



**Strengthening social dialogue in the hospital sector in the new
Member States and candidate countries**

A project for EPSU and HOSPEEM

Final report

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Economic and labour market context

Economic growth

Austria is one of the European Union's most developed countries. In 2006, the country ranked 4th in terms of GDP per capita (behind Luxembourg, Ireland and the Netherlands). However, economic growth was below the EU average in the first half of the decade, until a recent revival in 2006, with the pace of growth surpassing the 3% mark. This is fuelled by exports (9.2% change on previous year), and related investments (gross fixed capital formation rose by 5.6%).

Table: Key economic indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
GDP per capita in PPS (EU-25 = 100)	125.5	122.0	120.0	123.4	123.4	122.8	122.9
Real GDP growth rate (%)	3.4	0.8	0.9	1.1	2.4	2.0	3.1

Source: Eurostat

Employment

The employment rate is very high in Austria with 70.2% in 2006, following a significant increase from the previous year. This figure is the fifth highest in the EU, behind Denmark, the Netherlands, Sweden, and the UK only (the EU-25 average was 64.7).

Table: Key employment indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Number of people employed (annual average, in thousands)*	3,710	3,746	3,712	3,793	3,744	3,824	3,928
- male	2,090	2,082	2,044	2,094	2,061	2,095	2,147
- female	1,620	1,664	1,668	1,700	1,682	1,729	1,781
Employment rate (percentage)	68.5	68.5	68.7	68.9	67.8	68.6	70.2
- male	77.3	76.4	76.4	76.4	74.9	75.4	76.9
- female	59.6	60.7	61.3	61.6	60.7	62.0	63.5

Source: Eurostat, * Eurostat LFS, break in time series at 2004

Although the participation of women in the labour market is lower than that of men by 13 percentage points, Austria has high levels of female employment. The corresponding figure of 63.5% in 2006 strongly exceeded the EU average of 57.3%. Male employment was 76.9% in 2006, which is also much higher as the European average of 72.0%. The figures also indicate that the employment gap in Austria is only slightly narrower than in the European Union in general.

Unemployment

The unemployment rate in Austria is below the EU average and declined in 2006.

Table 1: Key unemployment indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Unemployment rate	3.6	3.6	4.2	4.3	4.8	5.2	4.8
- male	3.1	3.1	4.0	4.0	4.4	4.9	4.4
- female	4.3	4.2	4.4	4.7	5.3	5.5	5.2

Source: Eurostat

Employment trends in hospital sector

Employment in the hospital and social care sector has witnessed a small decline in 2006 after a significant increase in the previous year. While female employment in the sector continued to increase, male employment declined significantly. There is also an increasing trend towards an ageing workforce, with employment in the 15-49 age groups declining while employment in the over 50 age group increased.

Table 2: Employment in the health and social work sector (NACE N), 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Number of people employed in the health and social work sector (annual average, in thousands)	293.2	303	315.6	319.8	314.8	349.7	347.8
- male	72.6	74	71.8	76.3	76.8	88.4	80.2
- female	220.5	229	243.7	243.5	238	261.3	267.6
Employment in the health and social sector, as share of total employment (percentage)	8.0	8.2	8.6	8.5	8.6	9.1	8.9

Source: Eurostat LFS

Table 3: Employment in the health and social work sector (NACE N), broken down by age (percentage), 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Between 15 and 24 years	8.9	8.9	9.7	9.3	8.0	9.8	8.6
Between 25 and 49 years	75.4	76.9	75.3	76.0	76.2	72.3	71.4
Between 50 and 64 years	15.2	13.7	14.6	14.2	15.4	17.6	19.6
Over 65 years	0.5	0.5	0.4	0.5	0.4	0.4	0.4

Source: Eurostat LFS

Structure and organisation of hospital sector and key recent reforms

Funding and expenditure

According to estimates by the national statistical office (Statistik Austria), expenditure on health care amounted to € 25.1 bn, or 10.2% of the country's Gross Domestic Product (GDP) in 2005¹. Estimates published by the WHO and OECD² set expenditure in 2004 at between 7.5-9.6% of Austria's GDP. The latter would rank Austria 6th in the European Union (behind Germany, France, Belgium, Portugal, and Greece) in terms of health care expenditure. The level of expenditure in nominal terms grew steadily between 2000 and 2005, but only to maintain a relatively stable expenditure/GDP ratio of 10.0 to 10.3 percent.

Table 5: Health care expenditure, key figures, 2000-2005

	2000	2001	2002	2003	2004	2005
Gross Domestic Product (GDP) (billion euro)	210.4	215.9	220.8	226.2	235.8	245.1
Total expenditure on health care (billion euro)	20.9	21.6	22.2	23.1	24.3	25.1
- without long-term care	18.4	19.0	19.5	20.2	21.3	22.0
Total expenditure as percentage of GDP (%)	10.0	10.0	10.1	10.2	10.3	10.2
- without long-term care	8.7	8.8	8.8	9.0	9.0	9.0
Total health expenditure as percentage of GDP*	7.5	7.4	7.5	7.5	7.5	..
Total health expenditure, PPP\$ per capita*	2,170	2,162	2,240	2,306	2,365	..
Public sector expenditure as percentage of total health expenditure*	68.1	67	67.8	67.6	67.6	..

Source: Statistik Austria * Source: WHO-HFA estimates

Public funding of health care is still dominant in Austria (accounting for 71% of all expenditure in 2004³), although its share is decreasing, and is already below the EU average. The main source of financing is the statutory health insurance system, which provided 45.3% of all resources in 2004.

The system is decentralised, and comprises of nine territorial health insurance funds for the nine provinces (Bundesländer), and five national institutions for particular occupational groups. Nine major companies have their own traditional company health insurance funds, but it is not permitted to set up new company insurance funds by federal law.

The funds' revenues are made up predominantly from members' contributions, which were, in the basic case, a proportion of between 7.1% and 9.1% (depending on the respective insurance

¹ http://www.statistik.at/fachbereich_03/gesundheit_ausgaben_tab.shtml

² I.e. the WHO 'Health for All' (WHO-HFA) database (<http://www.euro.who.int/hfadb>), and 'OECD in Figures' (http://www.oecdobserver.org/news/get_file.php3/id/25/file/OECDInFigures2006-2007.pdf), based on OECD's Systems of Health Accounts (SHA) methodology.

³ Data from 'OECD in Figures'; corresponding WHO-HFA estimates set the level of public resources at 67%.

fund) of their taxable personal income in 2005⁴. For employees, the contribution is shared between them and their employers.

Membership of the statutory insurance system is compulsory for employees and the self-employed with a monthly income above a minimum threshold, for pensioners and those receiving other kinds of transfer benefits (e.g. unemployment benefits and childcare allowances), trainees, citizens performing their military or alternative service, as well as their dependants domiciled in Austria. The system covers 98% of the Austrian population. Employees earning below the income threshold and students can participate in a voluntary insurance scheme. As some of the funds ran into major deficits (that may exceed 5% of their budget), a national compensation fund has been established by the federation of the social insurance funds themselves to close such finance gaps.

Other public funds include direct contributions from the federal government, the provinces and local authorities. This contribution accounted for about 25% of all health care expenditure in 2004, and is financed from VAT revenues.

Private resources play an increasing role in Austria. In 2005, around 28% of health-related spending was funded by private households, outside the statutory scheme. The majority of this expenditure involves the costs of health services not covered by health insurance (indirect cost-sharing) and co-financing (direct cost-sharing).

There are legal agreements, based on the Constitution between the federal level and the Länder, to share the financing of hospitals – from social insurance revenues and general taxation.

Table 4: Key indicators of inpatient care, 2000-2005

	2000	2001	2002	2003	2004	2005
Total inpatient expenditure as percentage of total health expenditure	39.3	41.1	41.6	41.4	41.7	..
Expenditure on inpatient care, PPP\$ per capita	1,049	1,130	1,189	1,225	1,302	..
Public inpatient expenditure as percentage of total inpatient expenditure	80.2	80.6	80.9	80.9	81.4	..
Number of hospitals*	312	314	280	272	263	264
Number of hospital beds*	69,851	69,320	67,997	67,708	63,206	63,468

Source: WHO-HFA database *Break in time series at 2001, 2003

Austria had 264 hospitals at the end of 2005, with 63,468 beds altogether. Recent trends mark a slow decline in both figures. The big increases in the years 2002 and 2004, as shown in Table 6, are however explained by breaks in the time series:

- in 2001/2002 Vorarlberg restructured its hospitals, created one organisation, but did not include inpatient care departments within nursing homes
- in 2003/2004, Vienna did the same, they had around 5,000 beds in such departments

⁴ The contribution base is however capped, with the ceiling revised every year. The top threshold for the contribution base was a monthly €3,630 for 2005, and €4,235 for self-employed persons.

Organisational structure and management

Responsibilities in the health sector are divided between the federal state and the Länder.

National level

Most health care matters (prevention, pharmaceuticals, etc.) are dealt with at federal level, except the running of hospitals. The government is responsible for the professional supervision of the hospital sector. But the responsibilities of the federal government concerning hospitals only cover framework legislation, their running rests with the Länder.

The main federal responsibility lies with the Ministry of Health, Family and Youth. Oversight is carried out at different levels – on the basis of an agreement between federal level and Länder on different topics – e.g. planning of healthcare supply, or the system of hospital financing (that is revised every year).

Regional level (Bundesländer)

Most hospitals are operated by the Bundesländer, and they also have a number of nursing homes (Pflegeheime), some with hospital departments. For example in Vienna several units of the municipality are engaged in the coordination, management and financing of hospitals and in training. A separate unit represents also the association in negotiations with the trade unions.

Providers

Public and private sector providers are both present in Austria. Around 80-85% of hospitals are run by the public sector, around 5% are for-profit, and 16% non-profit, mostly church-controlled. Around 52% of beds are in hospitals run by the Länder. Health and other insurers (industrial insurer) also have hospital/rehabilitation beds in their own facilities. For example, the Vienna health association has 15 acute care establishments and 12 nursing homes - some (5) hospitals have been closed over a longer period (around 10 years).

These are not directly controlled by the local government, but are supervised by the hospital sector association for the Land. The association is a public legal body, governed by municipal regulations.

Hospital employees are usually public servants with a local contract, but the largest Vienna hospital (the “General Hospital”) has some staff (researchers in particular) on federal contracts.

Outline of the system of industrial relations

Austria has a well established system of tripartite interest intermediation and independent bipartite bargaining, largely at sectoral level. Social partners are also actively involved in the administration of social insurance benefits and active labour market policies.

Social partner organisations in the hospital sector

Employer side

There are four employers’ associations representing different types of hospitals in Austria.

The Austrian Association of Public and Social Economy (“Verband der Öffentlichen Wirtschaft und Gemeinwirtschaft Österreichs” – hereafter VÖWG) is the largest association for the public sector on the employer side. There is no healthcare-specific organisation, although attempts were made to establish such a separate association in 2006. Two of the nine regional healthcare affiliations – Vienna and Burgenland, which together employ approximately 34,000 health care employees – are members of VÖWG. VÖWG is a member of CEEP and HOSPEEM.

No single association is established for the private sector with each organisation carrying out separate negotiations. The representative organisations are the Association of Private Hospitals and Sanatoria (Fachverband der privaten Krankenanstalten und Kurbetriebe, FVPPK) and the Association of Private Hospitals in Austria (Verband der Privatkrankenanstalten, VPÖ).

FVPPK represents private hospitals, outpatients' departments and sanatoria according to the Act on Hospitals and Sanatoria (Bundesgesetz über Krankenanstalten und Kuranstalten, KAKuG) as well as private Old People's and Nursing Homes. It has around 45 member organisations in the sector with approximately 20,000 employees.

The VPÖ's membership domain encompasses all hospitals and nursing institutions which are owned/managed neither by the federal state, nor the regional governments nor the local state. It represents around 25 hospitals. It is affiliated to the European Union of Private Hospitals.

Church run hospitals are represented by the Association of Interest Representation of Catholic Hospitals and Old People's Homes and Nursing Homes (Verein Interessenvertretung von Ordensspitälern und von konfessionellen Alten- und Pflegeheimen Österreichs, VIO). The associations represents approximately 18 hospitals.

Employee side

There are four trade unions representing workers in the hospital sector:

- GdG (Gewerkschaft der Gemeindebediensteten), is a member of EPSU and is active in bargaining and social dialogue at federal/regional level. The union has approximately 35,000 members working in the sector.
- GÖD (Gewerkschaft der Öffentlicher Dienst), is a member of the social democrat unionists ("Fraktion Sozialdemokratischer GewerkschafterInnen") and is a member of EPSU. They also participate in social dialogue at federal/regional level. The union has approximately 31,500 members in the sector.
- GPA-DJP (Gewerkschaft der Privatangestellten, Druck, Journalismus, Papier) organises Austria's white collar workers, retirees, apprentices and the unemployed. It has around 1500 members in the hospital sector and is a member of EMCEF and UNI Europa. Membership of EPSU has been requested.
- Vida was founded in 2006 as the result of a merger of three smaller unions from the transport; social, personal and health services and private services sector. It has around 12,000 members in the health care sector and is a member of ETF, EFFAT and UNI Europa.
- ÖAK represents all dependently employed doctors as well as self-employed doctors with an operating licence to perform a liberal medical profession. ÖAK is not strictly speaking a trade union and has compulsory membership. It represents around 20,000 doctors.

Structure of collective bargaining and social dialogue in the hospital sector

A significant majority of employees in the sector are public servants and are covered by special service regulations unilaterally determined by the responsible authorities, particularly at Land level. Legislation covers basic terms and conditions and work organisation, and lays down the mechanisms of collective bargaining on issues other than wages and key terms and conditions. No social dialogue currently exists at the federal level for the hospital sector.

There are collective agreements for the private hospitals negotiated separately and separate agreements cover the terms and conditions of workers in church run hospitals. There is currently only one agreement which covers the whole national territory, concluded between the vida trade

union and the VPÖ and the VIO on the employers' side, which covers around 35 private hospitals. In addition, there are some Land level collective agreements. Apart from these agreements, which only cover part of the private hospital sector, there are many company level agreements, some of which cover specific groups of companies.

Some agreements also exist for the non-profit sector (e.g. Red Cross facilities).

Key issues for the hospital sector and the sectoral labour market in particular

Important negotiations were under way at the time of writing regarding the implications of the working time directive and the SIMAP and Jaeger ECJ judgements (working hours, on call time) between the medical doctors' association and trade unions. The aim is to follow a holistic approach for all hospital sector staff in relation to working time. Currently, it is possible to modify working hours set down in law, but such variations need the agreement of the relevant trade union.

A new law on telematics in healthcare is currently being discussed. Work has started on creating electronic patient records.

A new hospital framework law is currently being prepared, with the participation of the Länder who will ultimately be responsible for implementing it.

New legislation on patient's rights is also being developed at the national level. The Länder participate in these negotiations on a voluntary basis.

There is a federal law on quality in health services. The Länder and the social partners were involved in discussions on this law passed two years ago.

Undeclared work is an issue of great significance in the care sector (and the topic is high on the government's agenda) – a federal law is being considered, but responsibility for implementation will be shared with the Länder.

Demographic change and its impact on health care spending and employment in the sector are major concerns, although there is currently no shortage of skilled staff.

Other topics of social dialogue include (between the 9 affiliations at Länder level and the trade unions): equal treatment, diversity, violence, mobbing, but also telework, part-time work and lifelong learning.

Some good practice exists in the sectoral social dialogue at Länder level. For example, the social partners in the hospital sector in Salzburg reached an agreement on how to deal with violence in hospitals. Similarly, the sectoral social partners in Vienna negotiated an agreement on mobbing in the workplace in 2006. An initiative was also agreed to increase the number of women in management positions. A decision was made that if two candidates with equal qualifications applied for the same job, the woman should be given preference over the man. The goal is to address the current imbalance which means that while there are 60% female doctors, this percentage is reduced to 37% among more senior, specialised medical doctors and drops further to 14% among chief medical doctors.

Sectoral social dialogue is considered by both sides to be a positive factor enabling employers and trade unions to jointly address key issues in the hospital sector labour market.

BELGIUM

Economic and labour market context

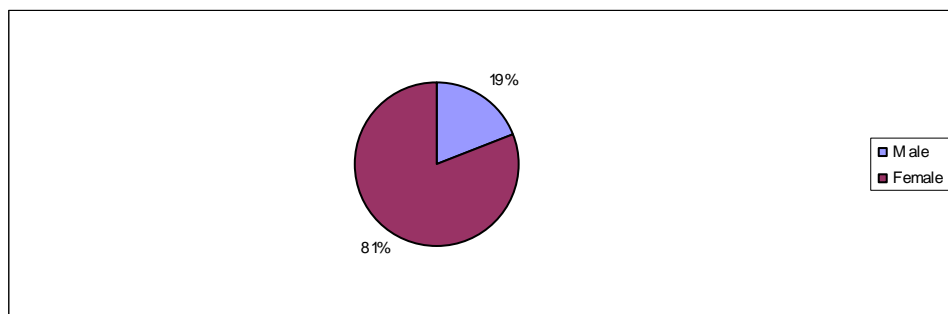
Belgium has an open economy, strongly integrated in the European Union. It enjoys high living standards (GDP of 118) based on high productivity rates. However unemployment remains high and the employment activity rate is low, especially in the Walloon part of the country and the Brussels region. The activity rate of older people is one of the lowest in Europe.⁵

Economic growth dropped sharply in 2001– 2002 owing to the global economic slowdown. The major problems facing the Belgian economy are a low employment rate and significant public debt (OECD 2005). The overall employment rate was 61% in 2005 (68.3 for men and 53.8 for women). Unemployment (as a % of labour force aged over 15) was 8.4% in 2005 (7.6 for men and 9.5 for women).⁶

Employment trends in hospital sector

In real terms, the number of all types of health care professionals has increased continuously since the 1970s, due mainly to a lack of control over the supply side of the market. It is generally accepted that currently there is an oversupply of physicians, dentists and physiotherapists in Belgium. In 2004, the density of practising physicians was 4.0 per 1000 population, clearly above the average of the countries belonging to the EU before January 2007.⁷ According to Eurostat figures (2006), employees in the health and social sector represent 13% of total workforce (all NACE branches).⁸ This figure was 5% in 1992 and 11% in 1996. The vast majority of employees in this sector are women (81%), and in the age group 25-49 (74%). Employees above 50 years old represent 18% of the total.

