Workshop Report

Health Care Privatization: Workers' Insecurities in Eastern Europe Geneva, December 6-7, 2001

InFocus Programme on Socio-Economic Security and Public Services International

International Labour Office, Geneva

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Contents

Report of Workshop December 6-7, 2001
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1. Introduction

The purpose of the workshop was to bring together affiliates of the Public Services International (PSI) from Central and Eastern Europe (CEE) with ILO staff and collaborators, to discuss the results of the research project undertaken during 2001 by the ILO's Socio-Economic Security Programme (IFP/SES) and PSI. Two independent, simultaneous studies were conducted under this project, by direct request to IFP/SES from PSI at the end of 2000. The research project has sought to investigate the impact on workers' securities in CEE, resulting from massive and dramatic changes in the health sector across the region, including privatization, commercialization and changes in management structures.

One study was conducted directly through the PSI affiliates, designed to examine the impact of major changes in the CEE health sector on the seven forms of workers' security as defined by the IFP/SES. The second study was designed to yield an in-depth picture of the impact of the changes on health workers in four countries: Romania, Ukraine, Lithuania and Czech Republic.

Background and the framework demonstrating the critical need for such joint research with unions on this important sector of workers was provided through opening remarks by:

Alejandro Bonilla, ILO Social Protection Sector;
Hans Engleberts, General Secretary, PSI;
Oscar de Vries Reilingh, Director ILO Sectoral Activities;
Coen Damen, ILO Bureau for Workers' Activities;
Bjorn Grunwald, ILO Bureau for Employers' Activities;
Guy Standing, Director ILO InFocus Programme on Socio-Economic Security.

2. Background

This research project has been carried out with the intention of translating the findings into actions to help catalyze improvements in the lives of health sector workers in CEE, and to provide empirically-based tools for trade union bargaining agents and policy-makers. The project is an integral part of the ILO agenda on socio-economic security and Decent Work. The profound changes that are taking place in health care services in Eastern Europe, and in many other parts of the world, are having negative effects on workers, and on the public as a whole. Management systems also have been negatively impacted by reforms in the region, accompanied by negative effects on the delivery of health services to both workers and the public.

Approximately one third of the PSI's world wide 20 million members are from the health sector. In Eastern Europe, the health sector trade unions are the single largest group of PSI members. Since 1991, there is a health union representing health workers in each country of the

region. There is great concern over the impact of health care reforms, particularly on wages, working conditions and job security, from reforms introduced by the World Bank. Efforts to control and or reduce costs via compensation and privatization have put a strain on already tight labour markets, which are unable to offer much by way of alternative employment for workers employed in the health care sector. Similarly, changing institutional set-ups and attempts to reduce the health sector labour force have had an adverse effect on industrial relations in the health system. Part of a global phenomenon, increasing numbers of female health care workers migrate to neighbouring countries to work in health services or to find other forms of precarious employment. These workers often find themselves exploited by employers who take advantage of their lack of knowledge of their rights. This has been the case, for example, of Filipino nurses in the United Kingdom. Using a participatory action research methodology, the present project has asked both trade unions and individual workers for their views on health reforms taking place in their countries. With the results, ILO and PSI have been able to gain an understanding of how such changes have affected the lives of health workers in Central and Eastern Europe.

An efficient and accountable health sector is an essential ingredient for the economic development of a country. Health care policies play an important role when it comes to generating productive employment and greater personnel opportunities, key to poverty reduction and to economic and social inclusion. These policies range from equal rights and entitlements for men and women to adequate economic and social protection against unemployment, ill health, and loss of main household income, disability and old age. Since the 1995 World Social Summit, more than 100 countries have committed themselves to making health a priority in the fight against poverty, with experience repeatedly demonstrating that countries economizing on health care provisions do so at the cost of their long-term economic well being.

The present initiative is a follow-up to an ILO/PSI CEE workshop on employment and labour practices in health care, held in Prague, May 1997, and to the subsequent 1998 ILO Joint Meeting on Terms of Employment and Working Conditions in health sector reforms, which concluded that successful health care reforms cannot be imposed from above and outside. Indeed, consultation, as a prerequisite for the successful implementation of reforms, has been recommended at all ILO-held meetings on health sector reforms. Yet all too often reforms have been introduced without union and worker consultations.

PSI and ILO support the principles contained in the 1996 Vienna Charter on reforming health care, which states that health care reforms must use a democratic process involving all social actors to address citizens' needs and to deliver health care to all. The transition process of many CEE and CIS countries has meant that 10 per cent of the population has seen a considerable increase in their standard of living while the rest face economic uncertainty, and a sizeable minority lives in acute poverty. Extremes in well being and wealth present a considerable challenge to the ability of governments to plan and manage future economic and social development. In the process of change, governments must not forget their responsibility as employers; while trade unions' role is to ensure a voice for those who face economic and social injustice, a particular challenge given decreasing trade union membership in the region; and private employers need to play a full role as social partners. Experience over the last decade has shown that often, private health care employers have not been prepared to recognize the role of trade unions.

