs are addressed;
- ensure priority is given to training and retraining staff with obsolete skills;
- seek guarantees on access to training for staff in rural areas;
- monitor training uptake by gender and so the equity of access to new skills and higher paying areas of specialization;
- push for training of those staff with responsibility for managing change;
- track any charges levied for training and lobby to secure free provision and to ensure employers or governments cover the full costs of staff participation;
- measure the uptake and applicability of training and the extent to which members are able to apply lessons learned; and
- consider positioning themselves to take on the role of training provider, perhaps working in partnership with academic institutions or professional associations.

## WORK SECURITY <sup>25</sup>:

7

### Conclusions and Policy Recommendations

The well being of health sector staff in the workplace depends on the physical conditions in which they work, their exposure to risk or violence, their hours, psycho-social stressors, as well as income, employment, skills and voice security. The pre-transition economies may not have prioritized the treatment of workers in health (since they were regarded as non-productive) but they were without exception ideologically committed to proper treatment of workers and to good practice in health and safety even if in practice this commitment did not always lead to ideal conditions. Since transition however, it seems that fewer workers are injured at work, fewer fall ill as a result of work related diseases and fewer are absent on any given day. All these might be interpreted as indicators that work security has improved in the last dozen years. In reality though the picture is far more complex.

Here, too, there is a clear divergence between the security “enjoyed” by staff on paper and the reality they experience. Officially, the incidence of injuries at work and work-related diseases are in decline throughout the region and falling absenteeism seems to bear out the “improvement”. Formal provision of disability and invalidity benefits (and to some extent pensions) seems generally to be standing up well over time. The reality is, however, that many staff are just too insecure to take leave of absence, whether they are ill or owed annual leave. They work long hours and face enormous stress, not merely due to the normal strains of working in the health sector, but also because they do not earn enough to feel secure and are afraid of losing their jobs. What appears to be a decline in work-related injuries and illnesses is merely a hidden reporting factor, in part due to staff not having time even to report work-induced injuries/illnesses, and in part due to weakened union structures which often lack staff and financial resources needed to maintain a proper reporting mechanism. Moreover, many live with the expectation that things are going to get worse rather than better.<sup>26</sup>

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25 The IFP-SES defines Work Security as protection against accidents and illness at work, through safety and health regulations, limits on working time, unsociable hours, night work for women, etc.

26 Over 60 per cent of Romanian and Lithuanian respondents expected future restructuring might further erode their working conditions, while 69 per cent of Lithuanian, and between 30 and 40 per cent of Czech, Romanian and Ukrainian respondents felt that future government plans would make their situation worse (ILO, 2001).

## Work Security

Some of this insecurity is associated with the deteriorating physical environment in which many workers operate, the result of a lack of investment in health sector infrastructure. Some stems from the re-emergence of infectious diseases, including tuberculosis, hepatitis and HIV/AIDs, which increases workload, brings staff into contact with stressful situations and exposes them to risk. There is also insecurity as a result of more general economic challenges that undermine benefit levels. However, the threats to work security that affect workers are not primarily about money. They are about the break down of regulation in practice. Responsibilities have been decentralized to local government and to institutions faster than it has proved possible to create appropriate administrative structures or to train officials to maintain proper oversight. The authority of trade unions to insist that health and safety legislation is implemented has been compromised and there is no evidence that governments themselves prioritize the enforcement of safe work practices.

The poorly functioning regulatory framework translates into health sector staff working under extremely difficult conditions, and sometimes with the threat of violence. The policy-making debate however, is rarely about how to improve the basic infrastructure or enhance government supervision. Instead physicians lobby for the purchase of highly sophisticated equipment, supported by West European manufacturers while international pressures are brought to bear for deregulation and the withdrawal of government. Neither of these strategies is designed to (or can) address the vulnerability of staff. The following recommendations seek to provide a counterbalance to these pressures and to enhance work security.

International agencies and bilateral assistance programmes should:

- recognize explicitly the role of government regulation in guaranteeing work security;
- address the underdevelopment of rural health services and promote strategies for investment in basic rural infrastructures;
- promote a review of infrastructure and conditions in parallel health services;
- insist, through conditions attached to loans and donations, that investment in infrastructure development meets basic needs and is aimed at providing appropriate technologies and not in high-technology gadgetry;
- encourage the routine involvement of trade unions and professional associations in developing, monitoring and enforcing health and safety legislation;
- support research into the underreporting of injuries and disease; and
- sponsor a review of the operation and enforcement of labour codes in Western and Eastern Europe to identify what protection is provided and evaluate the approaches in place.



### Work Security

Governments should be encouraged to:

- invest in the basic infrastructure of rural health services;
- restate or reinforce health and safety legislation providing for a formal role for trade unions in health and safety committees;
- insist on routine health and safety inspections and include within the remit of the inspectors responsibility for monitoring trade union involvement;
- devolve to the health and safety inspectorate the right to collect fines for non-compliance with legislation and provide an appropriate framework for enforcement;
- put in place legislation which would protect “whistleblowers” and secure the rights of workers drawing attention to breaches in health and safety policy;
- put in place mechanisms, involving trade unions, for the monitoring and recording of workplace injuries, stress related diseases and physical and psychological violence;
- formally devolve responsibility for training for all new entrants in healthy working practices to the level of the institution;
- promote workplace based measures to reduce stress and violence and to support staff experiencing them;
- provide all appropriate vaccination for staff likely to be exposed to blood products: and
- review and enhance benefit levels.

Trade unions should:

- encourage workplace representatives to compile a record of all injuries and accidents, indicating which if any were formally acknowledged;
- support “whistleblowers” calling attention to health and safety failures;
- establish mechanisms at the branch level to monitor the infringement of entitlements to leave (for holidays and during illness);
- survey members to better understand the extent and causes of presenteeism;
- insist on representation on health and safety committees and in the formal certification of compliance with legislation;
- develop and deliver training in health and safety for local staff, including in understanding and applying legislation and monitoring and recording breaches of regulations;
- consult across the region and with international counterparts to identify the most appropriate preventive measures and range of vaccinations to be provided to staff and promote best practice in terms of health protection;

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- lobby government and employers to recognize the ILO definition of violence and to incorporate the reduction or elimination of violence in the health sector into health and safety policy and organizational development plans;
- campaign at a national and local level to create an awareness of the issues surrounding violence, to foster a culture which rejects physical and psychological abuse, and to establish organizational, environmental and individual-based interventions to identify and remedy it when it occurs; and
- protest all occasions where employers put the purchase of high technology before securing basic safety.