Figure Employees in health and social sector broken down by sex – Belgium 2006



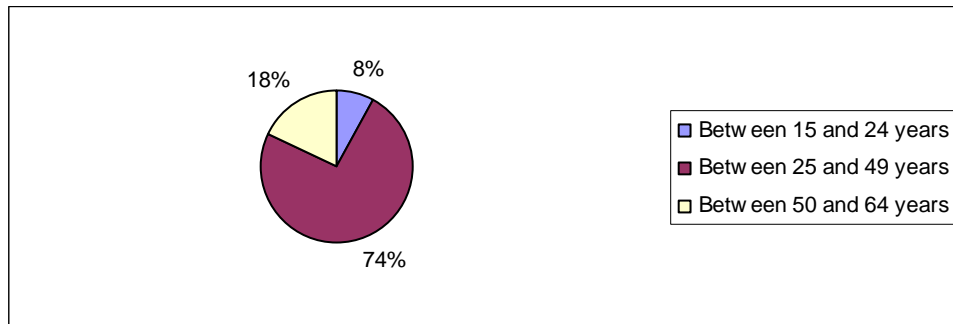
Source: Eurostat

⁵ Belgium industrial relations profile, EIRO <http://www.eurofound.europa.eu/eiro/country/Belgium.pdf>

⁶ Key employment indicators Belgium http://ec.europa.eu/employment_social/employment_analysis/eie/eie2006_annex_en.pdf

⁷ Corens D. Health system review: Belgium. Health Systems in Transition, 2007; 9(2): 1–172.

⁸ Classification of economic activities - NACE

Figure Employees by age groups in Health and social sector in Belgium – 2006

Source: Eurostat

Structure and organisation of hospital sector and key recent reforms⁹

Most Belgians have access to health care of high quality, financed mainly through social security contributions and taxation. Compulsory health insurance is combined with a mostly private system of health care delivery, based on independent medical practice, free choice of physician and predominantly fee-for-service payment.

Funding and expenditure

In 2004 total health expenditure as a percentage of gross domestic product (GDP) in Belgium was 9.3%. Health care expenditure expressed in US\$ per capita was 2922 in 2004, which was the fifth highest health care expenditure among all 27 European Union (EU27) countries.

The growth in health expenditure in Belgium can be explained by several factors, such as the increasing number of elderly people, higher expectations, growth in real GDP and the increasing implementation of new technology in the health care sector.

Social security contributions and subsidies from federal Government are the main funding sources for the compulsory health insurance system. In 2005, social contributions accounted for 74.8%, state subsidies for 11.4% and alternative financing (mainly from indirect tax revenues) for 13.8% of the general social security scheme.

The Belgian health system is based on the principles of equal access and freedom of choice, with a Bismarckian-type of compulsory national health insurance, which covers the whole population and has a very broad benefits package. Compulsory health insurance is combined with a private system of health care delivery, based on independent medical practice, free choice of service provider and predominantly fee-for-service payment. All individuals entitled to health insurance must join or register with a sickness fund: either one of the six sickness funds, including the health insurance fund of the Belgian railway company, or a regional service of the public Auxiliary Fund for Sickness and Disability Insurance. Almost 99% of the population is covered by compulsory health insurance.

Since 1991, the hospital financing system has drastically changed. Different measures have been taken in order to better account for the activities of hospitals and to progressively diminish the historical component of the budget. Moreover, incentives have been created to improve hospital efficiency. In 1994, diagnosis related groups (DRGs) were introduced in the hospital budget in order to financially reward or penalize those hospitals which make use of their beds in more or

⁹ Corens D. *Health system review: Belgium*. Health Systems in Transition, WHO: European Observatory on Health Systems and Policies 2007; 9(2): 1–172.

less efficient ways. Since 1995, the hospital budget has been based on patient characteristics, such as the type of pathology, the age (more or less than 75 years) and the nature of the stay.

Organisational structure and management

Over the decades, Belgium has become a federal state. The process of devolution has resulted in a shift in responsibilities from the national level to the communities and the regions. The Belgian health system is mainly organized on two levels, i.e. federal and regional.

The federal Government is responsible for the regulating and financing of the compulsory health insurance; determining accreditation criteria; financing hospitals and so-called heavy medical care units; legislation covering different professional qualifications; and registration of pharmaceuticals and their price control. The regional governments are responsible for health promotion; maternity and child health services; different aspects of elderly care; the implementation of hospital accreditation standards; and the financing of hospital investment.

The National Institute for Sickness and Disability Insurance (RIZIV-INAMI) is a public body accountable to the Minister of Social Affairs and Public Health. This institute is responsible for the general organization and financial management of the compulsory health insurance. Its most important tasks are: to prepare and implement legislation and regulation, to prepare the budget, to monitor the evolution of health care spending, to control whether legislation and regulation are correctly implemented by health care providers and sickness funds and to organize the consultation between the different actors involved in the compulsory health insurance.

With regards to secondary care, the communities are responsible for ensuring the implementation of norms and standards for hospitals and rest and nursing homes that have been set at the federal level, accreditation of hospital bed and medical equipment and authorizing hospital construction and renovation work.

Providers

Primary and secondary ambulatory care

Primary health care can be defined as the first point of contact between an individual and the health system. Since there is no referral system in Belgium, specialists often form the first point of contact with the patient in the health system. They are therefore considered in this section, along with GPs.

Most physicians – whether GPs or specialists – are paid on a fee-for-service basis. The patient pays the set fee for the consultation directly to the physician, and patients are then directly reimbursed by their sickness funds. Most services are reimbursed at a rate of 75%, so the patient shares 25% of the cost.

Secondary and tertiary inpatient care

In Belgium, hospitals can be classified into two categories: general and psychiatric. In 2005, there were 215 hospitals, of which 146 were general and 69 psychiatric. The general hospital sector consists of acute (116), specialized (23) and geriatric hospitals (7). The basic feature of Belgian hospital financing is its dual remuneration structure according to the type of services provided: services of accommodation (nursing units), emergency admission (accident and emergency services), and nursing activities in the surgical department are financed via a fixed prospective budget system based on diagnosis-related groups (DRGs); while medical and medicotechnical services (consultations, laboratories, medical imaging and technical procedures) and paramedical activities (physiotherapy) are remunerated via a fee-for-service system to the service provider.

The majority of hospitals in Belgium are **private hospitals** (151, equal to 70%). Most private hospitals are owned by religious charitable orders, while the remaining is owned by universities

or sickness funds. Public hospitals are for the most part owned by a municipality, a province, a community or an intermunicipal association.

Both private and public hospitals are non-profit organizations. Hospital legislation and financing mechanisms are the same for both the public and private sectors. The only differences are that for public hospitals internal management rules are more tightly defined and their deficits are covered, subject to certain conditions, by local authorities or intermunicipal associations.

Reforms

Although the Belgian health system has not undergone any major structural reforms since the 1980s, various measures have been taken mainly to improve the performance of the health system. Reform policy in recent years has included: hospital financing reform; the strengthening of primary care; restricting the supply of physicians; promoting generic substitution for pharmaceuticals; increasing the accountability of health care providers and sickness funds; tariff cuts; and more emphasis on quality of care, equity, evidence-based medicine, health care technology, benchmarking with financial consequences and economic evaluations.

Despite the importance attached to the principle of free choice of provider, measures are being taken to strengthen the position of the GP as the preferred entrance point for health care treatment. However, medical professional stakeholders continue to heavily oppose plans for a GP gatekeeping system.

Reforms aiming to increase accountability have also been implemented with regards to hospitals. In 2002 the Hospital financing reform was adopted: hospital budgets are based on the case-mix of the hospital ('justified activity'), surgical day hospitalization is included in the hospital budget, a specific budget for university hospitals is introduced and the hospital budgets are paid each month.

The most important reform in clinical biology was the introduction of a new method for the calculation of the fixed sum per treatment-day for each hospital. The objective of the new method of calculation was to introduce a more transparent system that took into account the hospital's entire case-mix and the significant proportion of fixed costs for laboratories.

Furthermore, the impulse programme for hospital construction launched in 2007 incorporates financial incentives for hospitals to rationalize and redeploy their supply as well as to search for complementarity with other existing hospitals within the same care area.

Outline of system of industrial relations¹⁰

Although certain employment and economic policies are decided on a regional level, labour law, social security matters, and the regulation of the collective bargaining system are still the responsibility of the federal state.

Main actors

At first glance, the social partners are well organised and influential decision makers in the institutional framework. Social partners have the freedom to conclude collective agreements at multi-sector, sector, and company level.

The social partners are consulted on several issues in policy making. Based on the parity principle, they are involved in a lot of steering committees and boards of the welfare state and labour market. Still, this autonomy is under close scrutiny by the government, which has recently taken part in the social dialogue on occasion.

¹⁰ Belgium industrial relations profile, EIRO <http://www.eurofound.europa.eu/eiro/country/Belgium.pdf>

Challenged by globalisation and budget austerity, the system is tending to turn into a kind of competitive corporatism with more state and government influence and with rising discontent on both sides, especially on reforms in welfare state provisions and labour market regulation. While the employers' side is asking for more changes, the unions' side very often opposes the proposed reforms or wants them radically changed.

Trade unions

Based on survey results and additional validation by a recalculation of the administrative union data, net trade union density is estimated at about 50%.¹¹ This is higher than the EU average (25%). The density rate is higher in the private sector than in the public sector.

There are two main trade union confederations: the Christian ACV/CSC with 1.7 million members and the socialist ABVV/FGTB with 1.3 million members.

The smaller, liberal union confederation ACLVB/CGSLB has 225,000 members. Because of their broad support, these three confederations have the status of representative unions, which means that they can sign agreements and present candidates in works council elections.

According to the European Social Survey, about 66% of employees declare having a trade union representative at the workplace – a high proportion compared to the European average. Workplace representation operates through separate channels. The whole workforce is represented by the works council (Ondernemingsraad/Conseil d'Entreprise). Trade unionists are further represented by the trade union delegation (Syndicale Delegatie/Délégation Syndicale).

Employers

The employers' organisational density rate of 72% is one of the highest rates in Europe. The main employer association is VBO/FEB (Verbond van Belgische Ondernemingen/ Fédération des Entreprises de Belgique). The VBO/FEB represents –indirectly by some 50 sector federations – more than 30,000 small, medium sized and large companies in a wide range of sectors, ranging from industry to services. The association works with three regional employer organisations to devise and promote a consistent message from employers. These regional organisations are: Voka – Vlaams Economisch Verbond, Union Wallonne des Entreprises, Union des Entreprises de Bruxelles (Brussels).

The CSPO/CENM is an association of federations for the health care, social-cultural, and educational sector. The smallest employer organisations represented in the social dialogue forums are Boerenbond and UPA, representing the agricultural sector.

Levels of collective bargaining

Collective bargaining is highly structured with three interlinked levels: a central level at the top covering the entire economy; an important intermediate level covering specific industrial sectors; and company level negotiations at the base level. In principle, a lower level can agree improvements only on what has been negotiated at the level above.

- At macro level the negotiations can result in two different types of agreement. On the one hand, the negotiations, which take place within the National Labour Council (CNT/NAR) result in **inter-professional collective agreements**, which are extended to all branches of the relevant activity and throughout the country. On the other hand, negotiations also take place every two years outside the official bipartite organisation and they result in **national cross-sector agreements**, which cover all companies in the private sector and coordinate the scheduled pay rises for the next two years. These agreements constitute

¹¹ European Social Survey 2004

political and moral commitments. Because framework agreements are decided on this level, the national cross-sector level is considered very influential.

- At **sector level** the collective agreements are concluded within the joint committees or the joint subcommittees by all the organisations that are represented by them. The sector collective agreement applies to all the employers and employees covered by the joint committees or subcommittees concerned. Because negotiations on this level implement the framework of the national cross-sector level, it is argued that the sector is the most important bargaining level.
- At company level a collective agreement can be concluded by one or more organisations representing employees (union delegates) and by one or more employer organisations or by one or more employers. The company collective agreement applies to all an employer's workers bound by an agreement, irrespective of whether they are members of a signatory workers' organisation.

Although the number of collective agreements concluded at company level has increased, the **bargaining system remains centralised**. Ever since the 1989 Preservation of the Country's Competitiveness Act, the power of central bargaining levels has remained strong, because the margin to bargain on pay increases is defined in the biennial cross-industry bargaining round. And even then, the social partners' freedom is limited, because the government can always intervene in order to preserve company competitiveness.

Terms and conditions determined through collective agreements

Wages: Belgium is one of the few countries in Western Europe that still has an extensive automatic index-linking in setting wages. This means that pay and social security benefits are linked to the consumer price index. However, each (sector) collective agreement usually has its own way of implementing the indexing mechanism in setting wages. The state tries to balance this automatic indexing of wages with a tight law on monitoring and intervention in the wage-setting system.

In 1975 the guaranteed average monthly minimum wage was introduced through a collective agreement concluded in the National Labour Council and given legal force through a royal decree.

Working time: Statutory weekly working time is 38 hours since 2002. Many companies have a shorter working week, defined by collective agreement.

Other issues: Traditionally, collective bargaining deals only with material benefits: wages, benefits, and working hours. Nevertheless, the number of issues discussed has been systematically extended since the 1980s. The reconciliation of work and private life, the creation of jobs, flexibility in all its forms, innovation in the organisation of work, and lifelong learning (for groups at risk) are new points of interest. The social partners made a commitment in the 1999–2000 cross-sector national agreement to extra training efforts.

The issue of equal opportunity has acquired a place in collective agreements. The law remains important when it comes to issues such as positive action, sexual harassment, or night work for women. Collective agreements have devoted attention to the right to a career break, parental leave, childcare, and gender discrimination within wage categories.

Coverage rate

Extension mechanisms ensure that collective agreements affect almost the whole workforce. Coverage rate is 96% compared to 66% on average in the EU25.

- Collective agreements cover all the employees – members of the signing union or not – of employers who are bound by the agreement.

- The agreements also bind employers, and their workers, who are not members of signatory organisations, but who are covered by the joint committee within which the agreement was concluded, in a supplementary way. The obligatory nature of an agreement concluded within a bipartite structure can also be extended by royal decree.

Policy concertation

There is a long-standing tradition of **informal tripartite social dialogue** in the industrial relations system. The first social pact dates from the end of the World War II. Since then the government consults the social partners regularly on important policy issues. However, since the 1980s it has become more difficult to establish this kind of tripartite social dialogue. The government of the day often turned plans on new social pacts into one-sided social reform programs. For example, in autumn 2005 the social partners and the government tried to reach an agreement on active ageing, the so called Generation Pact. In the end, unions rejected the pact and the government reframed it into a reform plan.

On a national level, all representative social partners participate in the **National Labour Council** (NAR/CNT), which has a general responsibility to give its opinion on matters of social concern to the government or to the parliament.

However, there are many other groups at national, sector, and regional level in which policy concertation takes place, including consulting socioeconomic councils on the federal and regional level (for example, CCB-CRB at the federal level).

Strike activity is low in a historical context. The industrial relations system has an elaborate conciliation and mediation system (organised by the federal administration) that is often used successfully. Today, workers' protests are mainly for one of the following reasons:

- Restructuring, downsizing, or plant closings can lead to a company-related dispute.
- The second type involves large-scale, sector actions, mainly in the semi-public sector, such as health care, telecommunications, or transport. Budgetary constraints and changing working conditions in formerly state-owned sectors are the usual reasons for this action.

Social partners organisation in the hospital sector

Trade unions

Public hospitals

Three trade unions represent workers in public hospitals.

❖ **Centrale Générale des Services Publics (C.G.S.P.)**

On the socialist side, the Centrale Générale des Services Publics (C.G.S.P.) is part of the FGTB/ABVV represents all categories of workers in the public services and public enterprises, regardless of their status (employees in the administration, of ministries, in the education sector etc). In the hospital sector it covers 100% of public hospitals and represents about 30-35% of workers. CGSP was created in 1945.

It is a member of EPSU and ETUC.¹²

❖ **CSC-Services Publics (ACV – Openbare Diensten)**

¹² <http://www.cgsp.be/code/fr/home.html>

On the Christian side, the CSC Services Publics/ ACV- Openbare Diensten represents the interests of persons employed by communal and provincial authorities, by ministries at the federal and regional levels, etc. It was created around 1930.

They have more than 160,000 affiliated members (about 23,000 in the hospital sector). CSC-Services Public is the most important trade union in the public sector. It is part of the negotiation committees for the public sector such as Comité A (equivalent of National Work Council), Comité B and C. CSC-Services Publics is a member of EPSU and EUROFEDOP.

❖ **Syndicat Libre de la Fonction Publique**

SLFP has a more limited role as it is a minority trade union in this sector. It is affiliated to EPSU.

Private hospitals

Two major trade unions represent employees in private hospitals. Together SETCA and CNE represent about 30% of employees.

❖ **SETCA**

On the socialist side, employees are represented by the FGTB/ABVV-affiliated Belgian Union of White-Collar Staff, Technicians and Managers (Syndicat des Employés, Techniciens et Cadres de Belgique/Bond van de Bedienden, Technicien Kaders van België, SETCa/BBTK). SETCA has approximately 10,000 members in the sector.

SETCA represents approximately 13% of employees in the sector and is a member of EPSU.