Over this past ten-year period, PSI has been increasingly concerned about the reforms that have been introduced in health services, often with detrimental effects on workers. The health system in Moldova, the poorest country in Europe, is close to collapse, with serious consequences for health care workers and patients. In spite of structural changes, one element has remained constant over the past ten years – health workers have continued to work, but with increasing difficulty due to deteriorating conditions in medical facilities, often meaning that hospitals operate without heating or lighting, with buildings leaking, few materials and grossly outdated equipment. For some it has been with a background of military conflict and for many there has been low pay or no pay. Over the past few years, PSI has responded to the acute crisis in health care in CEE by organizing information and training seminars on different aspects of reforms based on the demands of its affiliates, as well as presentations to Ministries of Health and World Bank offices.

Inadequate information is available on all aspects of reform, making difficult assessment of whether the reform process has actually achieved its objectives. The pace and extent of health care reforms in CEE has been dramatic, but the speed has often been counterproductive and the process poorly managed, causing a near collapse of health care services in some places. Most governments have been engaged in large-scale experiments. Changes in ownership, financing and provision are taking place in the context of lower resources and growing needs. This makes recovery from errors or accidents in the reform process more difficult, since no resources can be found to solve problems. In some countries, health care budgets have been cut by more than half. Serious illness involving medical care is an expensive proposition and many families cannot afford to pay; statistical evidence on life expectancy bears witness to this.

At the ministerial level, the planning and management of the health sector has also been a cause of serious concern. Ministries of Health have a lower status evidenced by the constant turnover of staff in key positions. One of the most important and damaging aspects of the reform process has been the lack of consultation between the agents of reform, trade unions, and the staff associations representing workers. International experts who are often responsible for advising governments or regional authorities rarely consult with workers' organizations before making their recommendations, in spite of the fact that those very recommendations could result in considerable job losses and job restructuring. Unfortunately, only a few governments have been prepared to maintain a regular dialogue with union representatives, yet increasingly governments have turned to professional associations, particularly those representing doctors, for advice on various aspects of the reform process. PSI recognizes the need for reforms and restructuring in health services; PSI is not ideologically against privatization in all its manifestations but is critical of the way in which privatization has been put forward as the only solution to the provision of better health care. Democratic, technical and social factors are continuously evolving, as are diseases, treatments and other health issues. If health services are to meet the changing needs of the populations they serve, there must be constant review of performance and structures, with a readiness to introduce reforms as required. Change is, therefore, a necessary and on-going process and should be undertaken within the framework of social dialogue with all the stakeholders: consumers, governments, private employers, workers and financial institutions.

This research project has been carried out in response to the concerns expressed by a meeting of CEE health workers' representatives in Vilnius, Lithuania in September 2000. They have been facing a series of reforms to their health care systems, social insurance systems and austere national budgets, and were at wits end to work how best to respond. They wanted to get a clearer picture of what is happening around them as well as gain a better understanding of what is

happening at the level of the workplace. What can be learned from these studies will serve as a sound basis for action at international, national and local levels.

The following questions provided the framework for both studies – one survey sent out to all PSI affiliates in CEE and the other conducted in four countries by the European Centre for Occupational Health, Safety and the Environment (ECOHSE), together with IFP/SES and PSI:

- To what extent is job insecurity increasing among workers in the health care sector?
- How can work insecurity be tackled given increases in other forms of insecurity?
- Are workers who are rendered unemployed by privatization in the health care industries able to find other areas in the labour market which can offer them employment?
- What impact is the privatization trend creating to further increase levels of income insecurity, skill reproduction insecurity, and employment insecurity of workers in the health care sector?
- What is the reality of "social dialogue" when it comes to representing health service employees in CEE countries?
- What are the main threats to workers in health care?
- What do trade union lay as well as official representatives actually do in terms of trying to defend their members' interests in the privatization environment?
- What constraints they face in day-to-day terms and in the wider political and policy arenas?

In Central and Eastern Europe, employers as a group are a new entity, a major change in a region where the State was essentially the sole employer prior to 1990. The recent development of employers as an independent body is occurring from the bottom-up. As the health sector was entirely public by definition prior to 1990, the health sector "employer" still today remains largely the public employer, with the growth of private health care employers taking root. Since the changes beginning in 1990, there is now an attempt to identify who has the responsibility as employer in the health sector.

Privatization has been a debatable and controversial topic in the service sector of western countries as well, providing useful lessons, particularly where the emphasis has been on "service" rather than "public". Market economies require an institutional and legal framework, without which they cannot function. Unsuccessful and incomplete transition in CEE has been in part due to the inability of advisors from the west to understand this requirement. Today a major question centers around who has the initial responsibility to invest the necessary resources in health care, including in occupational health and safety, which was the responsibility of "enterprises" prior to 1990. Workers' health and safety is an example of an area where the political establishment has a profound responsibility as employer.

The impacts on workers and the public from privatization and other changes in the health care sector are being mirrored in other parts of the world, such as Latin America, and Europe. Health services in the UK, for example, are accelerating the movement of patients away from the National Health Service (NHS) to the use of private medical insurance and private medical services. Public discontentment over long waiting periods for NHS-provided medical treatment has been a contributing factor. In 2000, an additional 200,000 people moved to private health care

to avoid the public waiting list. There is a process in the UK, as in many countries, of slow privatization, whereby people are obliged to seek medical care in a sector which can *provide* care, even when it means paying much more. Often this is the result of insufficient increase in public spending or reductions in public spending, causing a gradual decline in public services to the point where such services are no longer available to those in need.