## Conclusions and Policy Recommendations

It is possible to argue that trade unions of the communist era gave workers a collective voice and played a significant role in shaping employment policy, or to insist that unions were wholly compromised by the state and had no power independent of it. Whichever view prevails, there can be no argument but that trade unions since transition have faced a series of powerful challenges. The move to the “market” transformed their role as formal partners in social dialogue and ended their automatic economic and political incorporation into the state. The reform of health sectors across the region radically changed the environment in which they operated. The certainties of a highly structured, central planning process with clear human resource norms and incremental approaches to change have given way to fragmentation, inconsistency and, on occasion, chaos. Even within the union sector there have been huge upheavals with a dramatic decline in membership in many countries and in union income, the emergence of new unions and the burgeoning of professional associations pursuing the demands of particular occupational groups.<sup>28</sup>

Trade union membership has fallen, and many workers have left their unions. Voice representation security as a whole has been adversely affected, particularly in the face of decentralization, the introduction of insurance mechanisms and privatization. Some international agencies have been hostile to tripartite approaches to restructuring and concludes that while the trade union movement is sorely needed there are no guarantees that it will be able to play a part in shaping health systems so that they address workers’ well being and patients’ health as well as efficient service delivery.

Two things are eminently clear. First, trade unions have lost ground over the last decade. Second, they are needed more than ever. The conditions health sector workers face can only be addressed by collective voice but in many respects unions are caught in a cleft stick. They need to maintain high membership levels if they are to be able to claim legitimately that they represent health service workers and in order to be recognized as the leading partners for social dialogue. However, health sector staff are discouraged from continuing in

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27 The IFP-SES defines Voice Representation Security as 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.

28 It is still too early to identify a pattern of development as regards employers’ associations and so their contribution to voice representation security is only touched on briefly.

### **Voice Representation Security**

membership because unions have been overlooked by government and decentralized layers of health services management and have played little part in formulating health sector reforms. Workers are increasingly faced with the proposition of ever increasing amounts of their pay (bonuses and incentive schemes) being determined exclusively by management and insurance companies and without reference to their union representatives.

It has also been difficult for unions to demonstrate their effectiveness because of the scale of the upheaval that has affected health systems. Levels of pay, the investment in infrastructure that determines working conditions, the availability of training, even changing contract types have all been beyond the locus of control of Ministries of Health, let alone health unions. Furthermore Ministries have often withdrawn from their role as employer before any effective “replacement” has emerged. Employers are poorly defined and poorly organized and unions have had few effective counterparts. They cannot, therefore, be deemed to have failed because they could not deliver the impossible.

The position has not been helped by the legacy of distrust that some unions inherited from the pre-transition period, when they could be viewed as too close to central government and the communist party. Nor has the growth of professional associations reinforced a collective voice; rather they have undermined it. It is, of course, legitimate for professions to organize independently and secure their own representation, and many members of associations continue to belong to unions. Nonetheless, the breach in the solidarity between professionals and unskilled staff that existed in the era of single, general unions is to be regretted.

The negativity of some international agencies and donors has helped to exclude unions from playing a part in developing plans for reform, and even has ensured that they were seen to be excluded. This will jeopardize the reforms themselves, which will be formulated without the benefit of union participation and “buy-in”, and without drawing on the wealth of experience and understanding that health care system workers could contribute. It will also further undermine the credibility of unions. Certain donors may not like unions but if they succeed in undermining their viability they risk utterly destroying voice representation and the overall sustainability of the reforms. This would not only have adverse implications for a whole range of elements of socio-economic security (employment, work, income etc.) but would also be profoundly negative in and of itself, unless of course the international community would regard it as acceptable that the health workforce of Eastern Europe were denied a collective voice.

Public Services International has suggested trade unions “as workers’ representatives must demand to be treated as genuine social partners in all major social-economic planning and decision making. Full social dialogue. Nothing less. If these principles are respected by the government, then trade unions can

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consider any proposition because they will be able to negotiate in an atmosphere of genuine social partnership”.<sup>29</sup>

This captures the need to place unions at the heart of efforts to shape health systems so that they provide the best possible care for patients and look after the well being of their staff. Although there can be no guarantees that unions will be allowed this role, the following recommendations outline some possible steps towards achieving the vision touched on by PSI.

International agencies and bilateral assistance programmes should:

- review their thinking on the importance of social dialogue;
- make a formal commitment to fostering and working within tripartite structures that wholeheartedly include trade unions;
- advocate for governments to make a corresponding commitment;
- encourage national unions to review the situation analyses and country reports that provide the basis for developing aid and loan agreements;
- invite national unions to comment on aid and loan agreements before signature (incorporating their feedback into revised proposals);
- support research into levels of unionization and de-unionization in the private sector, and in parallel health systems and into social dialogue;
- sponsor a review of the impact of trade union support on the implementation of policy recommendations; and
- provide the resources for and facilitate the training of managers and union representatives in social dialogue.

Governments should:

- establish tripartite structures that include trade unions and all other relevant social partners, and ensure the involvement of all levels and branches of government and health service management;
- lobby extensively to build genuine acceptance of the social dialogue approach;
- develop specific and appropriate priorities for the tripartite structures to address and monitor progress against agreed agendas;
- pass legislation enshrining the right to union membership and for unions to be recognized by employers, with special reference to the private sector, to parallel health services and to small establishments like general or dental practices;
- work with unions and professional associations to identify mechanisms which will ensure full representation for an increasingly disaggregated workforce;

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<sup>29</sup> PSI Policy Statement on Social Dialogue, quoted in ILO (2002a).