❖ **CNE**

On the christian side, they are represented by the CSC/ACV-affiliated National Federation of White-Collar Workers (Centrale Nationale des Employés/Landelijke Bedienden Centrale, CNE/LBC). CNE is a member of EPSU.

❖ **AC-CG**

The General Federation (Centrale Générale) represents blue collar workers working in private hospitals. No clear data are available on the number of union members in the sector.

❖ **ACLVB-CGSLB**

The ACLVB Liberal trade union has approximately 2000 members working in the private hospital sector.

Employers

A large number of organisations represent employers' interests in the hospital sector and are mostly organised by ownership status of the respective member organisations.

Confédération des Entreprises Non Marchandes (C.E.N.M.)

The CSPO/CENM is an association of federations for the health care, social-cultural, and educational sector. These sectors are typically not represented in the VBO/FEB. This confederation has at a regional level two similar associations, and all three have gained some influence in the national social dialogue. CSPO is currently an associated member of the National Labour Council and an observer in the Central Economic Council.

CENM was created in 1994. It is an interprofessional organisation representing employers of the non-for-profit sector in Belgium. It represents employers in public and private sectors such as health care, education, social services, performing arts etc.

CENM represents in total more than 24,000 undertakings or 15% of salaried work (2003). It promotes the interest of employers in the non-profit sector as social partners who are part of social dialogue. It is represented in the CNT (Conseil National du Travail (CNT) and Conseil Central de l'Économie (CCE). However CENM is not mandated to negotiate with the government or social partners. Collective bargaining takes place between social partners and individual employers' organisations.

CENM members in the health sector (twenty organisations) are employers organisations such as the Association des Etablissements Publics de Soins (AEPS) and Association Francophone d'Institutions de Santé (AFIS).

- Association des Etablissements Publics de Soins (AEPS) – an association with around 48 member companies employing around 50,000 workers in the municipal hospital sector
- Association Francophone d'Institutions de Santé (AFIS) - organises around 20 public and private care institutions in the Brussels and Walloon regions
- Coordination Bruxelloise d'Institutions sociales et de santé (CBI) - organises around 8 non-for profit Christian care institutions in the Brussels region
- Croix-Rouge de Belgique
- Fédération des Associations Sociales et de Santé (FASS)
- Fédération de l'Aide et des Soins à Domicile (FASD)
- Fédération des Institutions Hospitalières de Wallonie (FIH-W) - organises 31 private, not-for-profit, Christian care institutions in the Walloon region
- Fédération Nationale des Associations Médico-Sociales (FNAMS) – organises around 82 general and psychiatric hospitals with approximately 80,000 staff
- Fédération des Centrales de Services à Domicile (FCSD)
- Nationaal Verbond van Medisch-Sociale Verenigingen (NVMSV)
- Rode Kruis Vlaanderen
- Socialistische Vereniging van Vlaamse Gezondheidsvoorzieningen (SOVERVLAG)
- Solidariteit voor het Gezin
- Union des Villes et des Communes de Wallonie (UVCW)
- Verband deutschsprachiger Krankenhäuser und Altenheime (VDKA)
- Verbond Sociale Ondernemingen (VSO)
- Verbond der Verzorgingsinstellingen (VVI) - organises around 566 Flemish, private, catholic care institutions and hospitals employing 14,000 workers
- Vereniging van Openbare Verzorgingsinstellingen (VOV)
- Vlaams Welzijnsverbond
- Wit-Gele Kruis Vlaanderen (WGKV)

Other employers' organisations:

On the Christian side, Caritas Catholica brings together two associations (one Flemish, the other French-speaking). The Christian Confederation of Social and Healthcare Institutions

(Confédération Chrétienne d'Institutions Sociales et de Santé) represents the mutual hospital institutions stemming from the Christian Workers' Movement (Mouvement Ouvrier Chrétien/Algemeen Christelijk Werknemersverbond, MOC/ACW);

On the socialist side, the employers' federations are those belonging to the Union of Socialist Mutual Societies (Union des Mutualités Socialistes). They are grouped in the Socialist Association of Healthcare Institutions (Association socialiste des Institutions de Santé, ASIS), which is in turn split into French-speaking and Flemish chapters (Association Francophone des Institutions de Santé, AFIS and Socialistische Vereniging van Vlaamse Gezondheid, SOVERVLAG).

Structure of collective bargaining and social dialogue in the hospital sector

The **National Council for Hospital Facilities** is composed of stakeholders from the hospital sector. It plays an important role in the formation of Belgian health care policy by advising the Minister of Social Affairs and Public Health on issues related to hospital planning, accreditation and financing.

The recommendations of the department for hospital financing are primarily related to the health care budget, accounting matters and the financing of hospital construction and renovation.

The **multipartite consultation** structure for hospital policy has existed since 1996; however, it was reformed in 2002 with clearly defined advisory responsibilities. The goal of this consultative structure is to build bridges between the RIZIV-INAMI (providing insurance for inpatient care) and the FPS Public Health, Food Chain Safety and Environment (responsible for the organisation and quality regulation of inpatient care) to improve administration in the hospital sector. Within this structure, an equal number of hospital physicians, hospital administrators and sickness fund representatives consult with each other and give advice on matters which concern both the hospital budget and the fee-for-service system for physicians.¹³

Social dialogue is structured differently in public and private hospitals.

Public hospitals

In public hospitals, negotiations on terms and conditions in the hospital sector take place between representatives of the federal government (Ministry of Health and Social Security) and the trade unions. The state acts as an employer in this case. These negotiations concern wages, salary scales, pension schemes, training, career scales. Recent negotiations focused on the issues of recruitment and internal training of staff to address the shortage of nurses and medical assistants.

Negotiations are a complex process. To be complete and to take effect, agreements which are concluded at the federal level should be followed by agreements at the community (French and Flemish) and regional level. New discussions take place between trade unions and representatives at the local level.

At the federal levels agreements also determine the subsidies allocated to hospitals.

The last collective agreement was negotiated in 2005 and will expire in 2010. In general agreements are renegotiated every 4 to 5 years.

¹³ Corens D. *Health system review: Belgium*. Health Systems in Transition, WHO: European Observatory on Health Systems and Policies 2007; 9(2): 1–172.

In the public sector, industrial relations are regulated by the law of 19 December 1974 on status of trade union in the public sector (*loi sur le statut syndical*). It applies to workers in federal, community and regional administrations, public institutions, local administrations etc.

The law specifies that any measure proposed by the public authority must be preceded by a negotiation or concertation with trade union organisations. Preliminary negotiation is compulsory for a number of terms of conditions: pay, status, pension schemes, relations with trade unions, working time and work organisation.

Negotiation and concertation takes place in special ad hoc committees. They are structured on the parity principle, with representatives of the authorities at different levels – regions, communities, federal government – and representatives of the trade unions.

In the hospital sector the competent committee is the **Comité A**, also competent for the public sector in general: federal, community and regional administration, public organisations, public education etc. The Comité A is the equivalent, in the public sector, of the National Work Council (Conseil national du Travail) in the private sector. In principle, a cross-sectoral social programme is negotiated every two years. The Committee is competent for questions regarding social benefits, pensions, family allowances, sick leave, career breaks etc. A modification of these rights is only possible after negotiation in the Committee.

Comité B is competent for federal public services and Comité C for local and provincial administrations.

There are currently three 'representative' trade union organisations sitting in these committees.

Private hospitals

In private hospitals collective bargaining follows a three-stage process.

- 1) Negotiations between trade unions and the Government: the first stage of the negotiations involves trade unions and representatives of the government (at federal and regional level). Sometimes employers' organisations also take part in this phase of the negotiations. The main issue is the agreement on the public subsidies that will be allocated to hospitals. Trade unions present the various levels of government concerned with a list of demands for the whole of the 'not-for-profit' sector (salary rise, recruitment etc) and try to find an agreement with the government. Agreements are usually negotiated every five years. The most recent one was negotiated in 2005 and will expire in 2010.
- 2) Collective bargaining with employers: in a second phase the agreement on financing reached with the government has to be 'converted' in a collective agreement signed by trade unions and employers. The details of the general agreement are discussed to find a consensus on how to allocate the budget. Once the agreement is signed, the collective agreement is then applicable to all private hospitals in Belgium. Trade unions have to negotiate with the numerous sectoral employers' organisations in the *Commission paritaire*.
- 3) In a third stage the collective agreement has to be validated by the government administration (allocation of the subsidies).

In addition to the collective bargaining process, a permanent negotiation process is taking place in the hospital sector. This is partly due to the fact that a change of government entails the renegotiation of certain parts of the agreement, in particular when new ministers want to implement changes.

Discussions between trade unions and the government also take place in the context of the 'Maribel scheme' or *Maribel social* which seeks to create additional jobs in the public and private

not-for-profit sector through reductions in employers' social security contributions. New social Maribel social security contribution reductions have been in force since January 2003. There are currently 15 000 jobs in Belgium financed through the Maribel fund. It has contributed to create many jobs in the not-for-profit sector.

Social dialogue also takes place in working groups, round tables or pilot projects gathering trade unions, government, universities and employers representatives.

Key issues for the hospital sector and the sectoral labour market

Revision of pay scales

Demands are centred on the revaluation of salaries and harmonisation of pay scales among federal, community and regional levels, as well as a call for tripartite dialogue (rather than merely bipartite) involving subsidising authorities as well as employers and trade unions.

Reduction of workload

To address the problem of the excessive workload of medical staff, a system has been put in place for senior workers since 2000. Workers over 45 years old can benefit from a reduction of working time of two hours per week (four hours for those above 50 and six hours per week for those above 55).

Staff retention

The issues that are currently discussed by social partners are related to the question of staff retention and on-the-job training. One of the main problems facing Belgian public hospitals is to recruit qualified staff such as nurses. Less and less people are willing to accept the constraints and work conditions (e.g. night shifts, strenuous work conditions) attached to these professions. The number of entrants in the medical professions is decreasing. Additionally, the number of part-time workers is increasing, which makes shortages even more acute. Indeed the proportion of part-time workers is 70% in the private sector.

The workforce is also predominantly female (80%). There is an increasing demand on the employees' side for flexible working time and better childcare facilities to improve work/life balance.

Turnover is high and even higher in the private sector where employees do not benefit from the public sector status. Seniority in the private sector is on average 10 years.

One of the solutions put in place has been the implementation of flexible training systems whereby unqualified hospital staff can benefit from training to raise their level of qualifications (e.g. to qualify to become a nurse for instance). Part time training has been encouraged. These training programmes resulted from the discussions in the last collective agreement and were put forward by the trade unions.

In the private sector a project called 'Project 600' aims at creating 600 jobs by replacing employees who are attending training. This creates new job for low-qualified employees, while around 1500 employees upgrade their skills.

Other measures include better accompanying measures for new recruits and employees who resume their career after an interruption; the creation of a "gateway" between licensed nurse and graduate nurse status; and a continuing training programme to take into account technological developments in the area of healthcare.

Cost containment

Another challenge facing public hospital is the increasing difficulties of the financing system. A project of reform consists in the restructuring of the entire public hospital network (which could entail the closure of some hospitals and the rationalisation of the network) to reduce costs and improve efficiency. Public hospitals are financed in the same way as private hospitals but their functioning entail higher costs (e.g. average duration of stay longer in public hospitals). This is partly due to the fact that the public sector addresses the needs of a population coming from a variety of socio-economic backgrounds.

A diverse workforce in a multicultural environment

The Belgian hospital sector is becoming more and more multicultural, both in terms of workforce and in terms of patients treated.

In recent years, hospital have recruited more and more foreign workers, partly due to the shortage of medical staff in Belgium and the difficulty to find qualified employees. Many of these workers come from Eastern European countries. This created new challenges in terms of qualifications (which degrees are recognised, which additional training should be made compulsory etc) and language skills.

The language issue also exists for Belgian medical staff who are now treating patients with diverse cultural backgrounds. The number of language course for hospital employees is increasing.

BULGARIA

General economic and employment situation

The People's Republic of Bulgaria collapsed in 1989. Since the development of a new constitution in 1991, Bulgaria has introduced a democratic form of government, held multiparty elections and privatized its economy. Today Bulgaria is a democratic, unitary, constitutional republic, a member of the European Union and of NATO. Bulgaria's current population is 7,679,290, a decline of 1.5 million since 1989. Following the liberalisation and the "opening" of borders, over 800,000 Bulgarians, most of them qualified professionals, have emigrated due to the economic difficulties.

Bulgaria's real GDP annual percentage growth in 2007 was 5.7 per cent. In 2005, the employment rate (% of population aged 15-64) was 55.8 per cent (60.0% male and 51.7% female). The same year the unemployment rate (% of population aged 15-64) was 10.1 per cent (10.3% male and 9.8% female)¹⁴.

Employment trends in hospital sector

The recent restructuring of the health-care sector was accompanied by a drastic decline in jobs. This was in line with the pressure of the international financial institutions insisting on the optimization of employment in the public sector and on restrictive budgetary policy. The dynamics of employment in the period 1998-2005 shows a decrease in the public sector by about 33 per cent (53,188 people). Part of that decrease was absorbed by the private sector where employment increased sevenfold or by 16,248 people.

During the initial stages of the reforms, different professional categories of healthcare workers were affected by the outcomes in different ways (see chart below). Over the period 1990-2002, jobs had decreased by more than 47,000 with the greatest impact on auxiliary medical personnel. The positions available for doctor's assistants (feldshers) had been reduced by 3.2 times, for midwives by 2.2 times and for nurses by 1.9 times.

The number of physicians and dentists stayed more or less at the same level. The ratio between physicians and staff with secondary/college education (auxiliary medical personnel) was inadequate; in 2002 it was 1:1.6 while in Europe the average was between 1:3.0 and 1:3.5. The dramatic decrease of pharmacists by 11 times and of the assistant pharmacists by 17 times was mainly due to the restructuring and privatization of the pharmacies.¹⁵

¹⁴ Employment in Europe Report 2006, Statistical annexes.

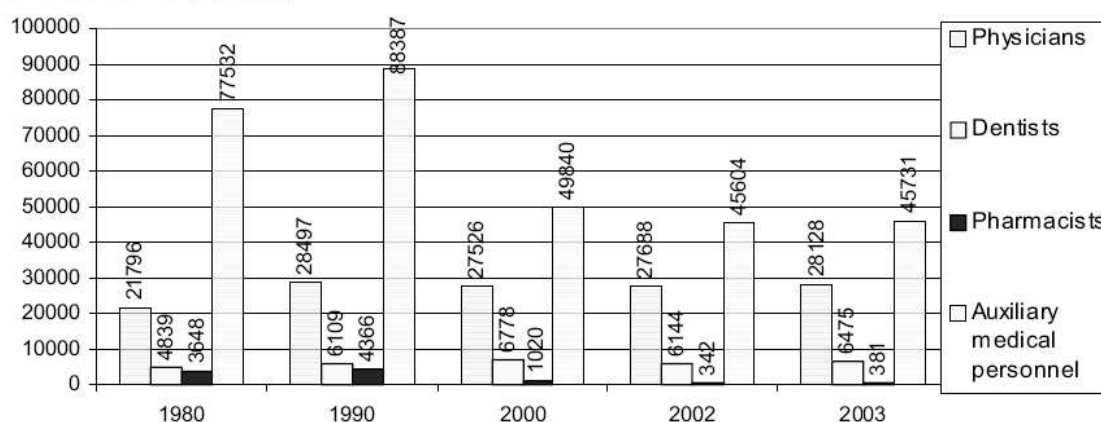
http://ec.europa.eu/employment_social/employment_analysis/eie/eie2006_annex_en.pdf

¹⁵ Dr. L. Tomev, Dr. N. Daskalova, Ms. T. Mihailova. Sectoral Activities Programme. Working Paper. Social dialogue in the health sector: Case study Bulgaria. International Labour Office. Geneva, 2005.

<http://www.ilo.org/public/english/dialogue/sector/papers/health/wp235.pdf>

Table: medical personnel (numbers)

Medical personnel (numbers)



Source: National Statistical Institute Health care, 2004.

The number of specialists is still high compared to general practitioners (GPs), despite the introduction of new training courses and specializations in family medicine. In 2004, Bulgaria had approximately 68.9 GPs per 100 000 population, comparing to 245.9 specialist doctors per 100 000 population. The number of GPs is higher than the EU10 average, but the number of nurses is one of the lowest among all EU countries¹⁶. Bulgaria was and still remains the country with the highest number of dentists in Europe (83.42 dentists per 100 000 inhabitants), which in 2004 almost twice exceeded the EU10 average (43.19 dentists per 100 000 inhabitants) and was 25% higher than the overall EU average (62.64 dentists per 100 000 inhabitants)¹⁷.

Structure and organisation of hospital sector and key recent reforms

Health expenditure

Total health expenditure as a percentage of gross domestic product (GDP) has been increasing in the period from 2000 till 2003 (3.7-4.8%) and declining since to reach 4.3% in 2005. This is still much lower than the EU-25 average¹⁸. In absolute terms the total health care expenditures in Bulgaria have increased by 181% 2005 in comparison to 2000 (this amount does not take into consideration the inflation rates that were around 10% in 2000 down to 6% in 2004). The increasing trend in health care spending reflects the improvements in the country's economy as a result of restructuring, efforts to obtain EU membership and better development of compulsory health insurance, bringing resources to the health system through compulsory contributions and legalization of private practice. However, there was a general decline in levels of public health expenditure, accompanied by a relative increase in private sources from 34.6% in 1999 to 45.5% of total health financing in 2003¹⁹.

¹⁶ Health Systems in Transition. European Observatory on Health Systems and Policies. HiT profile in brief: Bulgaria 2007. <http://www.euro.who.int/Document/E90023brief.pdf>

¹⁷ WHO Regional Office for Europe. European Health for All database (HFA-DB). Copenhagen, WHO Regional Office for Europe, 2006 (June update).