Findings from recent IFP/SES enterprise-based surveys in Russia, Ukraine, Hungary and Moldova reveal that contextual changes taking place in the region impact the public health care sector. Enterprises across CEE have been abandoning health and safety departments and committees in workplaces. Whilst large proportions of firms have been cutting back health and safety departments, accidents and incidents of ill health and problems associated with working conditions have intensified, contributing to an increased demand for medical attention.

The IFP/SES enterprise-based surveys further reveal that a very large proportion of industrial enterprises have been transferring their social facilities and social services from the enterprises to the community. This often leads to the abandonment of vital services that have health care built into them, resulting in a vacuum of vital services available to the public and to workers.

IFP/SES has recently conducted a huge national household survey of workers in the Ukraine, covering over 8,000 families. One striking finding shows that some 88 per cent of the population reports that they cannot afford the health care that they need. Many people report having to go into debt to obtain needed health care, many people have no access to health care services simply because they cannot afford it. In Hungary, a much richer and successful transformed economy, findings from the IFP/SES Peoples' Security Survey reveal that 82 per cent of households report that they cannot afford the health care that they need. These terrible dramatic findings, based on scientific samples of the population, demonstrate the extent of worry about the health care that exists in the region. Such contextual facts also suggest the urgency for health care reforms to provide better services for all.

This workshop was convened with the objective of making recommendations that will guide future work in CEE aimed at restructuring health services, in the areas of social dialogue, collective bargaining, wages and working conditions and training, based on full respect of core ILO Conventions. The process of social dialogue must engage all partners, based on commitment, training, trust and knowledge. The workshop is an opportunity to take stock of lessons learned by health workers over the past ten years of change in CEE. Outcomes from the present research and discussion will be used in preparation for the October 2002 ILO Tripartite Sectoral meeting on health services, and for the 2003 ILO meeting on National Social Dialogue in Public Service.

3. Highlights from study of PSI affiliates

At the time of the workshop, results were available from eleven countries participating in the study of the impact of changes in the health sector on workers' security conducted through PSI affiliates in CEE. Based on surveys of those 11 countries, reforms that have taken place in the region were presented in the workshop, followed by results of the survey, and conclusions drawn from the eleven surveys analysed.

3.1 The main reforms shaping health care systems identified by PSI CEE affiliates are the following:

a. Decentralization: the extent to which countries in the region have passed on responsibilities to local authorities varies; an increase in local levels of funding and provisions are typical features of the decentralization;

b. Social health insurance schemes: a common factor in the make-up of CEE and CIS health care systems, with almost all countries reporting the existence of, or plans for the introduction of social insurance;

c. Out-of-pocket payments: introducing or recognising payments by service users is a significant change, particularly for Armenia, Croatia and Moldova. Charges vary but typically include co-payments for pharmaceuticals, private charges for dentistry, as in Lithuania and Poland, and co-payments for a wider range of standard services. All health care users in Armenia, other than those deemed "vulnerable" or falling under certain defined conditions, now pay out of pocket for all health care.

d. Privatization: the introduction of insurance and the formalization of out-of-pocket payments are not considered as steps towards privatization in the present analysis. Privatization has been introduced in varying degrees in Croatia, Czech Republic, Latvia, Lithuania, Moldova, Poland and Romania. Despite some variations, there is a great deal of consistency in what is being privatized: there has been significant privatizing of pharmacies and dental practices, and a limited use of private mechanisms in private health care. Hospitals and funding remain mostly public.

Four categories of privatization:

1. Financing mechanisms: many countries in CEE and CIS have shifted financing responsibilities to mandatory insurance funding. These can be considered private, as these are mostly government rather than voluntary agencies. Few countries have allowed independent agencies significant control of public financing and those which have are not-for- profit, e.g. Czech Republic.

2. Private ownership of facilities: extensive privatization of pharmacies and dental clinics has occurred across the region. A few spas and rehabilitated facilities, especially clinics, have been privatized as well, but with little overall impact.

3. Employment: there have been a few small experiments with private sector development; privatization of employment contracts is negligible. Where private ownership of facilities is relatively extensive, employment contracts may be vested in the private institutions where the individual works, e.g. Latvia. Privatization of pharmacies, dentistry and some primary and ambulatory care have increased self-employment.

4. Standard and limited use of private contracts: this has occurred particularly in secondary health care where it is possible to contract out or use private contracts for functions such as cleaning, catering or computer services. Evidence from Western

Europe suggests this is an area of concern where pressures are to reduce wages and working conditions.

3.2 Survey results

In analyzing the structural issues affecting health care workers, three key aspects of health care systems in CEE have emerged:

1. Primary health care reforms and restructuring of management: changes have been widespread and affect the roles of family doctors, nursing care and support care, as well as financial management and public health. These changes have a negative impact on workers' basic security.

2. Budgetary cuts and expenditure below a given GDP is important: some of the countries report levels of public expenditure that compare well with other CEE countries and with averages in western Europe. Croatia, for example, has a 7 per cent expenditure on health care services, while other countries experience great difficulties in terms of their overall budgets, such as Moldova, where public health expenditure in 2000 was only 2 per cent of the GDP, a dramatic drop from previous years.