### **Voice Representation Security**

- re-assert the role of collective bargaining, confirming the statutory role of unions in national and sub-national negotiations and as the partner of government;
- clarify the jurisdictions of different levels of management, particularly in terms of collective bargaining;
- balance the role of professional associations (in standard setting, training and negotiations on remuneration and bonuses) with proper consultation with unions and mandate insurance bodies to do likewise; and
- maintain and strengthen existing bipartite structures at enterprise level to ensure full consultation on the details of specific issues relating to work, job, employment and skill reproduction security.

Trade unions should:

- ensure that they reach out to all staff and in all employment settings, including in small decentralized units, private and single-handed practices and in the parallel health services;
- review internal structures and processes and adapt them as necessary to facilitate the involvement of staff employed in the private sector and in small employment units;
- identify and mobilize staff whose careers are under threat from modernization either of institutional or career structures, lobbying to ensure they are re-trained and otherwise properly supported in making a transition to a new employment setting;
- seek to motivate and encourage health service workers to join and take an active part in trade union activities, making particular efforts to adapt internal processes and structures so that they empower women and to incorporate their concerns and priorities into bargaining strategies;
- identify and link up with Western European unions who have effectively tackled falling membership to identify strategies that will ensure their relevance to workers and attract new and active members;
- liaise with international organizations, academia and non-governmental organizations (particularly where they are committed to securing access to health care services for populations) to secure the skilled and expert inputs needed to respond to proposed reforms and suggested structural changes;
- demand clarity about the level at which collective bargaining will be carried out and insist on binding agreements;
- establish links with health insurance bodies and other third party payers insisting on equal rights to associations in all negotiations and convincing associations to hold joint negotiations;
- champion social dialogue across the health sector; and
- comment actively on loans and demand a role in the negotiation of aid and loan packages.

## INCOME SECURITY <sup>30</sup>:

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### Conclusions and Policy Recommendations

Health service staff are poorly paid in much of Europe and health workers in the CEE and CIS are no exception. They express an overwhelming dissatisfaction with salary levels and although dissatisfaction on the part of staff does not prove that pay levels are inadequate, the evidence of genuine income insecurity and hardship is utterly compelling. Low pay in the sector is a long-standing feature and reflects the value attached to health service work before transition<sup>31</sup> as well as the collapse in the value of public expenditures over the past decade. It is also testament to the fact that policy-makers and international financial institutions still will not prioritize health care systems. There is little evidence that the position is improving markedly or equitably, even though many of the region's economies have been growing over recent years.<sup>32</sup> (Although doctors in one or two countries like the Czech Republic or Poland have secured significant increases, most occupations have not).

This section examines health sector pay and the paucity of formal income levels, which may encourage staff to seek work in Western Europe. It touches on the problems of payment in arrears, and the inadequacy of benefits and pensions. It reflects on the fact that the monetization of in-kind benefits has made staff ever more vulnerable to under-investment in the health sector and reviews further evidence of insecurity, provided by data on overtime worked and the numbers of staff holding second jobs. It also discusses the importance of informal gratitude or under-the-table payments. It concludes that the reforms that health systems have undergone have exacerbated rather than resolved problems of income security not least because they have focused on ways of manipulating performance, redefining workers' roles and cutting costs rather than looking at the people who work in health. It suggests that the focus on controlling outputs and on the payment of doctors as a key lever for achieving this control has

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30 The IFP/SES defines Income Security as protection of income through minimum wage, wage indexation, comprehensive social security, progressive taxation, etc.

31 Health sector pay was traditionally low because working in health was considered "unproductive" and was therefore less well remunerated than "productive" work such as manufacturing. The fact that the majority of the workforce was (and still is) female both reflects this and compounds the situation.

32 The fact that there are so many women in the health workforce has not helped prompt a readjustment.

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disadvantaged the majority of health sector staff, and ultimately the users of health care services.

Pay in the health sector is low and staffs routinely works additional hours and additional jobs simply to earn enough to survive. It is not just the fact that pay is so poor, which causes income insecurity. It is rather a combination of circumstances. First, most staff experience or feel that they are experiencing falling real wages. Second, there are growing differences in levels of pay between different occupations in different places; and third, many staff is paid late. They have also lost in-kind benefits, which have made them more vulnerable to inflation in the cash economy, while there is no comprehensive social security system for them to fall back on.

The evidence on income security gives little cause for optimism. The policy debate gives even less. It is dominated by concern for the various dimensions of health system performance and by Western European assumptions about the role of physicians, the levers for changing professional behaviour and what motivates staff. It is hard to see why a combination of payment mechanisms designed to placate English general practitioners opposed to the national health service in 1948 should provide a gold standard for organizing family medicine in Eastern Europe, or why the fee-for-service approach that has seen German health care costs spiral should act as a model for paying doctors in Central Asia. Most worryingly there is an assumption that doctors need to be given performance related payments if they are to do their best for their patients but that nurses, cleaners and auxiliaries can continue to labour for sub-standard public sector salaries with little prospect of any significant improvement.

If health system reforms are to maximize the “public good” achieved for the resources invested and if they are to encourage patient centred and responsive services they must address the needs of all the occupational groups in the sector. It is not “wrong” to adapt payment mechanisms or to introduce incentives, and too much security may foster complacency (albeit that health sector workers are a long way from this point), but unless some basic guarantees are provided then staff cannot be expected to function adequately. This means ensuring that all staff can have union representation in negotiating pay, in order to maintain some national standards for all employees. The ambivalence, even often contempt, towards trade unions displayed by some of the international agencies supporting salary structure reforms indicates that this may be a forlorn hope. However, if the health system cannot provide at least a certain level of income relative to other sectors of the economy; if it cannot sustain that income over time and in the face of inflation; and if it cannot create incentives that include all staff then the problematic and widespread custom of under-the-table payments will continue. This is undesirable from an employment perspective because it is unreliable and because it creates inappropriate inequalities between staff. (Those who have more contact with patients or more power will “earn” more than those who carry out support functions or are unassuming). It is even



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more undesirable from a health policy perspective since it challenges fundamentally the equal right of all patients to health care. Furthermore, if the health sector cannot address income security it is liable to see increasing numbers of trained staff take their skills and their experience and apply them in the health services of Western Europe. The following recommendations attempt to map steps that could strengthen income security and, by improving conditions for staff, improve the chances that health system objectives would be achieved.