¹⁸ Eurostat data: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-CD-06-001-03/EN/KS-CD-06-001-03-EN.PDF

¹⁹ Health Systems in Transition. European Observatory on Health Systems and Policies. HiT profile in brief: Bulgaria 2007. <http://www.euro.who.int/Document/E90023brief.pdf>

Health reforms in the 1990s brought about wide-ranging changes in health care organization, financing and delivery, and a new type of relationship was established between users, providers and financing. Before the structural reforms of the 1990s the organizational arrangement of health care, decision-making and funding were centralized.

The reforms led to the reorganization and decentralization of the main functions, whereby the Ministry of Health and its 28 decentralized regional health care centres develop and implement comprehensive national health policy and National Health Programmes. Following the transition to a democracy, Bulgarian health care switched to a system of payroll contributions, establishing a semi-autonomous National Health Insurance Fund to raise revenue, allocate resources and govern providers. The Fund's operational activities have been decentralized to the regional level and delegated to the 28 regional health insurance funds.

Privatization is another important feature of the Bulgarian health system. The Health Care Establishments Act outlined procedures for the privatization of both state and municipality medical establishments. Private practice was legalized in 1991 and has since expanded significantly, and in 1992 ownership of most health care facilities was devolved to locally elected municipalities.²⁰

The Bulgarian health care system is still under reform with the social partners and experts attempting to improve its organisation also through the implementation of good practice from the other Member States. The success of the system is highly dependant on an appropriate financing and rational spending of the resources available. The data on the funding of health care institutions in Bulgaria presented in the table below illustrates the key principle of the reform, which was the transition from general taxation budget financing to financing on the health insurance principle.

Table Health Care Expenditures by Funding Institutions (thousand BGN)

Consolidated State Budget	2000	2001	2002	2003	2004	2005
Total health Care Expenditures	980 063	1 195 976	1 438 844	1 697 681	1 769 000	1 773 000
% of Total Health Care Expenditure in GDP	3.7	4.0	4.5	4.8	4.6	4.3
Including:						
Hospital Care	141 938	427 483	624 932	795 606		
% of Hospital Care expenditures in Total Expenditures	15	36	43	47		
National Health Insurance Fund	126 832	428 182	585 084	775 039	882 000	
% of NHIF Expenditures in Total Health Care Expenditures	13	36	41	46	50	

²⁰ Health Systems in Transition Vol. 9 No. 1 2007. Bulgaria: Health system review.

<http://www.euro.who.int/Document/E90023.pdf>

Municipalities	416 217	183 772	209 664	218 802		
Ministry of Health	291 936	493 432	572 585	598 426		
Including:						
Budget Organizations and Central Supply	149 998	218 898	266 949	218 307		
Hospital Subsidies	141 938	274 534	310 255	335 236		
Other Ministries and Agencies	125 622	74 845	70 042	103 793		
National Budget	19 456	15 745	1 469	1 621		

Source: National Health Report, 2004²¹

The percentage of the total expenditures covered by NHIF being gradually increased from 36% in 2001 to 50% in 2004.

Financing the health care system

The healthcare system is financed through:

- Taxes, part of which are subsequently allotted for healthcare as per the Law on the State Budget of the Republic of Bulgaria;
- Mandatory health insurance contributions to the amount of 6%, an amount which is determined every year by the Parliament through the Law on the Budget of the National Health Insurance Fund. They diminish the taxable income base of the person;
- Voluntary health insurance contributions – determined on a market principle by the private health insurance companies for voluntary health insurance;
- Insurance premiums - determined on a market principle by the private insurance companies;
- Subscriptions by employers for specified health services as part of the social package provided to their employees;
- Cash payments by citizens to private practicing doctors, dentists or health establishments, which have not concluded a contract with the National Health Insurance Fund;
- The regulated patient's co -payment for use of healthcare amounting to 1% of the minimum monthly salary for the outpatient sector and 2% of the minimum monthly salary for each day of stay in a hospital, but for no more that 20 days per year. Persons, who suffer from diseases, specified in the National Framework Contract, socially disadvantaged (people who are eligible to social assistance or receive unemployment benefits), children deprived of parental care, military invalids etc. are relieved from this fee. Co- payments are not deductible from the taxes of insured people, but are subject of turnover tax for the doctor.

Since the year of its establishment and currently there is no deficit in the National Health Insurance Fund budget. The Fund ends the year with considerable reserve and is at present the most financially stable institution in the country. The NHIF Budget is approximately 10% of the total State Budget²².

²¹ http://www.gpn.org/research/privatization/priv_bulgaria_engl.pdf

²² http://ec.europa.eu/employment_social/social_protection/docs/bulgaria_final.pdf

The Ministry of Health (MOH) is the second largest source of health care financing in Bulgaria. Its share in public health expenditure went sharply up in 2001 but has remained stable since then. In 2003 expenditure of the Ministry of Health on hospital care accounted for 60% (or 360 009,000 BGN) of total state budget expenditure; mainly these resources went to cover operational and administrative costs of health facilities. Allocations of external funds as well as national health control programmes accounted for about 20% of total state expenditure in 2003. Through the national health control programmes the Ministry of Health funded the centralized procurement of a defined set of life-support and lifesaving drugs, vaccines and consumables for health facilities, health prevention activities and diagnostics services. The Ministry of Health increased the budget for these services by 62% in 2003 compared to 2001.

Organisational structure and management

The organizational structure of Bulgarian health care has been undergoing rapid transformation since the latter part of the 1990s. During the 1990s highly integrated, tax-based and hospital-oriented care was gradually replaced by a compulsory health insurance system, strengthening primary health care based on a model of general practice and rationalization of the services delivery network.

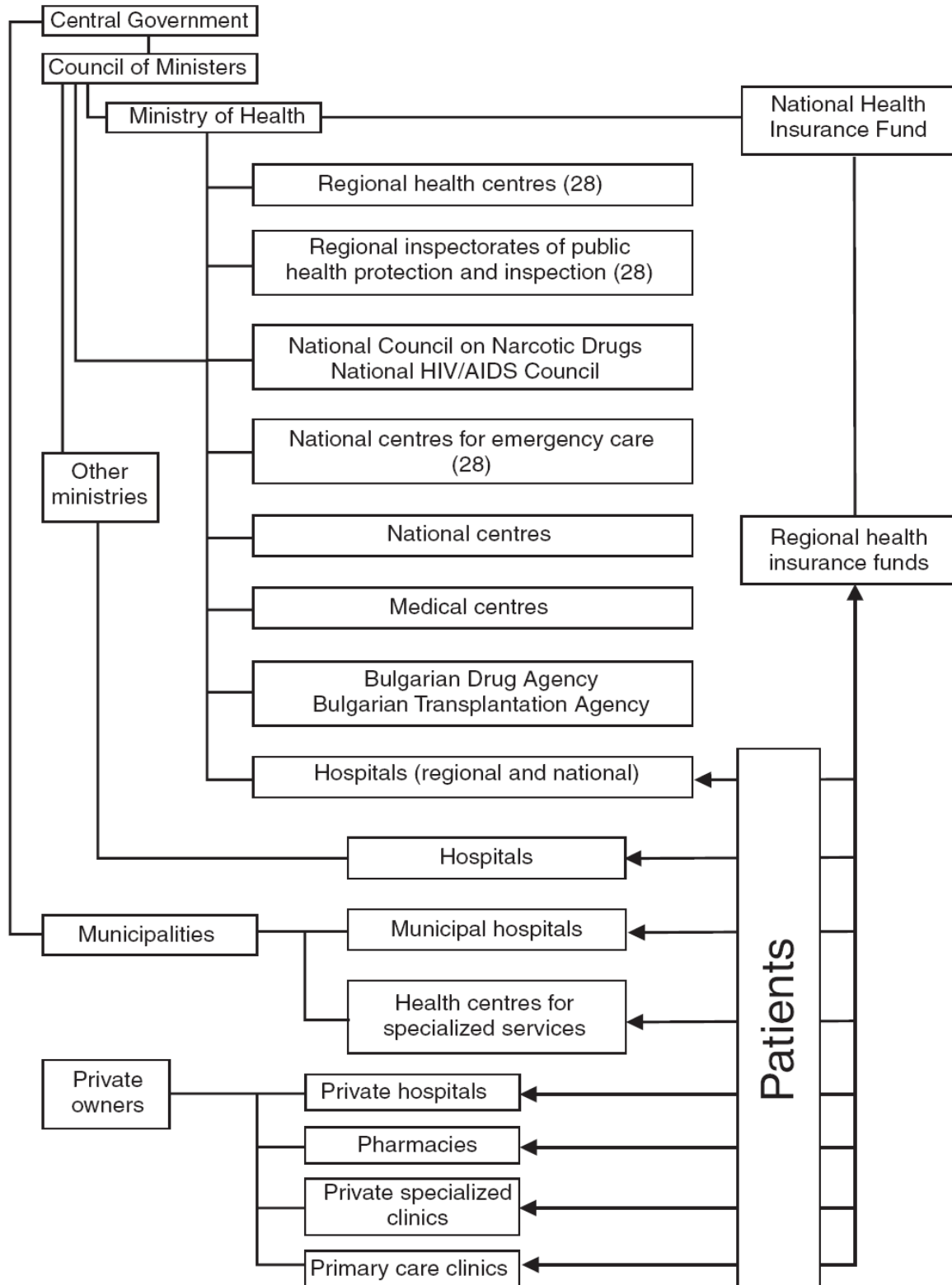
The current organizational structure of the Bulgarian health system is defined by the interaction of public and private players and a mixture of decentralized and centralized structures. The main stakeholders in the Bulgarian health system are the Parliament, the Ministry of Health, the NHIF and the Higher Medical Council. Private practice has expanded significantly, now including dental practices, pharmacies, physicians' surgeries, laboratories and outpatient clinics and polyclinics. All major stakeholders and their main interrelationships are shown in the figure below. Their significance for the individual stakeholders and their functions are described in more detail here.

The Parliament takes part in the development of national health policy. The Parliamentary Health Committee is the main body for the adoption of health related legislation. The Parliament approves the budget of the NHIF together with the state budget. With the need for transparency and a higher level of citizen involvement in the decision-making process in mind, the Parliamentary Health Committee has organized round-table discussions, public hearings and conducted public opinion surveys on what are perceived to be the most sensitive issues, such as regulations on transplantation of organs, tissues and cells, control of narcotic substances and precursors, and pharmaceuticals.

The Ministry of Health develops and implements a comprehensive national health policy, defines the goals and priorities of the health system, works out the National Health Programmes for improving the health status of the population and develops draft legislation concerning the health sector. It also plans and supervises the ongoing structural reforms in the health sector, including the harmonization of health legislation with European norms. The Ministry of Health is also responsible for the emergency care network throughout the country, as well as the public health network. The Ministry registers private health care establishments in accordance with the 1999 Health Care Establishments Act and drafts guidelines, regulations, indicators and methodologies for health facilities accreditation. In the pharmaceutical sector the Ministry also governs and administers the Executive Agency on Pharmaceuticals, which registers drugs and controls the country's pharmaceutical market. It carries out privatization procedures of pharmaceutical and health trading companies and oversees the central purchasing of life-supporting and life-saving pharmaceuticals. The Ministry of Health consists of 28 decentralized administrative bodies (regional health care centres), which are responsible for carrying out national health care policy for each of the 28 regions in Bulgaria. The Ministry currently directly manages a number of national research centres, including the National Centre of Emergency Medical Care, the National Centre of Radiobiology and Radiation Protection, the Centre of Public Health, the Centre

of Drug Addiction Problems, the Centre of Haematology and Transfusion, the Centre of Infectious and Parasitic Diseases, Physiotherapy and Rehabilitation, and the Centre of Health Informatics. In addition, the Ministry administers the National Executive Transplantation Agency.

Table Overview chart of the health system



Since 1991, municipalities have been partly responsible for financing health care facilities which were more than 50% municipally owned. Since 1992, municipalities are given the ownership of most health care facilities, including diagnostic and consultative centres, municipal hospitals for acute care, specialized hospitals and outpatient clinics, all of them serving the needs of the respective municipality.

In accordance with the 1998 Health Insurance Act, the National Health Insurance Fund was established in 1999 as an autonomous institution for compulsory health insurance. Its main functions include management of financial resources for medical care in accordance with the Health Insurance Act and the National Framework Contract and to guarantee access to health care services for the insured population.

The NHIF consists of a central office, 28 regional health insurance funds (RHIFs) – one in each regional centre in the country – and 105 municipal offices. The structure, built in this way, is responsible for the 265 health regions coinciding with the municipalities in Bulgaria. NHIF finances the entire health care network for outpatient care and those hospitals with which it has stipulated a contract. The NHIF Budget Act determines the amount of health insurance contribution. It develops and stipulates contracts with drug wholesalers and oversees drug claims for the purpose of payment confirmation.

Twenty-eight RHIFs prepare their regional compulsory health insurance schemes and stipulate the contracts with the health care providers within their territory on behalf of the NHIF and in accordance with the National Framework Contract. The NHIF pays for the delivered health care services through its 28 RHIF offices in the country.

Private practice was legalized in 1991 and has expanded significantly, now including dental practices, pharmacies, physicians' surgeries, laboratories and outpatient clinics and polyclinics. The number of private inpatient establishments increased from 32 in 2003 to 40 private inpatient facilities in 2004. Private hospitals account for 16% of all hospitals and 2% of the total number of hospital beds. Most of them do not have contracts with the NHIF and the patients pay in full for the services provided. However, most patients cannot afford to pay out-of-pocket or through VHI for medical care. This is why private providers aim to contract with the NHIF and provide publicly funded services.

The medical universities, consisting of the Medical Universities of Sofia, Varna and Plovdiv and the Medical Schools in Pleven and Stara Zagora, are largely autonomous institutions, coordinated jointly by the Ministry of Health and the Ministry of Education and Science. Since the beginning of 1999, university hospitals have been financed and administered by the Ministry of Health and the teaching activities in these hospitals have been funded by the Ministry of Education and Science.

Providers of health care

The law on therapeutic establishments divides the hospitals into two groups: general and specialized. The general hospitals represent 55 per cent of all hospitals with 71 per cent of the total number of beds. In 2004 the number of general hospitals was 141, the specialized hospitals are 117 and there were 58 specialized hospitals for active medical treatment and 49 dispensaries. The number of private facilities for hospital care increased to 32 representing 13.6 per cent of the total number of hospitals. Most of them did not have contracts with the NHIF. The patients pay entirely for the services provided. There is a considerable decrease of beds in all health establishments in the country during the period 1998 – 2004 dropping to about 49,000 beds. The number of beds per 10,000 of the population is 70 as compared to 128 in 1995. Hospital beds per 10,000 of the population are 58 while in Europe the average is 77.8. Private hospitals account for 16% of all hospitals and 2% of the total number of hospital beds.

Key challenges facing the hospital sector and reforms in the last 5 years

The situation of the hospitals has deteriorated dramatically in the past five years and is now threatening the success of the whole health sector reform. Accordingly the National Health Strategy 2001-2007 addresses now problems at the hospital level. The most burning issues in Bulgarian hospitals are:

- a. Insufficient budget allocation: Frequently patients have to pay by themselves for drugs and for basic consumables, such as wound dressings and disinfectants, because the hospital has no money.
- b. Squandering and financial mismanagement of the hospital administrations.
- c. Corruption in the hospitals: Staff is trying to compensate their low salaries by requesting 'under the table' payments from the patients.
- d. Exodus of highly skilled specialists and nurses: staff leaves public facilities either for the local primary care sector or for other countries.
- e. Last but not least, poor quality of the services provided in the hospitals and in particular inadequate hygienic conditions which cause a high risk of hospital acquired (nosocomial) infections (NI). A large part of the problems associated with NI arise from the lack of information, lack of adequate basic and continuous training of medical and paramedical staff in the field of nursing and hygiene standards and a lack of treatment guidelines. There are also loopholes in the quality assurance and control system.

The practical implementation of the new Strategy for Restructuring of the Hospital Sector has major challenges. The restructuring of the 300 hospitals in the country is underway and coincides with the introduction of an obligatory 5-year accreditation scheme. The credit points assigned to a particular hospital provides a basis for the funding allocation of the health insurance. In addition treatment costs in the hospitals are covered according to specified clinical pathways. New medical standards in all basic and interdisciplinary therapeutic areas have been introduced, including quality assurance measures at all levels in the health care system. Basic training for all healthcare workers has been harmonized with the training requirements in other European countries and a credit-points-based system for continuous medical education has been established.

Outline of system of industrial relations

In line with most new Member States, collective bargaining started to develop in Bulgaria as a result of the setting up of free markets in the 1990s. This period also brought significant amendments in labour legislation in order to adapt to the new scenarios as well as meeting with the requirements of the Community acquis. The Bulgarian Labour Code was amended in 1992 and provided greater scope to collective bargaining.

CITUB (the Central Council of Bulgarian Trade Unions) is the main cross sectoral trade union confederation. The establishment of trade union pluralism in Bulgaria has contributed to the recognition of unions as key actors in the reform process, particularly during the years of preparation and implementation of tripartite cooperation and collective bargaining. The policy of supporting reform at an acceptable social price and of introducing a new consensus culture of labour relations via social dialogue also strengthened the authority of the trade unions and made it possible for them to play a leading role in building up a new system of industrial relations and social partnership.

CITUB's counterpart on the employer side is the Bulgarian Economic Association.

Social dialogue in Bulgaria grew from nothing. One of the indisputable achievements of democratic development is precisely the transition from centralized labour relations pre-defined by the State to an industrial relations model based on social dialogue and the creation of institutions for its realization.