3. The World Bank suggests that a severe lack of funds is due to 70 per cent of spending going to electricity, heating and other physical aspects of running hospitals, leaving few resources for salaries and treatment costs, in turn leading to a reliance on informal under- the-table payments.

The survey of PSI affiliates in CEE set out to measure the levels of insecurity in seven aspects of a worker's life.

Labour market security: focuses on adequate employment opportunities. Results of the survey revealed conflicting evidence. A surplus of labour in the health sector is often cited in CEE. Survey data show job losses in four countries whilst another four reported increases in job numbers. While data for private sector employment are lacking, information available for the private sector shows a substantial effect from the private sector absorbing staff losses in the public sector. Croatia, Czech Republic and Poland are prominent among countries that appear to have phased out certain public sector jobs, substituting them with similar numbers in the private sector. It is unclear, however, whether these are the same jobs. Contracted hours remain constant across the region (the surveys indicate actual hours worked). Marked changes have occurred only in two countries, with actual hours worked rising in the Czech Republic and the opposite occurring in Lithuania. Nonetheless, working hours remain long, for example, 90 per cent of Polish doctors work between 60-90 hours per week while in Moldova, support staff work around 58 hours per week. Globalization is having an important impact on the health sector, particularly where the migration of health care professionals has a detrimental effect on national and local health systems.

Employment security: examines the protection against arbitrary dismissals and the regulation of hiring and firing. All surveys revealed that all categories of workers maintain their entitlement for severance pay, although levels vary among countries, from one month in Armenia,

to six months in Poland. Details of the contractual status of workers give cause for concern: in Kyrgyzstan and Poland, around one quarter of staff work on temporary contracts, without the benefits enjoyed by permanent workers. Latvia reports an even worse situation, with 90 per cent of health sector staff on temporary contracts. In line with other benefits, women maintain their right to maternity pay in all countries. Difficulty receiving these benefits was not reported. In Croatia maternity leave entitlement is four months.

Job security: protection of occupation, skill areas and protection against de-skilling. Overall there is a tendency for countries to upgrade job categories and for the actual number of job categories to be left either unchanged or to rise. Moldova and Poland report different trends in public and private sectors: job categories in the Polish private sector remain stable while rising in the public sector; the reverse scenario is taking place in Moldova.

Skill reproduction security: as a provision of widespread opportunities to gain and retain skills, including apprenticeship and employment training. All countries report the provision of training, with variations in the extent. In some cases training has increased to meet new legal requirements, as in Croatia and Kyrgyzstan, while the amount of training seems to have declined in Armenia, Moldova and Poland. The provision of training is not equally available to all in the sector. Reports of exclusion of many national unions in Croatia, Czech Republic, Lithuania and Poland from the design of training and re-training are cause for concern.

Work security: addresses protection against accidents and illness at work through safety and health regulations and limits on working time. The data reveal a decrease in the numbers of work related injuries between 1990 and 1999. In many instances, the reduction has been significant, as in Armenia, Kyrgyzstan, Latvia, Moldova and Ukraine. In parallel, absence due to injuries has dropped in many of the reporting countries, sometimes as much as 80 per cent, as in Latvia. In the Czech Republic, however, despite fewer injury *incidents*, the average *length* of absence resulting from a work-related injury has risen. This is a phenomenon warranting further investigation. The payment of disability and invalidity benefits has remained largely unchanged across the region, with no reported difficulties in receiving benefits, although the amount of benefits varies widely from country to country. In Armenia and Kyrgyzstan, average disability and invalidity benefits amount to 100 per cent of wages comparing favourably with Croatia where benefits stand at 10 per cent of the average wage.

Details about worker absenteeism across the CEE and CIS are unclear. However, data show that absenteeism is decreasing. Qualitative data would be needed to capture the reasons for absenteeism. Most worrying, however is the evidence revealing "presenteeism" across the region, whereby increasingly workers attend work when they are ill, due to fear of losing their jobs if they remain at home, or because they depend on the direct payments from patients for survival. Stress among health workers is not reported to have risen universally throughout the period concerned, but remains an issue of concern in most countries. Major causes for stress are reported as economic hardship, threat of job loss, and the strains of working in a medical environment.

Representational security: examines the protection of the collective voice in the labour market. Distressing trends emerge from the surveys. The near 100 per cent union membership that was typical in the region has not proved sustainable. Only Krygyztsan and Ukraine report membership rates close to those previously associated with the region. In some cases, such as Latvia, steep declines in union membership could be linked to the hostility of management

towards union membership. However, little evidence was found of similar trends in the public sector. The role of trade unions appears to have evolved in some countries over the last ten years, mainly toward attending to a set of common activities. In most national systems, unions focus on core areas of negotiation: wages, benefits and training. Most of the unions reported engaging in consultation with national partners in addition to undertaking collective bargaining, but great divergence was reported in the periodicity of consultations, types of issues discussed, and whether unions feel they are successful in meetings with national partners. For example, such meetings were thought to be helpful in 60 per cent of the cases in Moldova but in only 6 per cent in Lithuania. The finding that agreed bargaining power and consultation procedures do not guarantee a voice for workers or their unions is cause for concern.