International agencies and bilateral assistance programmes should:

- invest in programmes to support the development of civil society and to encourage compliance with tax and insurance regimes so that the countries of CEE and CIS are able to maintain adequate funding for public services;
- advocate a minimum percentage of GDP be devoted to public health expenditures;
- link investment funds to guarantees of basic payments to staff;
- recommend the formal involvement of trade unions in national pay negotiations;
- promote the indexing of the minimum wage to the average national wage;
- encourage national governments to limit differentials between occupational groups;
- sponsor a meeting to pull together all research on under-the-table payments to better understand the scale of the informal economy in health; and
- support a review of the evidence on the efficiency of performance-related pay in health.

Governments where possible should:

- commit themselves to working in partnership with unions on income, staffing and migration related issues to develop national strategies to provide income security;
- revise the minimum wage, linking it to national average earnings;
- review average pay across the health sector in light of national average earnings and realign wages accordingly;
- make a firm commitment to occupational pensions provided by the state within the health sector;
- examine differentials between occupational groups and between staff in different regions and sectors and in parallel health systems and review changing pay patterns from a gender perspective;
- scrutinize mixed-payment formulae in light of their impact on income security and the evidence on the efficiency of performance related pay;

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- establish some links between the level of pay of doctors and that of auxiliary staff to ensure progression in pay across the whole health care system;
- legislate to protect the pay of staff in the private sector and in independent provider units and to outlaw late pay in any setting; and
- improve the remuneration of health sector staff, so workers are paid a decent wage on time and provided with appropriate benefits and entitlements, in order to enhance the prestige of staff and avoid under-the-table payments.

### **Trade unions should**

- pursue through collective bargaining the best possible levels of income for staff in all occupations and in all areas;
- put pressure on the governments that have ratified ILO conventions on pay and late payments to honour the terms of those commitments;
- advocate for nationally negotiated pay frameworks that will protect staff in poorer regions and in smaller institutions and ensure pay equity;
- promote the pay claims of auxiliary staff, occupations that do not directly influence health system expenditure and those that have no direct contact with patients to ensure no group becomes marginalized or particularly insecure;
- seek to ensure that the staff in national and local health authorities with responsibilities for introducing and implementing change are included in efforts to secure decent wages and working conditions;
- monitor the pay of support staff employed by single-handed or small group practices to establish whether there is divergence from national norms;
- examine pay in the private sector and its trends relative to public sector pay;
- track differentials between occupational groups with particular reference to the pay of auxiliary or relatively unskilled staff and to ensure that any inequities based on gender are highlighted and corrected;
- negotiate with government and employers to address pensions and to resist attempts to pass responsibility for pension provision to the individual; and
- develop a communication package to allow local officials to review with members the implications of under-the-table payments for income security.

## CONCLUDING REMARKS

# 10

The upheaval in the economies of CEE and CIS during transition has been catastrophic for workers. Price liberalization preceded restructuring and contributed to hyperinflation. Production faltered, GDP values collapsed, and there was a breakdown in the collection of public revenues and taxes. Reforms destroyed much of the work-benefit regime that had guaranteed a basic level of socio-economic security for the majority of eastern Europeans. Rising unemployment, including long-term and hidden unemployment appeared for the first time in decades, yet governments singularly failed to establish the kind of comprehensive benefits systems that could have adequately protected their populations. Instead public spending was cut back, often under pressure from international agencies like the IMF and World Bank, while the informal dimension of economies burgeoned and peoples' lives become increasingly precarious.

Health workers across the region have suffered at the same time as the rest of society, although the problems they face are not identical. The nature of health and health care ensure two things, a demand for services whatever the economics of transition, and that governments and international agencies will be under pressure to see that some basic provision continues to function. Certainly the scale of job cuts and the ensuing unemployment has been markedly lower in health than in some other sectors, despite the clamour from expert advisers for action on what was portrayed as significant overstaffing. Large-scale job losses may not have materialised but labour market security has been severely compromised nevertheless. It has been diminished by the anxiety generated by the talk of cuts and by the reforms taking place, most of which the workforce believe will jeopardize jobs. Decentralization, privatization and the restructuring of primary care all involve variations on the same theme, the passing of employment contracts from the state to individual employers. Hospitals, polyclinics, dentist, diagnostic and general practices have begun to hire (and fire) staff directly, fragmenting employment, concentrating considerable power in the hands of a few senior (typically medical and often male) managers and making it more difficult for trade unions to organize and to represent workers effectively. Pressures to "modernize" and to harmonize with EU standards threaten job security. Nurses are expected to expand their roles. Whole sub-specialities are being closed down. Workers fear the future and have become less secure as a result.

They have also been beset by other material concerns. Work security has been undermined by a lack of investment in facilities and by the weakening of health and safety structures. Staff are scared to take time off work in case they lose their jobs and because they cannot afford the loss of earnings. Skill reproduction security has been undermined by the introduction of charges for

### Concluding Remarks

training in some countries, and by the shifting of indirect costs to trainees in others. (Staff are expected to take unpaid leave to attend courses, pay for books and so on). Pay, which was never particularly high, has dropped further compared to national averages, and although doctors in some countries have won significant increases, most staff feel less able to manage and increasingly they resort to second jobs or to accepting under-the-table payments, which cannot by their nature provide real income security. Throughout this the trade union movement, which had helped to enforce safety regulations, secure access to training and protect pay, lost ground. Antipathy from neo-liberal governments, the IMF and World Bank and discouragement on the part of members eroded voice representation.

The most obvious conclusion of any analysis of the seven dimensions of health workers' security is that transition has made health sector staff significantly less secure. Reviewing their experience in the light of that of other workers does not challenge this even though there are certain features of health systems, like a guaranteed demand for their services, which have tended to protect staff a little from the changes taking place. It also seems that despite extensive upheavals and numerous reforms and reorganizations, there is a sense in which staff have managed to struggle on and to preserve much of what went before, albeit at considerable personal cost.