In 1990, the first tripartite negotiations were conducted and a General Agreement was signed between the Government, CITUB and the Bulgarian Economic Association. The General Agreement includes paragraphs on the creation of a system for the conciliation of interests and collective bargaining, including amendments to the Labour Code. A national tripartite committee for the reconciliation of interests was established and regulations for its functioning were adopted. Thus the basis for institutionalizing social dialogue was actually set up; following amendments and additions to the Labour Code, adopted in 1993 and 2001, this institutional basis shaped the framework of the system for social dialogue and partnership in Bulgaria.

Social partner organisations in the hospital sector

Compared with many other sectors in Bulgaria, social dialogue and collective bargaining in healthcare is relatively well developed at all levels. There is, for example, a Sectoral Council for Tripartite Cooperation in Healthcare, which negotiates collective agreements and acts as a forum for cooperation. In early 2006, new collective agreements are being negotiated at sectoral and municipal levels, against a background of continuing healthcare reform.

There are three representative trade union organisations in the healthcare sector:

The Federation of Trade Unions in Health Services (FTU-HS) is affiliated to the Confederation of Independent Trade Unions in Bulgaria. It has 9,300 members (of which 6,800 are in the hospital sector), grouped in 370 union organisations. About 75% of members are women. There has been a 46% decline in membership since 1999, when the reforms in the sector started. The fall is a result of the restructuring of healthcare establishments, the introduction of new principles for outpatient healthcare, the major staff cuts caused by public sector reforms and the introduction of obligatory membership of the professional associations of dentists and doctors. Nevertheless, some stabilisation of membership has occurred since 2002 and new members have been recruited. This is viewed by the leadership of the federation as a result of successful social dialogue at all levels and especially of the collective agreements concluded. Nevertheless, in private healthcare establishment union organisation is difficult, reportedly because of the resistance of employers.

The Medical Federation Podkrepa (MF Podkrepa) is affiliated to the Confederation of Labour Podkrepa and has about 4,000 members (of which 3000 are in the hospital sector), who belong to 210 sections throughout the country.

The Federation of Independent Trade Union of Governmental organisations (FITUGO) has 7500 members of which only 300 are active in the hospital sector.

All federations are members of Public Services International (PSI) and the European Federation of Public Service Unions (EPSU).

The employers' organization in hospital sector is the National Association of Employers in Health²³ (NAEH), founded in 2001. Membership of NAEH consists of 35 healthcare establishments - mostly large medical establishments in Sofia, centres in other large cities, university hospitals and municipal hospitals. NAEH is a member of the Bulgarian Industrial Association, which is recognised as a representative employers' organisation at national level.

A number of Municipal Councils for Tripartite Cooperation (MCTCs) have been set up in healthcare. These councils are made up of equal numbers of representatives of the trade union employers' organisations recognised as being nationally representative, and of the local authorities. NAEH has not yet established local structures, so it does not participate fully in the social dialogue at this level. Conducting negotiations and concluding municipality-level collective agreements are among the most important areas of the MCTCs' work.

Social dialogue in the health sector is developing at sectoral/branch and municipal level, as well as the establishment level. The general framework for social dialogue in the health sector is shown in the table below.

Table 4. Framework for social dialogue in the health sector

Level	Social partners	Agendas	Social dialogue institutions	Social dialogue elements, instruments and mechanisms
National*	Government: Vice-President, ministries, deputy ministers Representative employer organizations: BIA, BCCI, UPEB, UEI Representative trade union confederations: CITUB and Podkrepa CL	Wage policy in the public sector Minimum wage Labour and social legislation Socio-economic policy and reforms Overall policy for social dialogue and collective bargaining	National Council for Tripartite Cooperation (NCTC) Commissions at NCTC Specialized tripartite bodies Expert working groups on different issues (e.g. labour legislation)	Social dialogue Negotiations Information Consultation Framework agreements National agreements Action plans
Sectoral/branch	Ministry of Health FTUH-CITUB National Association of Employers in Health (NAEH) Medical federation Podkrepa	Specific labour and social legislation Sectoral policy and reforms Collective bargaining Industrial and labour conflicts	Sectoral Council for Tripartite Cooperation in Health (SCTCH) Ad hoc and permanent working groups	Social dialogue Negotiations Information Consultation Sectoral/branch agreements and collective agreements Conflict resolution procedures
Regional/municipality	Mayor/ and representatives Employers' structure (if any) Territorial Coordinating Council TCC-CITUB Medical Regional Council Podkrepa	Collective bargaining Health reform in the municipality Restructuring and privatization Labour disputes in the establishments	Municipal Council for Tripartite Cooperation (MCTC)	Bargaining Information Consultation Collective agreement Conflict resolution Control over the implementation of collective agreements
Health-care establishment	Employer Trade union organizations	Collective bargaining Internal rules Health and safety at work Pay system General policy Labour disputes	Bargaining group	Information consultation Collective bargaining Collective agreement Code of conduct

* National level is presented as far as income policy in the public sector and legislation on health reforms are negotiated at that level.

²³ Национална асоциация на работодателите от здравеопазването в Р България

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CYPRUS

Economic and labour market context

In the past 20 years, the Cypriot economy has shifted from agriculture to light manufacturing and services. The services sector, including tourism, contributes 77.6 per cent to the GDP and employs 72.1 per cent of the labour force.

Unemployment, at 5.3 per cent in 2005, has remained fairly low, and the employment rate is above the EU average at 68.5 per cent in 2005.

The economic outlook remains bright for Cyprus in 2007. Economic growth is projected to reach 3.6 per cent in 2007, marginally lower than the 3.8 per cent recorded the year before.

Figure - Employment and unemployment rates in Cyprus and in the EU-25, 2000/2005

	Cyprus in 2000	Cyprus in 2005	EU-25 in 2005
Employment rate – total	65.7%	68.5%	63.8%
Employment rate – male	78.7%	79.2%	71.3%
Employment rate – female	53.5%	58.4%	56.3%
Unemployment rate – total	4.8%	5.3%	8.7%
Unemployment rate – male	3.1%	4.4%	7.9%
Unemployment rate – female	7.1%	6.5%	9.8%

Source: European Commission (2007) *Employment in Europe 2005*.

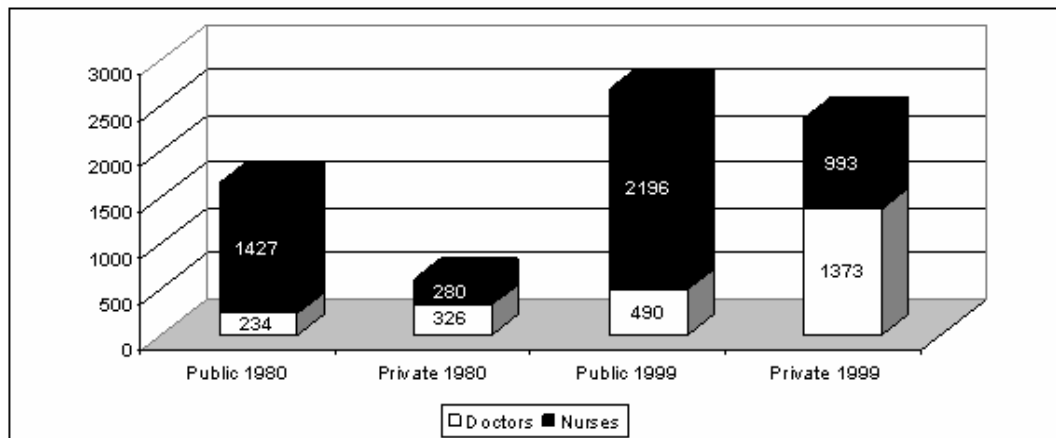
Employment trends in the hospital sector

The number of active doctors and nurses in Cyprus has risen constantly over the past two decades. In 1980 the health sector employed 2,267 workers and by 1999 the number had more than doubled to 5,052. During this time the number of physicians more than tripled.

The number of both doctors and nurses employed in the private sector has grown disproportionately in comparison to the public sector. In 1980 just over a quarter of all workers (27 per cent) were employed by the private sector but this figure rose to nearly half of all employees (47 per cent) by 1999. Nearly three quarters (74 per cent) of all doctors work in the private sector, while just under a third of all nurses (31 per cent) work in the private sector.

Private medicine is dominated by a large number of physicians in individual practices; the number of private hospitals is low. A number of polyclinics have recently been established in urban areas offering a wide range of medical services, at all levels of health care, including highly specialised services like cardio surgery and other treatments. Not-for-profit medical institutions have also been established.

Figure – the number of doctors and nurses in private and public health sectors, 1980 and 1999



Source: GHK Consulting, 2007, on the basis of information from Ministry of Health

Structure and organisation of hospital sector and key recent reforms

Cyprus has a highly centralised public administration system, with most administrative and regulatory functions taking place at the state level. This also applies to the health and hospital sector. Other central features of the health system have been the lack of a comprehensive National Health Insurance Scheme (NHIS) and the extensive role of the private sector in the healthcare delivery. However, a health reform is underway focusing on functional decentralisation and in 2001 a National Health System (NHS) was enacted into a law by the House of Representatives. The slow pace of reform nevertheless has caused a lot of anger among the public as well as social partners. The role of the private sector in the healthcare delivery is more extensive than in any other EU country²⁴.

Organisational structure and management

The Council of Ministers has the overall responsibility for the state's role in the social protection and health care system in Cyprus. It exercises this authority through the Ministry of Health, the Ministry of Labour and Social Insurance and, to a smaller extent, the Ministry of Finance:

- The Ministry of Health is responsible for the organisation of the health system and the provision of state-financed health services. The Ministry formulates national health policies and coordinates the activities of public and private hospitals and health centres.
- The Ministry of Labour and Social Insurance implements government policies on employment, social insurance, social welfare and industrial relations.
- The Ministry of Finance is responsible for the administration of specific allowances and grants e.g. mobility allowance, child benefits and mothers' allowance.

A top-heavy bureaucratic hierarchy exists within the public hospitals, with considerable civil service and ministerial control of management and decision-making²⁵.

²⁴ Golna, C. et al (2004) Health Care Systems in Transition – Cyprus. The European Observatory on Health Systems and Policies.

²⁵ Golna, C. et al (2004) Health Care Systems in Transition – Cyprus. The European Observatory on Health Systems and Policies.

*Health care delivery*²⁶

The health care delivery is twofold: the state-operated public system and the private system provided by private physicians and hospitals. Patients are free to select the physician or specialist of their choice. The following gives more information on primary and secondary health care, including hospitals, and the role of private providers in these fields:

- Public and private primary care. Public primary health care is provided at 4 hospital outpatient departments, 7 suburban outpatient departments, 5 urban and 23 rural health centres and 274 sub-centres. Most private health services are provided by practising physicians and dentists who offer all types of outpatient services in their own surgeries, mainly in towns or large villages. However, through amalgamation, private clinics have established specialised facilities, which are often used by the state sector too. The government also purchases private sector facilities for specialised treatment (i.e. heart operations, oncology, kidney transplant). General hospitals (with the exception of Nicosia General Hospital) offer only specialist outpatient primary care.
- Secondary and tertiary care. Secondary and tertiary health care is provided by district hospitals and specialist centres (e.g. Cyprus Institute of Neurology and Genetics). Nicosia General Hospital acts as the overall referral hospital for certain specialties not provided elsewhere in the country. Also, three small rural hospitals in relatively isolated areas provide a comprehensive set of services including specialist inpatient services. There are two specialized public hospitals: a psychiatric hospital and a hospital for children and women. Not-for-profit medical institutions have also been established.

Health care expenditure

The health care expenditure remained significantly below the EU average in Cyprus in 2003. The expenditure as a share of GDP stood at 4.1 per cent in 2003²⁷.

Funding

Government provision of health care services mostly is funded through general taxation with a small amount financed from charges imposed on some services. The private health insurance schemes provide some financing but at a relatively low level.

Hospital budgets are included in the annual budget of the Ministry of Health. This means that individual hospitals do not take control over their own budgets. Consequently individual hospitals have little or no information on spending, resulting in little awareness of costs and no incentive to control them.

Reforms

The health sector is facing several different challenges at the moment, including limited monitoring and regulation of the private sector and few incentives to improve productivity due to the centralised form of managing public hospitals. A range of different reforms are nonetheless underway, which are attempting to tackle some of the most acute problems.

²⁶ European Commission (2003) Study on the Social Protection Systems in the 13 Applicant Countries – Cyprus Country Study

Golna, C. et al (2004) Health Care Systems in Transition – Cyprus. The European Observatory on Health Systems and Policies.

²⁷ Eurostat (2007) Europe in Figures – Eurostat yearbook 2006-2007.

- The planned NHIS will address some of the main structural weaknesses of the public health system by reforming the purchasing systems and provider payment mechanisms to improve efficiency and quality of care. Furthermore, with the introduction of the NHIS, the Ministry of Health will lose its managerial powers over individual public sector providers and assume a regulatory role over public and private providers.
- The NHIS will be universal as regards to the population coverage and will be financed by contributions from the state, employers, employees, self-employed, the pensioners and all those who have non-employment incomes.
- The primary health care centers in the rural areas are being strengthened with additional staff and equipment in order to upgrade and extend the scope of their services.

The slow pace of the reform has however caused a public uproar. According to the original plans, the NHIS system should have been implemented already by 2006.

Outline of system of industrial relations

The industrial relations system in Cyprus is based on two fundamental principles; voluntarism and tripartite cooperation. National policies are designed after extensive consultation with the social partners. Despite collective labour agreements not being legally binding, sectoral and company level bargaining has traditionally played a leading role in labour market regulation, with legislation playing a secondary role.

Main actors

The main national trade unions are the Pancyprian Federation of Labour PEO (63,871 members), the Cyprus Employees Confederation SEK (64,733 members), the Democratic Labour Federation of Cyprus (DEOK), and the Independent Trade Unions (POAS).

The largest employer organisations are

- Employers' and Industrialists' Federation OEB. The members of OEB employ over half of the workforce in Cyprus.
- Cyprus Federation of the Associations of Building Contractors
- Cyprus Association of Bank Employers,
- The Pancyprian Association of Hoteliers (PASYXE)
- Cyprus Chamber of Commerce and Industry (CCCI)

Level of bargaining

Bipartite collective bargaining takes place at sectoral and company levels. In 2003, there were 13 sectoral agreements (covering 26.7 per cent of workers) and 450 enterprise agreements in force.

Coverage rate

Bargaining coverage currently stands at 65-70 per cent and covers all employees with the exception of senior managers. The trade union density is around 70 per cent.

Policy concertation

A tripartite national council was set up soon after the country gained its independence in 1960 and tripartite concertation is today at the heart of industrial relations in the country. Cyprus now has over 50 tripartite committees and bodies that contribute to policy-making in the country through discussions and joint agreements. The nature of tripartite cooperation, nevertheless, tends to be advisory. Some of the most important tripartite committees are:

- Ministry of Health (Health Insurance Organisation Management Board GESY)
- Ministry of Labour and Social Insurance (Labour Advisory Board; National Committee on Employment; Social Insurance Council; Annual Leave's Central Fund Council; Redundancy Fund Council; Human Resource Development Authority Board; District Labour Offices Advisory Committees; Pancyprian Council on Health and Safety; District Advisory Committees for tourism; Council for the rehabilitation of people with disabilities).
- Ministry of Finance (Advisory Economic Committee; Statistics Council)
- Ministry of Commerce and Industry (Advisory Committee for Industrial Development; Board of Directors of the Cyprus Standardisation & Certification Company; Consumers Advisory Committee, etc).
- Ministry of Education and Culture (Advisory Committee of Tertiary Education)

Social partner organisations in the hospital sector

Trade unions

The Federation of Public Services Employees Cyprus (FPSEC-SEK) represents 6,100 workers in the public sector.

The Pancyprian Public Employees Trade Union PA.SY.DY (Pankypria Syntechnia Dimossion Ypallilon) represents mainly white collar public servants in Cyprus. Most of its members work in the postal or health sector. It has a total of 12,400 members of which 2,848 work in Cypriot hospitals.

The Cyprus Turkish Civil Servants Trade Union (KTAMS) represents 2,500 workers across the public sector.

The Pancyprian Union of Government Doctors (PASYKI)

The Pancyprian Union of Government Nurses (PASYNO)

The Federation of Private Sector Workers

The Cyprus Industrial, Commercial, Press-Printing and General Services Workers' Trade Union (SEVETTYK)

The Pancyprian Government and Military Workers' Trade Union (PASYEK)

Employers' organisation

For public hospitals, the employer is the state and therefore the Ministry of Health. In the private sector, the Employers and Industrialists' Federation has some membership in this sector (approximately 56 hospitals and care facilities).

Structure of collective bargaining and social dialogue in the hospital sector

Basic wages of nurses are set by national legislation. Though there is no national minimum wage, current legislation sets minimum wages for six different occupations in Cyprus (clerks, sales staff, nurses, school assistants, baby minders, and child minders). Collective bargaining for public sector staff takes place within the Joint Staff Committee.

All public sector doctors are salaried employees of the Ministry of Health and belong to a centralised civil service staffing system that allocates them to posts based on defined needs. Doctors can not move from their post unless another vacancy becomes available.

There are very few multi-establishment agreements in the private sector (it is estimated that only 30% of private hospital sector workers are covered by collective bargaining). For all other workers, terms and conditions are set at the local level.

Key issues for the hospital sector and the sectoral labour market

Need to improve education and training

There are concerns over education and training of both doctors and nurses:

- As Cyprus has no medical school, primary training of health care professionals takes place primarily in Greek and British universities or in other universities abroad. With the new reform under way, there are some plans to establish a medical school in Cyprus.
- The current lifelong learning policy of nurses allocates staff to training courses according to their seniority, rather than need. Consequently there should be a more rigorous method for assessing training needs.

Problems around nursing staff

There are multiple problems around the quality and quantity of nursing staff in Cyprus. First of all, all public sector nurses are registered but only less than a fifth of nurses in the private sector are officially registered. The Ministry of Health lacks a strategic role in setting, updating and enforcing standards for nurses in both public and private sectors²⁸. Evaluations on the Cypriot healthcare system have suggested that the ministry should devolve the management of nursing resources to each individual hospital where more flexible arrangements (e.g. negotiation and agreement on shift patterns) could be introduced.