Income security: while data were incomplete in this area, they revealed that health workers in Armenia and Belarus experienced a decrease in income relative to national average wages for doctors, nurses and allied health professionals. Even where wages are reported to have risen, problems persist, as in Kyrgyzstan where despite reported wage increases for all occupations, wages are still lower than subsistence level. Evidence from only two countries suggests that remuneration packages have risen significantly. In the Czech Republic, physicians' salaries in the public sector are twice the national average, and in Poland there has been a 20-30 per cent increase in wages for doctors, nurses and administrative staff. Given the prevalence of low wages, a dependence on secondary income in most countries is not surprising. Income from secondary jobs constitute one third of total wages for doctors, administrative staff and nurses in Belarus, while in Poland secondary jobs play a dominant role. It is less clear to what extent workers are forced to rely on informal gratitude payments but it is clear that these play a significant role for many workers in the region. Widespread wages arrears are another cause for concern, compounding the insecurities felt by the work force.

3.3 Conclusions from the survey of PSI affiliates

While it is difficult to make statements about workers' experiences, the surveys reveal labour market insecurities with job numbers falling in some countries and increasing in others. The data on employment and work security provide a more uniform picture, with entitlements and benefits remaining poor, but generally constant. Region-wide there has been a shift with regard to injuries at work and absenteeism rates, both of which are in decline. Absenteeism seems to be a reflection of workers' employment and income security. There is a worrying trend in the types of contracts emerging in some countries, with temporary contracts playing an increasingly important role. Decentralization has overlapped with the shift from tax to social insurance. This appears to have created socio-economic security problems, where funding responsibilities have passed to an authority, which lacks the resources, or the capacity needed to meet their obligations. This in turn creates income insecurity for workers. The shift to insurance may increase perceptions of insecurities, the overall impact of which has yet to be clearly understood. Insurance funds may negotiate coverage and reimbursements with less professional associations, but in doing so will overlook trade unions, which has been the case in the Czech Republic. Although reform has taken place in most of the countries surveyed, privatization in the health sector is still limited. Hospital sectors are still overwhelmingly public and the State remains the major employer of staff in the health system. The impact of contracting out of services is an interesting area for future investigation. In reviewing the issues that have affected health care systems in CEE, scarce resources seem to have the most discernable impact: Armenia, Belarus, Kyrgyzstan, Moldova, Romania and Ukraine all recorded low national health care expenditures, while these same

countries report that salaries are paid late repeatedly, and that administrative expenses and wages remain below minimum levels.

4. Highlights from four in-depth country studies

What has occurred in the sphere of health care in CEE is merely a manifestation of a wider social catastrophe in which health standards, living standards and workers' rights have been massively eroded. Even were universal health care to be reinstated tomorrow in CEE, it would probably take at least three generations for social recovery to take effect in terms of health and welfare of the working population. This catastrophe is what has been called "reform," or the reform process. It is not one single process but a number of inter-linked processes, manifesting differently in different national contexts. This is the rationale for having chosen to conduct in-depth country studies, to enable the construction of generalizations based on evidence, rather than starting with broad global statements. In-depth studies were conducted in the Czech Republic, Lithuania, Romania and Ukraine. The objective of the studies was to be able to gauge how restructuring/reforms have affected the working conditions of health care workers by looking at hours worked, overtime worked, overtime pay, relative earnings, job security, and the role of unions in defending workers' rights. 2000 returned questionnaires have been analyzed, providing a substantive body of evidence, and allowing a representational picture of the experiences of health care workers in the respective countries to be painted.

This research attempted to identify a strategic sample of two or three health care institutions in each country representing typical workplaces for health care workers, and in which some changes have occurred over the past 5-10 years. Each sample included polyclinics, secondary health care and in some cases, tertiary institutions. Where possible, the research team tried to gain the support of management in carrying out the surveys. The study was designed to include both union and non-union workers, in an attempt to produce a representative and non-biased sample.

Results from the four country studies reveal that workers are unhappy with their present situation; they fear the future and have the perception that life will get more difficult in the future, rather than easier. Workers feel either not protected or less protected, by government, management as well as their unions. Reform is at different stages within the region, which impacts working conditions and workers' perceptions.

The following are some of the key findings presented based on the four-country study:

1. The majority of respondents in all four countries either disagreed or strongly disagreed with the statement that, by the standards of their country their working conditions were excellent;

2. When asked to comment on the statement that taking into account inflation, workers were paid less than five years ago, more than 75.0 per cent of Romanian, Lithuanian and Ukrainian respondents either agreed or strongly disagreed;

3. 93.0 per cent of Romanian respondents felt their greatest worry was not being able to rely on their wage;

4. 48.5 per cent of Ukrainian, 38.7 per cent of Lithuanian and 26.7 per cent of Romanian respondents noted that they had experience with not receiving their full pay in time;

5. A majority of Romanian and over 60 per cent of Lithuanian respondents expected future restructuring to further erode their working conditions;

6. Nearly 70 per cent of Lithuanian, 40 per cent of Romanian, nearly 40 per cent of Czech and 36 per cent of Ukrainian respondents reported that future government plans would make their situation worse;

7. As many as 43.2 per cent of Lithuanian respondents feared they could lose their job within one year;

8. Over 65 per cent of Lithuanian, nearly 60 per cent of Romanian and 44 per cent of Ukrainian respondents said they would have difficulty finding another job if they were dismissed;

9. As many as 58.9 per cent of Lithuanian respondents noted that their job has become less secure than it was five years ago;

10. Over 60 per cent of Lithuanian, 56 per cent of Romanian and nearly half of all Ukrainian respondents reported management being less concerned with the needs of workers than it was five years ago.