The reforms of health care are far from complete. It remains to be seen what the impact of further change will be on staff, or how the accession process will impinge on them. It is clear however that building a number of straightforward steps into the reform process will afford health sector workers far better protection than they have now and allow them to concentrate on improving health services performance free of the stresses and fear of job losses they experience now. These measures would reduce the likelihood of future health systems reforms being at the expense of health workers' security.

First, health policy-makers, international agencies and health care reform experts need to wake up to the implications for staff of reforming health systems. Protestations that staff and their motivation are central to the success of reforms are commonplace yet health system literature is just not adequate in the way it thinks about workers. It is exceptionally rare to find any full consideration of the impact on staff of proposed changes. Assertions that staffing levels are too high are not accompanied by attempts to measure the cost of alternative (perhaps more capital intensive) models of provision or of adding to unemployment. Neo-liberal prescriptions about minimizing government regulation do not factor in the consequences of reducing health and safety standards in a hospital setting. Plans to change contract types and payment mechanisms (to facilitate efficiency and responsiveness) seem to ignore the evidence that insecurity undermines trust in the work place, which in turn affects performance and the service, that patients receive. If quality of care is to be an important outcome of health care

### Concluding Remarks

reforms, then reformers need to give real consideration to how the people who provide that care are treated.

Second, planners and health economists need to go beyond their current focus on doctors and pay more attention to other occupational groups. It is no doubt true that physicians are the main drivers of expenditure in the health sector and account for all spending relating to admissions, tests and so on but doctors alone do not account for the quality of care. Training ought to address more than the shift towards family or general practice. It might, for example, develop nurses' ability to care for the elderly or the mentally ill, equip administrators with the financial management skills demanded by the changes in health sector funding or better prepare health authority staff with responsibility for managing change. By the same token, efforts to adjust job boundaries should not be premised on the idea that nurses can substitute for doctors on occasion and chiefly as a cost saving measure. Instead the possibilities of expanding the roles of a range of staff should be explored, provided of course that they are compensated for additional responsibilities. It is particularly important that the "consideration" of all occupational groups extends to pay negotiations and includes gender equity. Doctors now often have (relatively powerful) physicians' associations representing them, with direct access to third-party payers and a role in accreditation. They are also best placed to generate additional income, through private practice. If policy-makers prioritize doctors' demands over all others they run the risk of creating a health system staffed by poorly paid, poorly motivated workers who service their well rewarded medical colleagues and their patients without the desired "responsiveness" or "humanity of care".

Third, the people and organizations that make decisions about health systems need to reconsider the role of trade unions. Even though they continue to work for members' interests in difficult circumstances and with some real successes, there is no question that unions have lost some ground in terms of membership and influence. Physicians' associations have, in many countries, supplanted them in representing the sectional interests of doctors and in addressing certain issues around professional standards and insurance/reimbursement. Many governments have moved away from meaningful tripartite and social dialogue approaches. Even those agencies that recognize the importance of engaging workers' representatives are failing to include them in a strategic way. An informal survey of international health experts (so informal as not be included in the substantive analysis of this Monograph) confirmed that unions just do not figure in the thinking of many of the professionals who advise Ministries of Health. The most common response to the question "are unions present in discussions of national reforms" was (to paraphrase rather wildly), "oh we had not thought of that". Nor could anyone give an example of general unions playing a part in training, although they did report that nursing and physicians' associations and academia were all actively

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involved. There was real sympathy for the notion that unions should be part of strategic planning at the very highest level. Clearly, unions should play a crucial role in guaranteeing voice representation for a whole range of staff. They also ought to be contributing, as of course many still are, in terms of pay bargaining, regulating health and safety, testing new legislation and rethinking demarcation issues. National governments and international agencies need therefore to re-examine how they facilitate this. They need to signal who unions are to negotiate with and how these processes are to work, particularly as central government withdraws from its role as employer and in the absence of established employers' associations.<sup>33</sup> They also need to review how they engage with trade unions as full partners in social dialogue so that workers' representation becomes part and parcel of the way health care reforms are designed, implemented and evaluated and so that the health system can benefit from "the close interrelation between social dialogue, decent work and quality health services" (ILO, 2002b).

Fourth, more consideration should be given to the implications of European enlargement for health sector staff. A dozen CEE countries joined the European Union in the past couple of years and the experience of Austrian, Finnish and Swedish accession provides very few clues as to the likely impacts of this enlargement. EU standards and training curricula have been adopted and specialties have been restructured to meet EU norms, often without consultation with the staff affected or enough consideration of the traditions that informed national approaches. Ministries of Health and international agencies are already endeavouring to assess the planning of human resources and how the movement of staff and patients is likely to affect numbers entering training and the numbers who will migrate. The problems of modulating the production of staff, supply and demand when unknown numbers will migrate westwards, and the possibility that CEE and CIS countries will end up subsidising the staff training costs of Western Europe are issues on policymakers' agendas. They must also consider how the change will affect existing staff and the implications for their future careers. This is particularly important if, as is likely, younger staff, trained to new standards and criteria are targeted for recruitment by richer EU Member States, leaving "behind" an experienced workforce but one with a relatively narrow skill and age profile.

Fifth, more research is needed to understand what is actually happening to workers. It is already clear from the ILO/PSI survey and from informal responses to questions posed to PSI affiliates that there is a vast gap between what workers are entitled to on paper and what happens in practice. It seems that many staff routinely work overtime without pay because of a mixture of

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33 For practical guidance for policymakers implementing public service and health sector reforms see WHO (2002a).