Secondly, some 97 per cent of public sector nurses work in hospitals. For this reason the number of nurses in community health care is too low.

²⁸ Golna, C. et al (2004) Health Care Systems in Transition – Cyprus. The European Observatory on Health Systems and Policies.

CZECH REPUBLIC

Economic and labour market context

The Czech economy is growing steadily since the beginning of 2000's. The recent GDP growth rates of the country are well above the average EU growth. In 2006, Czech real GDP growth was of 6.1%, representing a mild slowdown since 2005, when the growth was culminating at 6.5%²⁹.

Contrary to the neighbouring countries, unemployment rates in the Czech Republic remained relatively low, for an economy undergoing such drastic changes as the Czech Republic was in the nineties. Unemployment rates did not increase above 10% and remained close to the EU average as well as to the average of large economies such as France or Germany. As can be seen from the table below, today the Czech Republic is performing slightly better than the EU-27 average in terms of both unemployment rate and employment rates. Today, the Czech Republic has an unemployment rate of 7.1%, while 65.3% of total population are in employment. However, the gender differences concerning the employment situation in the Czech Republic are important. Unemployment among women is three points higher than unemployment of men and the proportion of the active male population is seventeen points higher than that of women.

It should be noted that while the unemployment rate in the Czech Republic is relatively low, the share of long term unemployment is high. According to Eurostat data, in 2006 3.9% of the Czech population were long term unemployed (i.e. unemployed for more than 12 months). Long term unemployment affects women more significantly than men.

Despite the fact that seven percent of the Czech population are unemployed, the Czech labour market is actually experiencing labour shortages, particularly among low-skilled jobs. This situation was created by the high level of foreign investment in the manufacturing industry, which generates a lot of low-qualified jobs.

Employment and unemployment rate EU 27 and Czech Republic

	EU-27	proportion female/male	CR	proportion female/male
Total Unemployment	7.90%		7.10%	
Males	7.10%		5.80%	
Females	8.80%	123.94%	8.80%	151.72%
Total Employment	64.30%		65.30%	
Males	71.60%		73.70%	
Females	57.10%	79.75%	56.80%	77.07%

Employment trends in the hospital sector

The Czech health and social care sector employs nearly seven percent of the Czech active population, which is three percent less than the average EU-27 figure. As shown in the table below the overwhelming majority of employees in the sector are women (80.27% of total employees in health care, that is 12.69% of total Czech active population). This trend dropped only slightly since 2000.

²⁹ Data source: Eurostat

In addition, the health and social care sectors are particularly affected by the challenge of an ageing workforce. As shown in the table below, nearly one third of Czech employees in health and social care are over 50 years old. In addition the proportion of young people entering the sector is very low. Less than six percent of the workforce in these sectors is younger than 25. These figures also reveal that the predominance of women in the sector is not decreasing among the younger generation. While 10.24% of the total active female population between 15 and 24 years are employed in health and social care, this is the case for only 1.6% of men.

Employment in health care and social sector per sex and per age category³⁰

50 years and over – Sex – Total						
EU-27	2000	8.22%	21.07%	2006	10.41%	26.63%
Czech Republic		as % of total 6.89%	as % of total 26.62%	as % of total 7.82%	as % of total 31.62%	
50 years and over – Sex - Male employment						
EU-27		population in HC 5.50%	population in HC 5.50%	population in HC 6.90%	population in HC 6.90%	
15 years and over – Sex – Total						
EU-27		8.63%	5.81%	9.54%	7.31%	
50 years and over – Sex - Female						
EU-27		16.83%	15.57%	16.83%	19.74%	
15 years and over – Sex – Males						
EU-27		13.85%	20.55%	13.09%	24.07%	
Czech Republic		2.02%	18.59%	2.37%	19.73%	
15 years and over – Sex – Females						
EU-27		15.43%	77.49%	16.76%	77.93%	
Czech Republic		11.33%	81.41%	12.69%	80.27%	
Between 15 and 24 years – Sex – Total						
EU-27		6.14%	7.95%	6.99%	7.52%	
Czech Republic		5.38%	10.43%	5.26%	5.94%	
Between 15 and 24 years – Sex – Males						
EU-27		1.91%	1.34%	2.28%	1.35%	
Czech Republic		1.08%	1.12%	1.61%	1.06%	
Between 15 and 24 years – Sex - Females						
EU-27		11.19%	6.60%	12.74%	6.18%	
Czech Republic		10.33%	9.31%	10.26%	4.85%	
Between 25 and 49 years – Sex – Total						
EU-27		9.19%	70.98%	9.62%	65.84%	
Czech Republic		5.96%	63.21%	6.60%	62.44%	
Between 25 and 49 years – Sex - Males						
EU-27		3.61%	15.67%	3.66%	13.82%	
Czech Republic		1.97%	11.69%	2.13%	11.37%	
Between 25 and 49 years – Sex - Females						
EU-27		16.33%	55.31%	16.94%	52.02%	
Czech Republic		11.01%	51.56%	12.40%	51.08%	

³⁰ Data source: Eurostat

Structure and organisation of hospital sector and key recent reforms

Czech health care expenditure level is slightly below the EU-25 average. While the Czech Republic spent 6.7% of its GDP on health care in 2004, the EU-25 average for the same period was 7.4%. The expenditure level in Czech Republic has been roughly stable in the last decade, oscillating between 6.3% and 6.9%³¹.

Financing of the system

The Czech health care system underwent an important transition in the nineties. From a system financed through general taxation under the socialist regime, it was transformed to a compulsory insurance based system.

The Czech insurance system is characterised by a multitude of health insurance companies. The number of health insurance companies is not regulated by the state. In the nineties there were up to 29 insurance companies, but the numbers dropped and there are currently nine insurance funds. The causes of such a reduction in number were diverse: for example, inadequate underwriting for small funds, high overhead costs for small funds, and too many special programmes (e.g. for the chronically ill, such as asthmatics). Some of the funds merged and others closed down, while some went bankrupt.

In order to prevent too small funds from entering the market there are currently several requirements for establishment of an insurance fund:

- Permission must be given by the Ministry of Health and the Ministry of Finance.
- The fund has to have a minimum of 50.000 people insured.
- The fund has to have a financial reserve which is stipulated by the law.

The supervisory board in each insurance company is composed of:

- members appointed by the State
- insured – these members are elected by the parliament
- employers – delegated by the Chamber of Trade and Industry

The numbers of these members are divided equally and all members have equivalent powers.

The largest health insurance company is the General Health Insurance Fund (Všeobecná Zdravotní Pojišťovna – VZP) which covers more than 68% of the Czech population. The VZP is a public organisation. In addition both the Ministry of Internal Affairs (police) and the Ministry of Defence (military) have their own insurance funds, which evolved from the parallel health care systems existing under the previous regime.

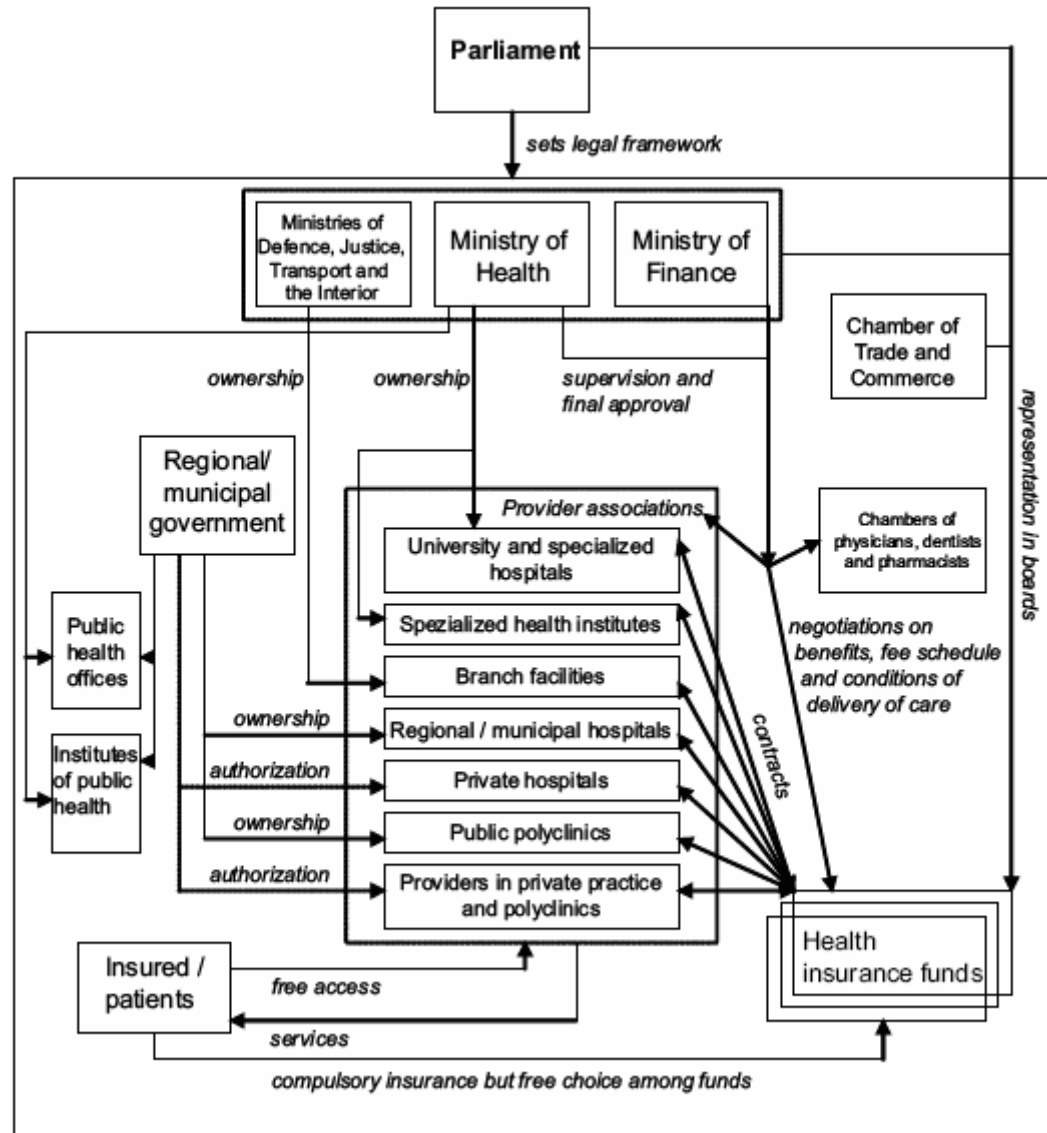
In general, health insurance companies are forbidden from making profits. Any surpluses go to the Reserve Fund. Each insurance company has a reserve fund which serves to bring accounts back to equilibrium in case they are negative.

Insurance funds receive contributions from employees, employers and the state. Contributions for economically active people are calculated as 13.5% of wages before tax. This is divided as follows: 4.5% for employees and 9% for employers. Health care insurance is compulsory. To illustrate the above figures, a contribution based on average wage (21.673CZK in 2005/ 722€) would be 2925CZK/ 97€. The system is slightly regressive as there is an upper ceiling for contributions which is set at 13.5% of six times the average wage. The state covers contributions for approximately 56% of the population (unemployed, pensioners, children and dependants up

³¹ Data source: Eurostat

to 26 years of age, students, women on maternity leave, men serving in the military, prisoners, and people receiving social welfare). The state contributions are calculated as 13.5% of estimated wage. In 2003 they were set at 467CZK (€15) per person per month. The state contributions are hence lower than contributions paid on basis of minimum wage (837CZK / 26€ in 2003).

Figure 1 – Structure of Czech Health care system³²



While health care services are covered by the health insurance funds, sickness benefits (sick pay, maternity leave, replacement pay when taking care of a sick person, etc.) are paid from the state-run social security fund. These are covered by different contributions. Altogether, insurance funds collect and redistribute around 90% of public financial resources in the health care system. The remainder is covered by state or regional budgets.

³² Source: European Observatory on Health Systems and Policies: *Health Care in Transition : Czech republic*, 2005; p.16

Healthcare coverage

All Czech insurance funds offer significantly the same coverage. This coverage is comprehensive and for the majority of interventions free at the point of delivery. Only a limited number of services are excluded from the statutory health care system, such as: cosmetic surgery for non-medical reasons and selected services made at the patient's request (primarily various medical certificates).

In the Czech Republic, cost-sharing is required mainly for selected drugs, dental services and some medical aids. A small number of services, including certain kinds of dental care, require co-payment. Prostheses, eyeglasses and hearing aids may be either partially or fully reimbursed. The levels of out-of-pocket payments are still very low in the Czech Republic. The country has actually the lowest share of out-of-pocket payments of all OECD countries (i.e. 8.6% of total health care expenditure in 2002).

Finance allocation

Individual health insurance funds contract hospitals and doctors for the provision of services. Originally, payments were calculated on a fee-for-service basis and were based on a "fee schedule", which indicated the number of points allocated to each type of service. The number of points was then multiplied by the monetary value of a point in order to calculate the reimbursement. Originally the monetary value of a point was not unified but set according to various criteria. In this system, insurance funds were not able to act as active purchasers of services but only as passive payers for services delivered by contracted providers. Such purely fees-for-service reimbursement system did not create incentives for rationalisation of health care delivery, but on contrary created adverse effects.

This situation changed in 1997 with new legislation, which more clearly defined the volume limits in the contracts and permitted the use of payment schemes other than fee-for-service. This legislation also introduced a uniform point value which results from the process of joint negotiations between insurance funds and providers, but needs the approval of the Ministry of Finance.

Since mid-1997, hospital inpatient health care has been reimbursed according to retrospective budgets. These budgets take into account the relevant period of the previous calendar year, taking the inflation rate into account. The points from the fee schedule are used to determine the activity of the hospital or, in other words, to evaluate whether an equivalent activity has been delivered for the budget.

Health care delivery system

Czech Republic has a rather dense network of health care providers. As will be discussed later the ownership of health care facilities has come through an important evolution recently. Therefore facilities range from private, municipal, regional to state owned.

Opening of a health care practice, for all primary, secondary and tertiary care, is conditioned by a receipt of licence delivered by the Czech Medical Chamber. No limitations to numbers of providers exist.

Primary health care

Citizens register with a primary health care physician of their choice and can re-register with a new physician every three months. There are no restrictions on patients' choice of primary health care physicians or on access to them. The following four types of primary physicians have a gatekeeper role: GPs for adults; GPs for children and adolescents (paediatricians); ambulatory gynaecologists; and dentist/ stomatologists.

In 2002, there were on average 1650 inhabitants aged over 14 per general physician post and 1050 persons aged 0–19 per GP for children and adolescents. As shown in **Error! Reference source not found.** below, the numbers of primary health care units in Czech Republic are far beyond the EU-25 average. The same table also indicates that the Czech system has a very elevated number of out-patient contacts per year. Czech Republic has the highest rates in this area in the EU. Such high contact rates reveal inefficiencies in the system. These are likely to be due to the already mentioned fee-for-service reimbursement mechanism.

Secondary and Tertiary health care

Specialised outpatient care is provided by independent practitioners, at polyclinics with several specialists, and in outpatient sections of hospitals. At the end of 2002, a total of 28 482 physicians (full-time equivalent) and 54 980 mid-level health care staff (full-time equivalent) worked in outpatient care.

At the end of 2002, there were 201 hospitals in the Czech Republic (11 university, 168 other acute-care hospitals, and 22 subsequent-care hospitals).

The table below shows that Czech Republic has much higher numbers of hospitals than the EU average. The inpatient and acute care admissions are also more elevated, and patients stay longer, than the EU average.

Data about the structure of Czech health care system (2004)³³

	CR	EU-25
Primary health care units per 100000	234.65	61.57
Outpatient contacts per person per year	15.2	7.82
Hospitals per 100000	3.56	2.65
Bed occupancy rate in %, acute care hospitals only	74.8	74
Acute (short-stay) hospitals per 100000	1.93	...
In-patient care admissions per 100	22.15	20.65
Acute care hospital admissions per 100	20.77	19.36
Average length of stay, all hospitals	11	8.13
Average length of stay, acute care hospitals only	8.2	7.99

Ownership

As noted above the ownership structure of Czech health care facilities has been evolving recently. Currently, provision is ensured by a mix of providers, when it comes to their ownership.

As a consequence of privatisation in primary health care about 95% of facilities were privatized by 2002. The entry of doctors into primary health care practice is controlled through licensing by the Czech Medical Chamber and the issuing of authorization permits by the regional authority. Doctors then contract individually with health insurance funds (health insurance funds should play a regulatory role in this sense).

While the vast majority of outpatient physicians have become private in recent years, most bed facilities remain public, but their status is undergoing dynamic changes in consequence of the public administration reform and its objective of decentralisation. As a result of decentralisation smaller regional and local hospitals' management was moved on to the regions. Before the end of 2002, 80 hospitals were owned by districts, which were handed over to the regions and municipalities as a result of the public administration reform.

³³ Idem

Currently, hospitals are owned both by the State and by private for-profit and not-for profit organizations, and we can therefore distinguish among hospitals managed directly by the Ministry of Health, regional, municipal and town hospitals, private hospitals and church hospitals. University hospitals have a specific status, which, in addition to their health care function, also perform educational and research roles. The complexity of the problems of university hospitals is due to the twofold hierarchy of its management. University hospitals are under the responsibility of two ministries – the Ministry of Education and the Ministry of Health. Hence, both the management and finances come from two centres, each of which has different ideas, demands and powers.

Reforms and main difficulties of health care sector

The main difficulty of the Czech health care system is currently its cumulated deficit. The deficit reached 9mld CZK (0,29 mld€) in 2004³⁴ and continues to grow. Such deficit creates significant time slips between the moment when health care services are delivered and when they are paid for by the insurance funds.