Reservations were expressed in the workshop regarding the value of international comparative studies and the value of aggregated statistics. Sources of data were questioned with the request that these be made explicit to readers. The impact of workers' environments and working conditions was emphasized as preventing health workers from meeting professional standards of practice. It was noted that this could cause burnout, an issue not covered by the study. It was highlighted that in general the focus of the study was on reform in general, not specifically on privatization. Low and decreasing levels of unionization of health personnel is a cause for concern.

5. Highlights from Labour Market and Employment Security Session

1. Various pressures have prompted most of the countries to undertake health care reforms. While there are a number of similarities among all countries studied, primarily the manner in which privatization has been carried out differs among the four countries studied;

2. The reforms have led to an increase in unemployment and the emergence of new types of employment status, not all of which are covered by labour law;

3. Unemployment exists more in some places than in others, for example, rural areas report greater unemployment than urban areas. Problems associated with financing

reforms to the health care systems have been felt in all countries. Solving these problems requires collective work and advocating for solutions;

4. In general, all countries report very poor working conditions and very low wages for health care workers;

5. Results from the four-country study shows that trade unions have played different roles in each country. In Poland and Hungary, for example, where unions have been active, conditions may have been worse had it not been for the role of the unions. In contrast, health workers in Russia report feeling little effect of the union's work in terms of labour and employment security, shown by the study conducted through the PSI affiliates.

There was an appeal for this meeting to lead to ideas and more development in the future, through ILO's partnership with PSI.

6. Highlights from Job and Skills Security Session

1. The link between working conditions and patient outcomes needs to be investigated to see whether a high level of job security results in a high quality of care.

2. Consumers should be consulted during the reform process.

3. Union work and workers cannot be considered in isolation; the social context is fundamental and includes:

    i. Financing systems, including the influence of the World Bank and the International Monetary Fund;

    ii. Outputs of the education sector;

    iii. A legislative framework. In one example, the Labour Code had to be changed in order to implement the desired reforms;

    iv. Prestige of the health professions and various categories of workers;

    v. The health sector continues to respond to an increasing demand and need for services;

    vi. There has been a noted decrease in the number of workplaces and hospital beds;

    vii. There has been a casualisation of staff, especially auxiliary staff;

    viii. De-skilling has occurred as a result of qualified personnel, e.g nurses taking employment in other service sectors (e.g. sales, hairdressing) either because of redundancy or because they seek better pay and working conditions;

ix. Highly qualified personnel, such as physicians, appear to be better protected;

x. While unions have negotiated the maintenance and in some cases the improvement of benefits, there is a general trend towards the loss of acquired workers' rights and reduced job protection;

xi. There is increasing difficulty in having access to continuing and further education, due to:
    a. introduction of course fees which workers cannot afford;
    b. lack of time to attend the courses;
    c. absence of study leave;
    d. fear of leaving the workplace due to fear of losing one's job if one is absent;
    e. often there are no state re-training programmes.

xii. While the traditional tripartite approach to negotiation remains, there is an increasing involvement of other organizations in civil society, such as professional associations and consumers;

xiii. Trade union leadership is confronted with new, complex and difficult challenges. The need for training in dealing with reform issues was emphasized.

7. Highlights from Work Security Session

1. There are common issues between eastern and western Europe, such as the playing off of health and safety against wages and other dimensions of basic security;

2. There is an important debate taking place as to whether laws should be enforced based solely on following rules or whether problem solving in health and safety should be integral. A minimum legal status is needed, which is often referred to in labour codes, but which alone will not address all health and safety issues;

3. Many occupational diseases are not recognized as work-related diseases. This leads to an under-estimation of the impact of occupational ill health and an over-estimation of accidents, allowing anyone to say that a work-related disease problem does not exist because it is not listed and therefore not addressed;

4. Hazard pay is essential to consider in CEE – if the full costs of accidents are not borne by employers, then they will continue to find it cheaper to pay workers for doing dangerous work.

8. Highlights from Income Security Session

1. Institutionally, a variety of legislation exists, much of which has not been fully respected. This may reflect poor decision-making;

2. The material situation is a significant limitation to making improvements in health systems, made evident by the fact that wages are not only lower in the economy as a whole but tend to be lower still in the health sector;

3. Low wages, delays in payments, non-indexing of wages, all contribute to a worsening situation. Issues of survival and non-access to basic needs have become the consequences;

4. An appeal is made for international organisations such as ILO/WHO to help, while recognising their individual mandates, and recognising that they are not as powerful as the Bretton Woods organizations;

5. The message of trade unions is to look outside: there are limitations to what they can do internally, but they are now looking to other institutions outside the country for help;

6. "Black Money" is an important issue to consider. Earning money "under the table" is inevitable when the rules of the game are not clear, leading in turn to the question of unequal distribution of income, and unequal distribution and quality of services. People with more resources can protect themselves better against disadvantages.