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coercion and conviction. Some feel that they cannot say no to employers or to double shifts, others cover for colleagues who are ill, most are motivated by “altruism”, “vocation” or “responsibility” and work additional, unpaid hours rather than leave patients without adequate support. Their extra shifts do not appear in hospital statistics. The almost region wide fall in absenteeism is another area where official figures do not capture the reality. Some of the drop can be attributed to changes in custom and practice. (Before transition, it was normal for staff in some countries to “use up” their sick leave entitlement, but this has changed as employment insecurity has increased.) Some is due to the new phenomenon of “presenteeism”. (Sick pay is so much lower than the daily wage and workers are so afraid of losing their jobs that staff who are sick still go to work.) Again the data do not uncover what is actually happening. There are also glaring gaps in knowledge, which can only be addressed by further research. The parallel health services are a case in point. It is unclear how many health workers are employed by other Ministries or by enterprises, how they are represented and what the implications of further health sector reform will be for them. Similarly, not enough is known about gender and security; the contracting out of services; or health care workers in rural areas; or the role of under-the-table payments in household income; or of the extent to which the minimum wage levels impact on health sector pay; or exactly why reports of accidents and injuries have fallen so steeply. Research is needed if policy-making is going to become increasingly evidence-based and reflect the real stresses that workers face. There is also evidence and analysis from other European countries, and other regions, that could usefully be made available to CEE and CIS policy-makers, and which would allow them to incorporate an understanding of the consequences of decisions tested elsewhere into their own policy formulation.

Finally, the health systems literature suggests that any one of a number of models of tax-based or social health insurance funding can provide reasonably equitable health care coverage and that it is legitimate for countries to choose between them depending on context and preference. It also suggests that shifting from one model to another cannot succeed in the face of immense resource scarcity and wholesale economic disruption. The evidence from the region bears this out. It is clear that many of the health system reforms of the last 12 years have created enormous socio-economic insecurity. This was absolutely not their intention nor was it a direct consequence (in most cases) of the reform model chosen. It was rather that governments engaged in root and branch reorganization of health care when there were neither the resources nor the technical wherewithal to accomplish the reforms necessary. This is not to argue that health systems could have remained untouched by the changes of transition. It is however to suggest that the scale of reforms undertaken and the ideological commitment to change for change sake were ill advised. The reforms that perhaps ‘should not have been attempted’ have clearly, if inadvertently damaged the people who work in the health sector. It is important therefore that

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governments and their advisers learn the lessons of a decade of transition and carry out the analysis that is needed to ensure that future reforms are feasible, manageable and sustainable and are not achieved at the expense of workers' security.

Health, unlike other "commodities" is permanently in demand. The health services of CEE and CIS will always employ huge numbers of staff even though the exact size of the sector may vary. If they are not to create a vast, permanent working poor or to perpetuate insecure employment then policy-makers must create an opportunity to address the needs of health workers. Talking to them and to their representatives would not be a bad starting point.

The following recommendations are intended to identify areas for action that cut across the seven dimensions of socio-economic security and address some of the challenges facing health sector staff in the round. They are intended not for any one group but to suggest areas where all health sector stakeholders can work together to create health services that promote the health and well being of staff and users alike.

International agencies and bilateral assistance programmes, governments, trade unions and associations should:

- explicitly recognize that the sheer scale of the health sector as an employer gives it very real macro-economic significance and reflect this in their approach to the sector;
- state clearly and unequivocally that the treatment of health sector workers, their socio-economic security, in all its dimensions, and their well being are important in and of themselves and because they have a direct impact on the health sector's ability to deliver high quality, efficient and responsive care;
- agree that social dialogue and the inclusion of trade unions and associations, local health authorities, government, third-party payers and employers as full partners in discussions at all appropriate planning and decision-making levels (together with appropriate involvement of user-organizations and other stakeholders) is central to the strategic development of the health care system nationally and locally (ILO, 2002b);
- review the employment impact of all proposed reforms as they are developed and implemented, including any suggested changes in contract type;
- develop and communicate clearly a 'road map' of reforms so that workers can get a sense of the scale of the intended change and their place in it;
- address national and local investment priorities so that adequate infrastructure and health and safety are guaranteed before high technology is acquired and so that male and female workers benefit from the investments made;
- include the staff of parallel health services and those working in decentralized settings, small or independent practices and the private



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sector in all policy deliberations, ensuring that equity and their socio-economic security are considered fully;

- establish a national framework for pay and conditions that protects against undue regional inequality or inappropriate or gender based differentials, and allows for the review of any proposed changes in payment formula in light of their impact on income security and equity;
- endeavour to secure adequate pay, pensions and benefits (and payment on time), for all occupational groups in all health service settings and with the opportunity to increase wages appropriately over time, including lobbying to secure a sufficient share of GDP for health to achieve this;
- engage in joint action to address the problems in collecting taxes and insurance contributions and the practice of under-the-table payments, which diminish the funds available to pay for the health sector;
- work to agree a legislative framework which will enshrine the existing protection that workers have and extend that protection to include the entitlement to belong to a trade union, to be consulted about job changes and to have all rights protected in the event that their employment contract is transferred to another employer (whether that be a decentralized public sector body or a private sector contractor);
- provide effective (useable) training and retraining without charge (direct or indirect) for all staff including managers and most particularly for those whose jobs are affected by changing standards, ensuring that they are fully consulted and that retraining allows them to take on new roles and functions and pursue alternative development paths, consistent with the reforms;
- ensure that the institutions are accredited, that accreditation includes reference to training provision, health and safety and the approach to staff socio-economic security and that all social partners, including trade unions, are involved in the accreditation process;
- monitor the consequences of EU enlargement, not only in terms of the movement of staff and the loss of qualified and dynamic personnel, but also as it affects planning of staff production, job boundaries, the disappearance of culturally appropriate specialities, and the morale of remaining staff;
- investigate the experience of health systems staff addressing late pay, administrative leave, reliance on under-the-table benefits, absenteeism, health and safety, violence and gender issues and disseminate data and case-studies that serve to illuminate the insecurity of staff; and
- create networks and channels of communication between partners for social dialogue, including between trade unions and association, and with international counterparts to promote the sharing of views, better understanding of concepts and terminology, training and the transfer of experience and learning between actors, regions and countries.