There have been several attempts to address the issue of deficit but any reforms proved difficult to put in place, mostly due to political instability. Indeed the Czech government went through three changes since 2004 and there was also important turnover on the ministerial chair in health care.

Despite the fluctuations the previous minister prepared a long terms conception of health care for the period 2005-2009. The short term objectives of this conception concerned on:

- stabilisation of management
- improvement of economic and health efficiency of services

Therefore the following priorities were defines:

- optimisation of the network of health care providers
- measures to improve management in health care insurance
- measures to improve hospital management

The conception proposed to continue the payment system based on categorisation of interventions, but the categorisation was to be reviewed. On macro-level, the health insurance yearly plans were to be considered binding as overall financial frameworks. On micro-level the health insurance companies should be encouraged to have an active role in the management of their costs and expenses.

Other difficulties underlines by this conception were:

- the fact that different health insurance funds have different proceedings for identical interventions where such differences are not justified (i.e. different costs of interventions)
- sub-optimal arrangements in the public provision of health care insurance (VZP). The VZP alone had a deficit of 6.9mldCZK in 2004 (0.22mld€)
- in order to optimise the network of health care providers it is necessary to cooperate between the central government and the regional administrations. Creation of common plans at regional level would be necessary

³⁴ Source: Reforma Zdravotnictví pro Českou Republiku v Evropě 21. století; p.19
http://www.healthreform.cz/content/files/cz/Reforma/1_Publikace/CZ_publicace.pdf

- Since there is no legal form which could cover a public non-profit hospital, many hospitals were transformed into limited company status. Such transformations create a risk for public goods provision.
- Further training of health care personnel in fields of management and health care economy is very weak

The previous government did not have time to implement concrete measures as it was replaced after elections in 2006. However many principles and observations of the conception are general enough to still remain valid. The positive aspect of the conception was that it launched a wider debate on health care reforms and acknowledged the necessity of forecast planning rather than ad-hoc measures.

However a wider reform was still awaited in summer 2007. The present coalition was preparing a large reform proposal in summer 2007 which was to be the largest health care reform in post-socialist period. At the time when this case study has been written the proposal was still not presented to the parliament. The following measures were put forward³⁵:

- Raising the part of co-payments. These should become nearly systematic, for example a visit to a specialist should be topped-up by a 50CZK (1.78€) out-of-pocket payment, for each pharmacy prescription a patient should pay between 20 and 30 CZK to the pharmacist (0.71- 1.07€), etc.
- Redefinition of what is covered by the compulsory health care coverage. Further dental, plastic surgery, baths and some health care tools should be excluded from the basic coverage or more co-payments would be required.
- On the other hand the basic health care would become a right which patients would be entitled to claim from insurance companies.
- Introduction of complementary health insurance

Industrial Relations

In the Czech Republic, tripartite negotiations exist at national, but also regional level, however these are not formalised neither binding.

The main tripartite body is the Council for Social and Economic Agreement (Rada hospodářské a sociální dohody – RHSD). The Council is:

*A common voluntary and initiative body of the government, trade unions and employers, for tripartite negotiations at the Government Secretariat General with the objective to achieve agreement on key questions of economic and social development.*³⁶

The plenary sessions of the Council are attended by the prime minister, seven members of the government, seven representatives of trade unions and sever employers' representatives. Currently the social partners for the government are:

On employees' side

- Confederation of Czech and Moravia Trade unions (Českomoravská konfederace odborových svazů)
- Association of Autonomous Trade Unions (Asociace samostatných odborů)

³⁵ Source: Hospodářské noviny 3 August 2007 http://hn.ihned.cz/2-21743400-500000_d-c7 and http://ihned.cz/c4-10041240-21744580-000000_d-pacienty-cekaji-radikalni-zmeny

³⁶ Source: Czech Government Secretariat General <http://www.vlada.cz/cs/rvk/rhsd/uvod.html>

On employers' side:

- Confederation of industries and transport of the Czech Republic (Svaz průmyslu a dopravy České republiky)
- Confederation of employers' and entrepreneurs' unions of the Czech Republic (Konfederace zaměstnavatelských a podnikatelských svazů České republiky)

Besides the socio-economic issues the Council has as a priority to strengthen social dialogue in Czech Republic's political system, to improve its representativity by involving other groups of actors to discussions at the highest level. The Council can also establish working groups and expert groups in order to support its work.

Social dialogue structures are also being established at regional and sectoral level. Some regions are establishing their own Councils (e.g. South-Moravia or Vysocina). Unions and employers can also enter into negotiation outside the Council with representatives of individual government departments.

Legal framework

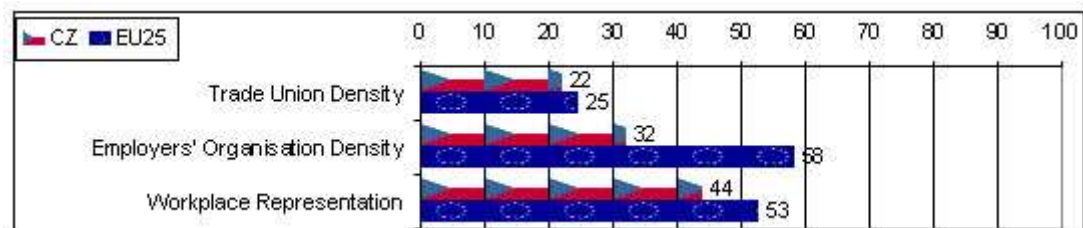
The Labour Code provides comprehensive regulation of all aspects of the employment relationship, including working hours, maximum overtime (150 hours a year), short time and temporary stoppage (layoff) in agreement with workplace trade union organisations, holiday entitlement, and health and safety.

In 2001, the 'Czech model' of a one-channel institutional workplace representation – when there is no union representation – was introduced.

Actors

The table below presents the density of the Czech population represented by trade unions and employers' organisations. Overall, the trade union density was 22% in 2004 while in 1995 it was about 46%. This declining tendency is generally expected to continue. The Czech Statistical Office estimated the density of unionised employers at 32% of employees at the end of 2004.

Representation³⁷



Employees

The main trade unions in Czech Republic are:

- The Czech-Moravian Confederation of Trade Unions (*Českomoravská konfederace odborových svazů – ČMKOS* <http://www.cmkos.cz/>). It is the biggest trade union federation in the territory. In 2004 there were 34 trade unions, with 611,000 members, affiliated to ČMKOS. The largest affiliate is the metalworkers' union. CMKOS stresses its non-party character, although its substantive positions place it near the Czech Social Democrats and, in some respects, the conservative

Popular Party. Some 70% of trade union members are in organisations affiliated to CMKOS.

- There are also several smaller union centres; in some cases these are occupational (such as 'radical' railway workers) and in others political or religious. These have joined together in the Association of Autonomous Trade Unions (Asociace samostatných odborů – ASO <http://www.asocr.cz/>), which was established in 1995. It should be noted though that the membership in its trade unions is declining and its influence is fairly limited – including at workplace level and for collective bargaining. In 2004 ASO comprised 14 trade unions with 170,000 members.
- Other small union centres include:
 - o The Confederation of Art and Culture (Konfederace umění a kultury – KUK). In 2004 its 13 member unions and associations had 59,000 registered members.
 - o Trade Union Association of Bohemia, Moravia and Silesia (Odborové sdružení Čech, Moravy a Slezska – OS ČMS <http://www.sweb.cz/oscms/>). Founded in spring 1991 OS ČMS has about 100 trade union organisations. In 2004 it declared that it had 15,000–17,000 members, more than 50% of whom are retired.
 - o Christian Trade Union Coalition (Křesťanská odborová koalice – KOK). In 2001 KOK had almost 15,000 members. Its membership is in decline, with KOK declaring 9,000 members in 2004.

Employers

There are two big confederations:

- The original largest employer organisation is the Confederation of Industry of the Czech Republic (Svaz průmyslu a dopravy ČR – SP ČR <http://www.spcr.cz/>), which consists of 30 organisations and professional associations affiliating about 600,000 employees in 1,573 companies. The confederation is a member of BusinessEurope and other international organisations. It was established in 1989 by directors of state-owned companies and underwent profound restructuring after privatisation.
- The Confederation of Employers' and Entrepreneurs' Associations of the Czech Republic (Konfederace zaměstnavatelských a podnikatelských svazů ČR – KZPS CR <http://www.kzps.cz>), consisting of five organisations and about 600,000 employees in member companies. It has grown strongly and overtaken the Confederation of Industry recently.
- The Association of Construction Enterprises was always an exception. Even after privatisation it represented at least 75% of companies.
- There is also an Association of Entrepreneurs, which represents mainly SMEs across all sectors.

Bilateral negotiations and collective agreements

Two types of collective agreements are legally defined in the Czech Republic. These can be either at company level or at higher level. However the current legalisation does not define a branch neither a sector, rather it says that higher collective agreements can be signed for a

higher [than a company] number of employees among the relevant trade union and employers' organisation(s).

Currently company collective agreements predominate. In 2003, 4,007 workplace agreements were concluded by workplace union covering more than 1.13 million of employees. These figures are declining. Higher collective agreement are becoming more and more difficult to close as employer associations often refuse to conclude or extend sector- level agreements.

The public sector is not subject to sector-level negotiation.

From the employers' side, there has been greater emphasis recently on individual employment contracts, especially in joint ventures. These contracts can also address particular aspects of discipline at work.

Social partner organisations in the hospital sector

National Level

When it comes to the health care sector, the negotiations at national level take place within a Working Group on Health Services, which is attached to the Tripartite Council. The working group works on basis of "a gentlemen's agreement". There are no formal bases for its existence and functioning, neither is there an obligation to come to an agreement. The Working group brings together representatives of the Ministry of Health, the employees trade union and several employers' organisations.

The sectoral trade union in health care is:

- Trade union of health care and social care in Czech republic (Odborový svaz zdravotnictví a sociální péče ČR – OSZSP <http://osz.cmkos.cz/>). It is the largest trade union in this sector with more than 45,000 members.
- Czech-Moravian Trade Union of Civilian Employees of the Army (ČMOSA) has around 4000 invoiced members.
- Trade Union of Doctors in the Czech Republic (LOK-SČL) with around 5100 members.
- Professional and Trade Union of Medical Workers of Bohemia, Moravia and Silesia (POUZPČMS) with around 12500 members.

Employers are represented by the following organisations:

- The Association of Czech and Moravian Hospitals (Asociace českých a moravských nemocnic ACMN - <http://www.acmn.cz/>). This association was originally bringing together small and medium hospitals, with 145 members (hospitals and other health care providers) it is today the largest employers' organisation in this sector.
- The association of Czech hospitals (Asociace nemocnic ČR – AN CR <http://www.ancr.cz/>). Bringing together approximately 75 providers.
- The Association of University Hospitals (Sdružení fakultních nemocnic SFN - <http://www.sfn.cz/>) defending interests of 14 state owned hospitals
- The Association of Specialised Centres (10 specialist clinics)
- The association of private hospitals ([Sdružení soukromých nemocnic – ASN](#))

There are a number of issues regarding employer representation in the hospital sector in the Czech Republic. The split into several different organisations is problematic for representativity

as some hospitals funded directly by the state communicate directly with the government, whereas others are organised at the regional level. A recent reform at this level has led to hospitals being merged into fewer regional companies, which means that for around 5-6 establishments there is now only one Director. As a result of these factors and widespread privatisation, it is often difficult to define who the employer is in the hospital sector, with many considering that this is the Director of each individual hospital. There are currently efforts to establish one national employers' organisation for the hospital sector, but this is a difficult process.

As a result of the current difficulties of defining an employers' organisation to negotiate with, there is no higher level collective bargaining for the hospital sector.

Collective bargaining largely takes place at the level of each individual establishment. The baseline for bargaining is the national minimum wage and regional tables adjusting the minimum wage for certain sectors. This is set centrally by government. It is possible for local collective bargaining to set wages below the regional sectoral tables, but not below the national minimum wage. There are different sectoral wage tables for the private and public sectors, with salaries in the public sector often being up to 20% higher.

Despite their role as financing organs for the health sector, health insurances are not involved in this dialogue, as the government opposed such involvement. There is a feeling that even when payments to insurance companies go up, reimbursements to hospitals for their procedures do not. There is also no compensation for the effects of inflation and other costs such as higher utility prices. This places significant restrictions on the level of salary increases hospitals are able to offer their staff, thus making it more difficult to recruit and retain workers.

Regional and local level

There is currently very little social dialogue at regional level, even though regions have important responsibilities in health care since the decentralisation reform. Regions and towns are very often owners of the hospital infrastructure. Many Czech hospitals were recently grouped into regional entities with one single owner, the region, which further complicated ownership relations as each hospital has a separate management board.

While regions have the competence to intervene in hospitals' management, through the health care councils, the extent to which they do so depends from region to region. In some regions they are very present and put a lot of pressure on hospitals and hospital directors while in others they intervene much less. Typically their responsibilities lay in appointing the directors and other members of management board of a hospital. Sometimes representatives of employees are invited to participate in such selection procedures.

Most hospitals do have some form of social dialogue at local level. At this level the main topics tackled are:

- Indexation of wages. As there is no higher collective agreement in health care (see section 0) indexation are negotiated at local level.
- Training of staff
- Working hours
- Other benefits such as: annual leave, canteen, complementary insurance of staff, etc.

Key challenges for sectoral social dialogue in health care

Structural difficulties for social dialogue at national level

As noted above the employers' representation in health care is currently very fragmented. This is, for the moment, a key structural challenge for social dialogue in this sector. Mainly for the reasons of such division it proves hard to bring all the involved partners together. Though, the trade unions have been trying, it proved impossible to sign a higher collective agreement so far. Ideally, one employer organisation should be created to represent employers at national level to create the possibility for national (or regional) collective bargaining.

In addition the fact that insurance companies are excluded from any tripartite or bipartite negotiations is considered as an important weakness as they are eventually redistributing finances in the system.

Remuneration and financing of the system

Like in many other countries and other sectors, the prevalent theme of social dialogue in Czech Republic is remuneration of staff which is very closely linked to the financing of the system. While employees' representatives try to obtain better wages, employers' organisations complain about underfinancing of the system, the complicated budgetary procedures and inefficiencies in finance redistribution by insurance companies.

The indexation of wages in health care is rather complicated as some staff is still managed by the public sector regulations while other is not. Discussions on wages are also complicated by the fact that, as stated above, employers' organisations have important divisions among themselves and therefore no collective agreements on indexation have been agreed on recently.

As noted in section 0, by lack of decisions at national level, negotiations on wages often take place at local level and are included in company agreements.

Recruitment and retention of staff

The Czech Republic is beginning to feel a lack of workforce, this is particularly the case in the health care sector. The health care sector is lacking personnel at all levels, from unqualified staff to highly qualified staff.

The reasons for such gaps are many. On one hand less and less young people are joining the profession (as nurses, technical staff as well as physicians). On the other hand significant numbers of qualified staff are leaving to work abroad, Germany and the UK being the most common destinations.

Despite the fact that a lack of resources has become a major problem for Czech hospitals it is, for the moment, not being dealt with within the social dialogue at national level. The obstacles to such a discussion are several. On one hand there is a lack of governmental planning for health care reform, which would cover the topic of resource planning. On the other hand, due to the lack of finances in the system, Czech employers can not offer salaries which would be competitive enough.

It was noted by employers' representatives that many physicians and also nurses who leave do not succeed in finding a job which would be equivalent, in terms of status and responsibilities, to the job they held previously in their home countries. It was suggested that better information of employees, possibly in the form of social dialogue with employees' representatives at regional or local level, on the type of problems encountered by health care staff leaving the country could contribute to staff retention.

In terms of international mobility, Czech Republic is actually affected by flows in both directions. Staff is not only leaving but also incoming. There is an important proportion of Slovak nurses and

doctors who practice in Czech Republic. Indeed as the wages are higher in Czech Republic than in Slovakia and Slovak staff does not meet language difficulties their integration is usually very smooth. Until recently the incoming numbers of Slovak staff used to balance for the leaving numbers of Czech personnel. Nowadays this is no longer sufficient. Though there is also staff from other countries, mainly Ukraine, willing to come to work in Czech Republic, their integration in hospitals is relatively difficult. In addition to the language barrier, these people meet important difficulties in having their qualifications recognised in order to be able to practice.

In addition to international mobility there are other issues for retention in the Czech Republic. These are:

- Difficulties in retaining older nurses. Indeed older nurses have very low incentives for staying in their positions. It is difficult for them to evolve after having reached a certain level. In addition the difficult working conditions and little valorisation of older workers do not favour retention of older staff.
- Problems in attracting workforce to some areas where the costs of living are high. It proved that higher salaries are not a sufficient motivation for staff to come to live in these areas. Therefore some employers are trying to provide or at least help with provision of housing in order to attract new staff.
- Lack of any forward planning of health care system which would enable to seek solutions to future transformation of the situation due to demographic change.

Skills and training

Another important issue for Czech Social dialogue is training of staff, mainly when it comes to further training. Further training is largely paid for by employers but their incentives to offer the possibility of such training to their staff are low. On contrary there are important negative incentives.

Further training of both practitioners and nurses takes place within university hospitals where the trained staff does the practical training. The length of practical training varies but it is usually rather long. In this period while the university hospital benefits from trained staff as cheap labour, the employing hospital bears all the costs of training in addition to the wage related costs.

On top of the costs of training, employers have to bear the risk of their staff being recruited by the university hospital during the training period. As university hospitals have more important budgets than medium and small Czech hospitals and less strict budgetary conditions being state owned, they can also afford higher wages. Despite this fact they also have to face staff shortages. Therefore they often benefit from the opportunity to recruit the staff being trained on their premises.