9. Highlights from Voice Security Session

1. The discussions in the workshop echo findings from ILO's work in the region, through the MDT in Budapest. While transition has been at different speeds in different countries, the challenges faced are the same across the region;

2. The question was raised to what extent the union is able to bring forward the voice of its membership. A representative voice from the membership at grassroots level was highlighted as important for collective bargaining, noting that meaningful participation in tripartite discussion at national level leads to having an impact on policy. The existence of political will helps to create forward momentum in a meaningful way for union members;

3. It was pointed out that problems become more serious when the government is not able or willing to listen;

4. It was recognized that the private sector appears unwilling to engage in collective bargaining or to consult with unions;

5. PSI and ACTRAV can help with capacity building, to develop strong voice representation between the unions and the membership. If union members do not feel that the union is representing them, they are unlikely to give continued support;

6. Participatory strategies can be developed and implemented to make the membership aware that the union is representing them. For example, in Lithuania, the union circulated a petition that was signed by 50 per cent of its members. Stronger communication bases can be developed even where there is a lack of capacity and resources. Sectoral bargaining at national level is one key;

7. The difficulty of finding employers to negotiate with was recognised.

10. WHO Perspective

Health organizations are highly dependent on their workforce, which are both strength and a weakness, particularly when the majority of health care budgets are allocated to wages/salaries. In all countries, the health sector is the major employer of human resources, accounting for a high proportion of budgets. Yet despite the cost of producing and maintaining human resources in health systems, there is no consistency between countries in the way that human resource policies and strategies are developed and implemented. In OECD countries, for example, there is no correlation between numbers of physicians, nurses and dentists to the population, and the level of health in the population. Changes in the context of health care over the past decade have greatly impacted human resources in health systems.

Numerous issues have contributed to the impact felt from health sector reforms: privatization, cost reduction, working efficiency, improving performance, equity and changes in the health modules, transformation in technology, information sharing and the introduction of different tools for communication. A demographic transition has also contributed to the impact of reforms - an increasing proportion of older persons in CEE, means that the users of health service systems have increased more than the countries can sustain.

The WHO is attempting to develop sets of best practices, or methods intended to help countries implement better health policies. In addition, WHO is developing support for research to collect evidence on best methods of remuneration for health workers, different methods of payments used by different countries, and ways that countries can improve their capacity to better locate their resources they have.

WHO is particularly concerned with workforce distribution in different levels of services, the regulation of education in professional practice, and the performance and quality of health care providers. WHO is beginning work in the following areas: accreditation, general parameters of work and conditions of work, incentive systems and pay mechanisms.

The WHO seeks partners to work with, and considers the ILO one of the best partners to work with, for developing best practices and using those to advise countries for policy development.

11. General Conclusions/Recommendations

11.1 An Eastern European perspective

A lack of funding of the health systems is commonplace across CEE, affecting both health care providers and consumers. In general, no one is satisfied with the quality or quantity of health care in these countries. Dissatisfaction with levels of wages/salaries has been revealed in most countries. Political and economic reforms have developed in different stages in CEE; some started with economic reforms leading to social and health care reforms. The first need is for respect from society for health care workers at different levels; greater funding can be a means to achieving this given that wage levels in CEE health care systems are generally below the average of those in western Europe. Varying stages of reforms in health care have resulted in significant loss of personnel, and increased fear and insecurity over job loss and loss of social security entitlements. Health care reforms have affected the health and safety at work and working conditions. The conditions under which health care workers perform their jobs have declined.

One recommendation is for governments to ratify ILO Conventions that could lend protection to health workers in CEE, such as a Convention to protect wages. Additionally, training and retraining programmes need to be designed to help workers be more competitive in the labour market. Trade union officers, for example, require special training and capacity building to enable them to participate effectively in shaping health care reforms, and to be considered as partners with governments and representatives of different institutions. Lastly, this process of data collection and exchange of information should continue, as it is very useful for the unions.

11.2 PSI perspective

The situation in the health care sector is extremely serious for many countries, particularly in those countries of the former Soviet Union. New evidence has been presented from the unions that workers and patients are facing enormous hardships. Countries are on a collision course of declining services with growing needs. There are problems of extremes of wealth, with some people benefiting well from the transition period while others face serious difficulties. The studies reveal that health workers in most of the countries surveyed are very unhappy about the present situation that they are experiencing. They report having great fear for the future – fear that life will get more difficult, concern for their job security, and voice security in being able to represent their members' views in different situations. Workers believe there is less protection for them today.

These studies have revealed that health workers are demoralized, with the word "humiliation" used more than once during the workshop. Despite difficult, often intolerable conditions, health workers continue performing a critical task for the future development of their countries. Without their expertise and their commitment, the conditions for many among the populations of CEE countries will become worse.

One major cause behind the issues discussed in this workshop is a lack of awareness and understanding. There is a lack of understanding at the international level, which directly impacts policy advisers and decision-makers; there is a significant gap in information, particularly in Western Europe, where neighbouring countries are not aware of the conditions existing in Eastern Europe. The physical wall separating Europe has become a wall between information exchanges.