## REFERENCES<sup>34</sup>

- Afford C. 2001. *Failing health systems: Failing health care workers in Eastern Europe* (Geneva, ILO).
- Brusati, L. *et al.* 2002. "Health care systems in transition: Belarus", in *European Observatory on Health Care Systems* (Copenhagen, in press).
- Busse R. *et al.* 2000. "Health care systems in transition: Czech Republic", *European Observatory on Health Care Systems* (Copenhagen).
- Cerniauskas, G. *et al.* 2000. "Health care systems in transition: Lithuania", in *European Observatory on Health Care Systems* (Copenhagen).
- Chenet, L. *et al.* 1996. "Changing life expectancy in Central Europe: Is There a Single Reason?," in *Journal of Public Health Medicine*, p. 18.
- Chetvernina *et al.* 1997. "Establishment of a system of unemployment insurance in Russia" in G. Standing *The Folly of Social Safety Nets: Why Basic Income is Needed in Eastern Europe*, p. 8.
- Contandriopoulos A.P. *et al.* 1990. "Systèmes de soins et modalités de rémunération. Sociologie du travail 1", in R. Saltman and J. Figueras *European Health Care Reform, Analysis of Current Strategies* (Copenhagen, WHO Regional Publications, European Series), No. 72.
- Department of Statistics of Lithuania. 1999. *Demographic Yearbook, 1998* (Vilnius).
- Domagala, A *et al.* 2000. *Public Service Reforms and Their Impact on Health Sector Personnel: Case Studies on Cameroon, Colombia, Jordan, Philippines, Poland and Uganda* (Geneva, ILO), pp. 169-207
- Dunford, M and Smith, A. 2000. "Catching up or falling behind? Economic performance and regional trajectories in the "new" Europe", in *Economic Geography* 76 (2).

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<sup>34</sup> This Reference lists the sources used for this Monograph and includes additional references that were integral to the reports that fed into it, namely Afford, 2001; Stepantchikova *et al.*, 2001 and ILO, 2001.

- Economist Intelligence Unit (EIU). 2001. *Business Environment Scores and Ranks* (London), August.
- Elliot, R. 1998. "Labour economics: A comparative analysis (London; McGraw Hill 1991)", cited in *Critical Challenges for Health Care Reform in Europe*, World Health Organization (Buckingham, Open University Press).
- EU PHARE. 1996). Romania Report. [www.lshtm.ac](http://www.lshtm.ac)
- Fashoyin, T. 2002. *The contribution of social dialogue to economic and social development in Zambia*, ILO InFocus Programme on Strengthening Social Dialogue Working Paper and referred to in the *Draft Report to the Joint Meeting on the Social Dialogue in Health Services: Institutions, Capacity and Effectiveness*, pp. 70-75.
- Gamkrelidze, A. *et al.* 2002. "Health care systems in transition: Georgia", in *European Observatory on Health Care Systems* (Copenhagen).
- General Health Insurance Company of the Czech Republic. 2000. *Annual Report for 2000* (Prague, General Health Insurance Company of the Czech Republic).
- German Foundation for International Development (DSE). 2000. *Public Service Reforms and Their Impact on Health Sector Personnel* (DSE, Berlin).
- Hall, D. 1998. Cited in *Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe*, Joint Report by the International Labour Organization/Public Services International (Geneva, ILO), p. 22.
- Healy, J. and Humphries, C. 1997. *Health Care Personnel in Central and Eastern Europe* (Geneva, ILO Sectoral Working Paper).
- Hovhannisyan, S. *et al.* 2001. "Health care systems in transition: Armenia", in *European Observatory on Health Care Systems* (Copenhagen).
- Hunter, D. 1998. Cited in *Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe*, Joint Report by the International Labour Organization/Public Services International (Geneva, ILO).
- Institute of Health Information. 2000. *Czech Health Statistics Yearbook 1999* (Prague, Institute of Health Information).

- International Labour Organization (ILO). 1992. *Note on the proceedings, Standing Technical Committee for Health and Medical Services, First Session*, (Geneva, ILO)
- \_\_\_\_\_. 1997. *ILO Yearbook of Statistics* (Geneva, ILO).
- \_\_\_\_\_. 1998. *ILO/PSI Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe, Prague 1997* (Geneva, ILO).
- \_\_\_\_\_. 1999. *ILO InFocus Programme on Socio-Economic Security – A Medium-Term Work Plan* (Geneva, ILO).
- \_\_\_\_\_. 2000. *Current International Recommendations on Labour Statistics* (Geneva, ILO), pp. 20-23.
- \_\_\_\_\_. 2000a. *Employment and Working Conditions in the Health Sector of Central Asian countries*, Report for the International Labour Office and Public Services International (Geneva, ILO).
- \_\_\_\_\_. 2001. *Health Care in Central and Eastern Europe: Reform, Privatization and Employment in Four countries*, Draft Report to the ILO InFocus Programme on Socio-Economic Security and Public Services International (Geneva, ILO).
- \_\_\_\_\_. 2002. *ILO/ICN/WHO/PSI Framework Guidelines for Addressing Workplace Violence in the Health Sector*, Joint Programme on Workplace Violence in the Health Sector (Geneva, ILO).
- \_\_\_\_\_. 2002a. *Draft Report of the Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness*, October (Geneva, ILO).
- \_\_\_\_\_. 2002b. *Conclusions on Strengthening Social Dialogue in the Health Services: A Framework for Practical Guidance*, Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness, Geneva October (Geneva, ILO).
- Kanavos, P. and McKee, M. 1998. “Macroeconomic constraints and health challenges facing European health systems”, in R. Saltman *et al. Critical Challenges for Health Care Reform in Europe*, World Health Organization (Buckingham, Open University Press).
- Karaskevica, J. *et al.* 2001. “Health care systems in transition: Latvia”, in *European Observatory on Health Care Systems* (Copenhagen).

- Karski, J.B. *et al.* 1999. "Health care systems in transition: Poland", in *European Observatory on Health Care Systems* (Copenhagen).
- Koulaksuzov and Todorova. 2002. "Health care systems in transition: Bulgaria", in *European Observatory on Health Care Systems* (Copenhagen, in press).
- Macroeconomic Commission for Health. 2002. [www.who.int](http://www.who.int)
- MacLehose L. *et al.* 2000. "Health care systems in transition: The Republic of Moldova", in *European Observatory on Health Care Systems* (Copenhagen, in press).
- McKee, M and Healy, J. (eds). 2002. *Hospitals in a Changing Europe* (Buckingham and Philadelphia, Open University Press).
- Marree, J. and Groenewegen, P. P. 1997. *Back to Bismark: Eastern European Health Care in Transition* (Avebury).
- Ministry of Health. (Lithuania). *The Lithuanian Health Programme* (Republic of Lithuania).
- National Training Fund. 2000. *Human Resources in the Czech Republic 1999* (Prague, Institute for Information on Education).
- Normand, C. 1998. Cited in *Workshop on Employment and Labour Practices in Health Care in Central and Eastern Europe*, Joint Report by the International Labour Organization/Public Services International (Geneva, ILO).
- Parliamentary Hearings. 2000. *Socio-Economic Status of Health Care Workers* (Moscow), April 12-13.
- Rainnie, A. *et. al* 2002. "Employment and work restructuring in transition," in Rainnie *et. al*, *Work, Employment and Transition: Restructuring Livelihoods in Post-Communism* (Routledge, London).
- Rochaix, L. 1998. "Performance-tied payment systems for physicians", in R. Saltman *et. al* *Critical Challenges for Health Care Reform in Europe*, *World Health Organization* (Open University Press, Buckingham).
- Russian Federation Government Report. 1992. *On Health Care* (Moscow).
- \_\_\_\_\_. 1999. *On the State of Health of the Population of the Russian Federation* (Moscow).

\_\_\_\_\_. 2000. On the State of Health of the Population of the Russian Federation (Moscow).

Russian Federation Ministry of Health Care. 1996. The Health of the Population of Russia and the Activity of Health Care Establishments (Moscow).

\_\_\_\_\_. 2000. The health of the population of Russia and the activity of health care establishments (Moscow).

\_\_\_\_\_. 2001a. Information letter about the state of occupational incidence among health care workers (Moscow, Federal Centre of Governmental Sanitary and Epidemiological Supervision).

\_\_\_\_\_. 2001b. On the process of realization of the health care and medical science development concept, the tasks for the years of 2001-2005 and for the period till the year of 2010 (Moscow).

Saltman, R. and Figueras, J. 1997. European health care reform: Analysis of current strategies (Copenhagen, WHO Regional Publications, European Series), No 72.

Sargaldakova, A. et al. 2000. "Health care systems in transition: Kyrgyzstan", in European Observatory on Health Care Systems (Copenhagen).

Scheil-Adlung, X. 2001. Building social security: The challenge of privatization (International Social Security Series, Transaction Publishers, New Brunswick).

Schlanger, J. 2000. "Health care in the Czech Republic 1998-2000", in A Trade Union View (Prague).

Scrivens, E. 1997. Accreditation: Protecting the professional or the consumer (Buckingham, Open University Press).

Standing, G. 1996. "Social protection in Central and Eastern Europe: A tale of slipping anchors and torn safety nets," in G. Esping-Andersen (ed.), Welfare States in Transition: National Adaptations in Global Economies (Sage Publications, London).

\_\_\_\_\_. 1997. "The folly of social safety nets: Why basic income is needed in Eastern Europe," in Social Research (New York, The Graduate Faculty), Vol 64, No.4.

- \_\_\_\_\_. 2002. "The babble of euphemisms: Re-embedding social protection in 'transformed' labour markets," in A. Rainnie et. al. *Work, Employment and Transition: Restructuring Livelihoods in Post-Communism* (Routledge, London).
- Stepanchikova, N. et al. 2001. *Socio-economic status of health care workers in the Russian Federation* (Geneva, ILO).
- Tomev, L et al. Forthcoming. *Workplace violence in the health sector - Country Case Study: Bulgaria, Joint Programme on Workplace Violence in the Health Sector*; forthcoming working paper, (Geneva, ILO)
- Trade Links. 2000. *Czech Republic Labour Code* (Prague, Trade Links).
- Thirkell, J and Vickerstaff, S. 2002. "Trade unions and the politics of transformation in Central and Eastern Europe", in A. Rainnie et al. *Work, Employment and Transition: Restructuring Livelihoods in Post-communism* (Routledge, London).
- Tragakes, E. et al. 2002. "Health care systems in transition: Russia", in *European Observatory on Health Care Systems* (Copenhagen, in press).
- United Nations (UN). 2000. *Human Development Report, 2000*, Romania.
- Vladescu, C. et. al. 2000. "Health care systems in transition: Romania", in *European Observatory on Health Care Systems* (Copenhagen).
- Vulic, S. et al. 1999. "Health care systems in transition: Croatia", in *European Observatory on Health Care Systems* (Copenhagen).
- World Bank. 2000. *Memorandum of the President of the International Bank for Reconstruction and Development of the International Finance Corporation to the Executive Directors on a Country Assistance Strategy for Ukraine* (Washington), Report No. 20723-UA, August.
- \_\_\_\_\_. 2001. *Country Report Moldova*. [www.worldbank.org](http://www.worldbank.org)
- World Health Organization (WHO). 1999. *World Health Report, 1999. Databases* (Copenhagen).
- \_\_\_\_\_. 2000c. *Highlights on Health in Ukraine*.

- \_\_\_\_\_. 2001a. WHO/ILO/ICN/PSI Public service reforms and their impact on health sector personnel: Critical questions: A Tool for Action (Geneva, WHO, ILO, ICN, PSI)
- \_\_\_\_\_. 2001b. The World Health Report 2000. Health systems: Improving performance (Geneva).
- \_\_\_\_\_. 2002a. Report of the Commission on Macroeconomics and Health. Macroeconomics and Health: Investing in Health for Economic Development ([www3.who.int/whosis/cmh/cmhreport](http://www3.who.int/whosis/cmh/cmhreport)).
- \_\_\_\_\_. 2002b. World Health Organization Regional Office for Europe, Health for All.
- Zapoliskiene, S. 2001. The survey of the Lithuanian economy (Vilnius, Ministry of Economy, Statistics Department of Lithuania), May.