Issues that unions must address today are becoming increasingly complex: the overall economic situation in many countries impinges on the health system; there is new legislation for EU-accession countries; there is privatization and restructuring. While these two studies may not have revealed widespread privatization taking place in the health sector, we have seen that privatization *is* taking place, with the expectation that it will grow. The concern for unions' centers around the way privatization is being introduced within the huge wealth gap existing in CEE. Another challenge facing unions is the need to bargain nationally and locally, having to represent all of their members while struggling to retain membership levels.

The role of unions is made more difficult when employers do not show strong interest in collective bargaining and retaining social dialogue. Interest varies from country to country, for example, regular dialogue is maintained in Czech Republic, but is not the case for the other countries.

PSI identified a number of areas to be addressed as follow-up to this workshop:

1. More information needs to be made available in a form accessible to unions; including more data from the ILO and from other international organisations.

2. International organizations, including PSI, need to develop further their capacities to be able to respond effectively to the complex issues presented. This requires improved resource utilization, and better coordination within the ILO to respond to the needs of the health sector workers in CEE. This meeting is an example of strong cooperation between different ILO Departments and Sectors, demonstrating the need to develop such cooperation further.

3. There is need to work closely with those at WHO having a common interest with ILO and PSI, i.e., an interest in workers.

4. There is need to work with the Bretton Woods organizations: the World Bank is the main influence in policy development in CEE countries, with direct impact on the health sector. The Bank's policy is changing, based on experiences of the past decade, recognising that many of their policies have not resulted in improving people's lives. In fact, more people are in worse conditions today as a result of World Bank policies. This is a good opportunity to engage in dialogue with the Bank, to ensure that the voice of the workers in those countries is heard, recalling that they know best the reality of the workplace.

5. PSI will continue to work closely with its affiliates on training programmes and information exchange, but there is a need to do much more. There is pressing need to get PSI affiliates in western Europe more engaged and involved in the process.

11.3 ILO IFP/SES Perspective

With the essence of "Decent Work" being to promote dignity, it is ironic that the functions of health workers are around decent work, i.e. keeping people alive, make peoples' life more normal, yet the workers themselves often are expected to do this under intolerable, undignified human conditions. The international arena has an obligation to state that such conditions are not

acceptable. With this obligation comes the risk of causing offence to people in authority by saying that workers in the health care sector may not be treated with impunity, exploited or oppressed. Shortages of health care providers do not disappear, but wages and conditions do not tend to improve because of the tendency for oppression and exploitation.

The public wants a good public health care system. Ideologically, however, there are forces working to ensure the decline of a public health care system. Cutting resources in a public health care system causes services to decline, resulting in cost increases, intensifying inefficiencies, ensuring that the public will find the public health care system useless, eventually calling for a private sector to replace it. This is how a public health care system becomes privatized, which is what has been happening around the world in health care for the last 25 years. What is important to note is that subversive privatization is sinister, while genuine privatization can be accomplished with effective government policies, clear reforms, and clearly stated objectives. A public-private mix can be effective and strong private sector employers are needed in the process, but the example of what has taken place in CEE to date is not a good model. Strategically tearing down the public sector causes suffering to many people, creates a general reduction of tolerance, and generates a vicious circle of blaming. Documents in Eastern Europe, written by representatives of big institutions have done little more than spread this sense.

The studies conducted have provided evidence of a pattern of strong employment insecurity, the insecurity of people, whose very jobs are under threat, growing poverty and growing inequality of income within the health care sector. The sector itself is divisive, with different groups working toward their own interests, and not working in social solidarity for the health sector as a whole. The studies also have revealed a fundamental weakness and fragmentation of collective voice. Trade unions are being pushed aside, in some cases to the point where even local offices cannot be staffed. Such conditions leave workers open to be treated with contempt by any employer or manager. Overcoming contempt is the first priority in collective bargaining. The first task for unions is to make sure managers take the union seriously.

IFP/SES commits itself to building on this project, and urges others working with us in the ILO to do the same.

Annex 1: List of Workshop Participants

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Name	Affiliation
1. Victor Nicolae Benu	Trade Union of Health Protection Workers (SANATATEA), Moldova.
2. Aurel Popovici	Trade Union of Health Protection Workers (SANATATEA), Moldova.
3. Jiri Schlanger	Trade Union of Health Services and Social Care, Czech Republic.
4. Jana Veselá	Trade Union of Health Services and Social Care, Czech Republic.
5. Tamila Kazarina	Central Committee of the Union of Health Workers of Ukraine.
6. Larisa Kanarovksa	Kiev Municipal Committee of the Union of Health Workers of Ukraine.
7. Aldona Baublyte	Lithuanian Trade Union of Health Care Employees.
8. Juozas Miskinis	Lithuanian Trade Union of Health Care Employees.
9. Ivan A. Kokalov	Federation of Trade Unions – Health Services, Bulgaria.
10. Beata Abramska	Health Protection Secretariat of NSZZ Solidarnosc, Poland.
11. Ágnes Cser	Democratic Trade Union of Health and Social Workers, Hungary.
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32. Krzysztof Hagemejer	ILO Social Protection Sector
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37. Carl Afford	InFocus Programme on Socio-Economic Security, International Labour Office.
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39. Ellen Rosskam	InFocus Programme on Socio-Economic Security, International Labour Office.
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