As a solution to avoid such staff "leakage" some employers started practicing conditional training contracts in which they specify that if the trained nurse or a doctors leaves the hospital during or within a specified period following the training, they have to partially reimburse the costs of training. Such contracts can be an important incentive for staff to stay with the employer as the costs of training to be recovered are high.

Another difficulty linked to staff training concerns the important proportion of young trained professionals who do not enter the profession. The drop out rate is particularly high among nurses. Because of the relatively hard working conditions and low wages, most trained nurses actually opt for other professions. As a possible solution, some employers try to sign contracts with nurse while they are still in training. In exchange to an engagement that they will start working in their hospitals, employers offer to cover a part of the costs linked to nurses' training.

DENMARK

Economic and labour market context

Denmark has a high overall employment rate of 75.8% and low unemployment of 4.9%. GDP decreased by 0.9 between 2006 and 2007 and growth was reported at 1.5% between 2000 and 2004³⁸.

The female employment rate was slightly below the national average at 71.5%.

Employment trends in the hospital sector

The Table below illustrates employment trends in the hospital sector 1994 – 2004. The proportion of doctors and nurses has increased between 1994 and 2004 by 4.7 and 3.0 respectively. However, the number of other care personnel has decreased by a total of 3.5%.

³⁸ Employment in Europe Report 2006,
http://ec.europa.eu/employment_social/employment_analysis/eie/eie2006_annex_en.pdf

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1994-2000 %	2001-2004 %
Doctors	9,193	9,316	9,665	9,890	9,994	10,158	10,114	10,369	10,561	10,976	11,351	1.6	3.1
Nurses	25,883	26,168	27,166	27,372	27,658	28,194	28,668	29,668	29,229	29,514	29,728	1.7	1.3
Other Care Personnel	13,967	13,924	13,519	13,009	12,852	12,789	12,523	12,633	12,915	12,652	12,010	-1.8	-1.7
Others	13,569	13,943	14,488	14,893	15,205	15,441	15,504	15,669	15,940	16,077	16,278	2.2	1.3
Other Personnel	19,671	19,741	19,873	19,962	19,855	19,270	17,813	17,502	17,442	17,264	16,874	-1.6	-1.2
Total	82,285	83,091	84,711	85,125	85,565	85,853	84,622	85,402	86,462	86,697	86,914	0.5	0.6

Source: *The Danish Health Care Sector in figures 2006, Ministry of Interior and Health, September 2006*

Structure and organisation of hospital sector and key recent reforms

Funding and Expenditure

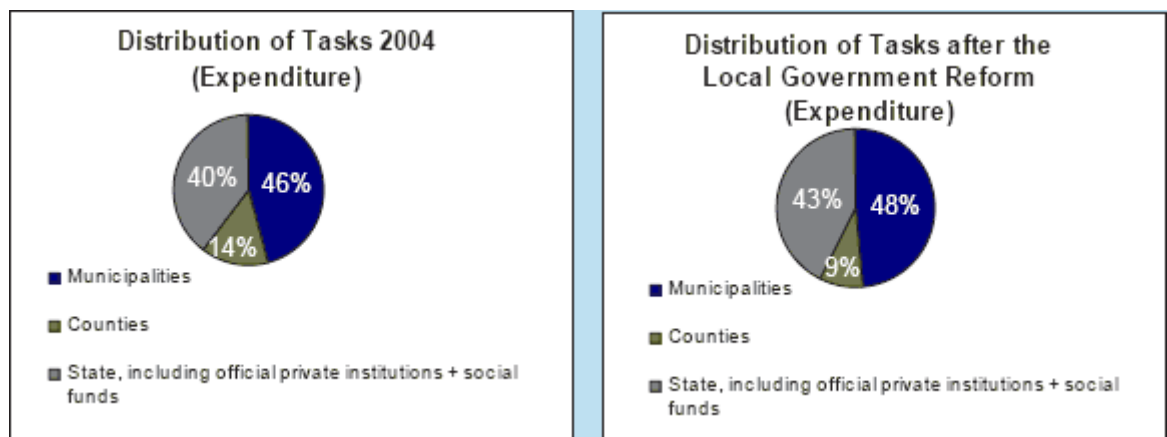
In 1999 total expenditure on health care accounted for 8.4% of GDP. Public expenditure on health care accounted for 6.9% of GDP.

The main system of finance is through general taxation. Resources within public hospitals are mainly allocated through prospective global budgets. These are set at a municipality level in negotiation with hospital administrators. They are based on past performance and are modified at the margin to account for new activities, changes in tasks and areas of specific need. Primary care and hospitals are free to the point of use.

Private expenditure on health care comes from out-of-pocket payments (16.2% of total expenditure) and voluntary health insurance (1.4% of total expenditure).

Structural reforms

Recent structural reforms have resulted in a redistribution of finances in the health sector. Regions now hold responsibility for health care and will be financed through contributions from the state and the municipalities.



Organisational structure and management

The health care system is regulated by the Danish Ministry of Health, although central government plays a fairly limited role in the organisation of the health sector. Its main functions are to regulate, coordinate and provide advice. The majority of health care is funded and provided, at a regional level, by the municipalities (counties). Key responsibilities include:

- Funding primary and secondary care;
- Regulating general practitioners;
- Owning and running prenatal care centres;
- Hospitals;
- Special institutions for disabled people;
- Providing district psychiatry services;
- Preventing ill health; and,
- Promoting health.

With regards to health sector staff, regional municipalities are responsible for:

- Nursing homes;
- Health visitors (including prenatal and postnatal home visits);
- Home nurses;
- Home help (assistance with daily activity);
- Municipal dentists; and
- School health services.

The majority of primary care is provided by General Practitioners who are paid on a capitation and a fee-for-service basis. The number and location of General Practitioners is controlled by the municipalities. General working conditions are negotiated at a central level.

Legislation requires counties and municipalities to develop a plan for the coordination of all their preventative curative health care activity every four years. The coordination process itself, varies from county to county. It is often based on meetings, seminars and joint committee work focusing on specific areas such as; child health, the health of elderly people or mental health. All plans must be submitted to the National Health Board for comments.

The National Board of Health is responsible for the technical aspects of health care. This includes the supervision of health care personnel and institutions and advising different ministries, counties and municipalities on health issues.

In addition to the above, the Ministry of Interior and Health is largely administrative holding responsibility for health policy, guidelines and legislation. This includes legislation on health care provision, personnel, hospitals, pharmacies, vaccinations, maternal health care, child health care and patients' rights. In addition to this, the Ministry of Finance has key a role in setting the overall economic framework in the health sector.

Traditionally, hospital care has mainly been the responsibility of towns and counties. However, in recent years the political focus on controlling health care costs has encouraged a greater degree of formal cooperation.

Key reforms

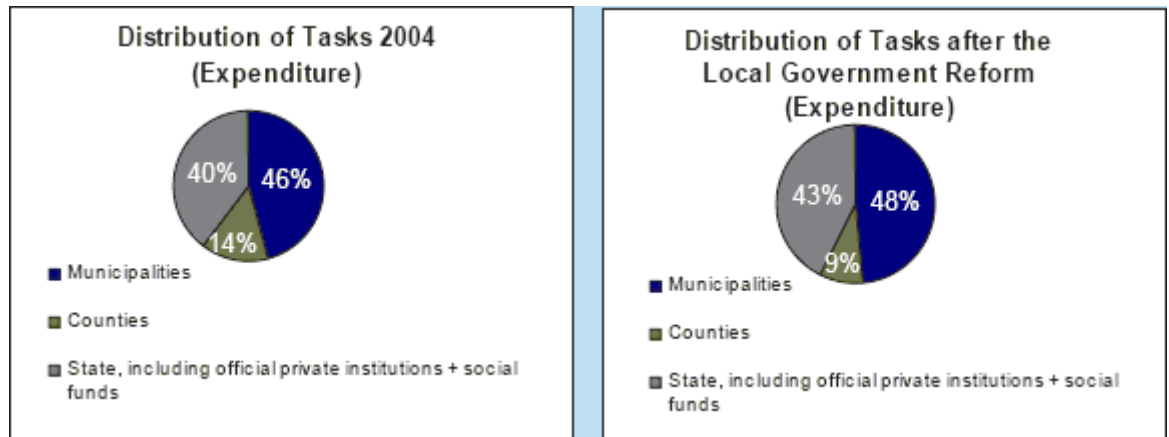
Local government in Denmark underwent reform early in 2007. This resulted in the establishment of five regions in Denmark.

On January 1 2007, five new regions were established:

- The Capital Region of Denmark
- The Sealand Region
- The Region of Southern Denmark
- The Central Denmark Region
- The North Denmark Region.

This resulted in a shift in responsibilities, with regions holding autonomy over health care, social services and special education and regional development. Figure 1, below, illustrates the redistribution of responsibilities before and after the reform.

Figure 1: Distribution of responsibilities before and after the local government reforms



Source: *The Local Government Reform in brief, February 2006*³⁹

Since the reform regions have taken on an increasing amount of health care services. This includes primary care, hospitals and rehabilitative care such as treatment for drug and alcohol abuse.

Health care services are now distributed amongst the following sectors:

Municipalities

- Preventative treatment, care and rehabilitation that does not take place during hospitalisation as well as special dental care
- Home care
- Treatment of drug and alcohol abuse

Regions

- Hospitals
- Psychiatry
- Health insurance (General Practitioners, specialists and reimbursement for medication)

State

- Speciality planning
- Systematic follow-up on quality, efficiency and IT usage.

Providers

A limited number of private hospitals exist, accounting for less than 1% of hospital beds.

³⁹ The local government reform – in brief
http://www.im.dk/publikationer/government_reform_in_brief/index.htm

Outline of system of industrial relations⁴⁰

Denmark has a long democratic tradition and has one of the earliest collective bargaining systems. The system is known more generally as the Danish Model; characterised by an institutionalisation of bargaining, high membership rates and a well-established process of cooperation. A number of fundamental changes have taken place over the last decade. The most notable is the leaning towards a decentralised collective bargaining system.

Employment issues such as wages and terms and conditions are usually regulated by agreements between sectoral employer and employee organisations.

Main actors

Trade Unions

Trade union density in Denmark is among the highest in Europe, although it has decreased over the last decade. The European Social Survey reported membership has fallen from 84% in 2000 to 83% in 2004. High membership can be explained by unemployment funds which are distributed by large unions. Additionally, a higher membership rate was reported for females.

Unions are mostly organised at sector or branch level. There are four main trade union confederations in Denmark (LO, FTF, LH and AC). The largest confederation is the Danish Confederation of Trade Unions (LO) and has 1, 385,775 in its affiliated unions. It was previously linked to the Social Democratic party, although these links have now been cut by the confederation congress.

In comparison to other countries, the other union confederations are large, although their membership rates are approximately half this number.

Employer Organisations

In contrast to trade union density, employers' organisations density rate is below the EU average. It has increased from 37% in 1997 to 58% in 2001. There is one employers' organisations confederation – Dansk Arbejdsgierforening (DA). This is the main organisation of private sector employers in manufacturing, the commercial sector, the service sector and small scale craft trades.

Traditionally the DA has been very powerful, as all collective agreements have to be approved by its board. It also decides if its affiliates can take industrial action regarding collective agreements.

Level of bargaining

The national sectoral level is the most dominant level of bargaining.

Regarding wage setting there are three levels of collective bargaining:

- Intersectoral level – an existing level of collective bargaining;
- Sector level – dominant level of collective bargaining; and,
- Enterprise level – an important (but not dominant) level of collective bargaining.

At the national level, the two main trade union and employer confederations negotiate a basic agreement that has a longer validity period than agreements made at company level. Such basic agreements develop a framework for bargaining the **sectoral** agreements through defining basic procedural rules.

⁴⁰ EIRO, Industrial relations report http://www.eurofound.europa.eu/eiro/country/denmark_2.htm

Using this framework collective bargaining on pay, working time and other conditions takes place at a sectoral level. Completed agreements are in turn used to form frameworks implemented at company level. Wage bargaining is reported to be highly centralised, 54% in 2003, compared to the 33% EU average.

Coverage rate

The coverage rate for collective bargaining was 83% in 2001, ranking high among the EU 25.

Policy concertation

There is no open policy on concertation, although the government tries to influence wage bargaining by providing an institutional framework for consultation or dialogue.

There is scarce legislation on collective labour law issues and no statutory definition of what constitutes a collective agreement. It is not possible to extend collective agreements to cover employers who are not signing parties.

As a result of obligations to implement EU directives a new version of the interrelationship among law and collective agreements has been developed. One example is the agreements on the Part-Time Directive were extended through legislation in order to cover employers who are not parties to collective agreements.

Social partner organisations in the hospital sector

Trade Unions

Trade unions represent the interests of different professional groups. Union membership is very high, above the EU average. They operate at national, regional and workplace level and are involved in collective bargaining.

FOA – Trade and Labour has 16,000 members in this sector.

Trade Union of Local Government Employees (HK/Kommunal) with 13.100 members working in the hospital sector

The Danish Nurses' Organisation (DNO) with 34.144 members working in the hospital sector

Statsansattes Kartel (StK)

Association of Danish State Employees' Organisations

State Public Servants Trade Union (CO II) with 1000 members in the sector

Danish Association of Biomedical Laboratory Scientists (Dbio) with around 5000 members.

Danish Association of Junior Hospitals Doctors, (YL) with just under 8000 members in the sector.

Danish Association of Medical Specialist, (FAS) with around 4900 members in the sector.

The Danish Association of Lawyers and Economists, (DJØF) with 500 members working in the sector

The Danish Society of Engineers, (IDA)

The National Federation of Social Educators in Denmark, (SL) has around 570 members in the hospital sector.

Danish Diet and Nutrition Association, Kost & Ernæringsforbundet with 1100 members.

Association of Danish Physiotherapists, Danske Fysioterapeuter with 2100 members.

United Federation of Danish workers, Fagligt Fælles Forbund ,3F with around 1600 members in the sector.

Danish Association of Pharmaconomists, Farmakonomforeningen with 620 members in the sector.

The Danish Association of Occupational Therapists, Ergoterapeutforeningen with just over 1000 members in the hospital sector.

The Danish Association of Midwives, Jordemoderforeningen with around 1400 members in the sector.

Danish Association of Professional Technicians, Teknisk Landsforbund has around 100 members in the sector.

Employers

▪ **Danish Regions**

Danish Regions represents the interests of all 13 Danish Regions, providing them with information, support and advice. Its core responsibilities include promoting and supporting the principles of regional autonomy, acting as a spokesman for the regional councils and acting as the central collective wage bargaining organisation for the regions. It does not undertake collective bargaining at a national level. A board is appointed for a four-year period.

The Danish Government and the Danish People's Party reached an agreement about the reform of public tasks and public services. Since this reform, negotiations at the regional level take place on a smaller scale.

Regarding European employers' organisations Danish Regions is a member of HOSPEEM, CEEP and EMR.

Structure of collective bargaining and social dialogue in the hospital sector

Collective bargaining takes place between Danish Regions and different groups of employees. National bargaining is the norm, but more local bargaining also takes place on additional benefits and work organisation.

Key issues for the hospital sector and the sectoral labour market in particular

Structural reform of public services and public tasks⁴¹

The local government reforms have had considerable impact on the organisation of public finances and responsibilities of each region. The responsibilities of each region include health care, the operation of social and special education institutions and regional development.

Specific responsibilities of the health care sector now include:

- Somatic hospital service
- Health insurance
- Mental health service

Since the reform, the regions are now responsible for the entire health service. The reform introduced a greater role for the municipalities with the local government. For example,

⁴¹ The Danish Regions – in brief

<http://www.regioner.dk/upload/publikationer/regionerne/thedanishregions%20-%20inbrief.pdf>

municipalities now have overall responsibility for any rehabilitation that does not take place during hospitalisation. Prior to the reform this responsibility was shared with the counties.

Municipalities have also taken responsibility for all preventative treatment and the promotion of health of all citizens residing in counties. The objective of this is to integrate preventative treatment with other local public services such as day care centres, elderly care and schools.

Quality reforms

At present the government is working on a quality reform. The aim of this reform is to address recruitment problems in the public sector and to increase the quality of provision. Tripartite negotiations are taking place on this issue. Discussions should be completed in summer 2007.

Retention and recruitment of staff

Recruiting key staff, such as doctors and nurses, is a key area of concern for health care services. There is currently a shortage of nurses in particular, in the hospitals sector. To address this issue, employer organisations (in particular Danish Regions) are cooperating with nurses' organisation to devise recruitment incentives as a means of encouraging more nurses to work in the sector. A greater amount of funding has been made available for this.

The recruitment of doctors has other difficulties. Doctors working in selected areas or with certain specialities are in short supply, although this is not the case across the whole health service. This is a widely debated political issue as employer organisations do not always agree with government propositions on this issue.

Demographic changes

Denmark is experiencing similar demographic changes to the rest of Europe. The ageing of the population, with a smaller younger population, represents a long-term challenge. It is impacting on health care services in terms of patient care – a greater number of elderly patients, requiring care – and is exacerbated further by staff exiting the workforce due to retirement.

ESTONIA

Economic and labour market context

Estonia's liberal economic policies and macroeconomic stability have fostered exceptionally strong growth and better living standards than those of most new EU member states. The economy benefits from strong electronics and telecommunications sectors.

Notwithstanding these many achievements, the economy of Estonia still faces challenges. The income differential between Tallinn and the rest of the country has widened in recent years as the cost of living differential has narrowed. The formerly industrial northeast section of Estonia suffered from economic depression as a result of plant closures in the early 1990s, although even this region has experienced strong growth in the last two years. The labour force is shrinking due to low birth rates and emigration. This tight labour market and the government's restrictive labour and immigration policies have led to wage pressure and challenges to future competitiveness.

Nevertheless, the Bank of Estonia predicts that the economy will grow by 7.3 per cent in 2007. The unemployment rate at 7.9 per cent was below the EU-wide average of 8.7 per cent in 2005. The employment rate is slightly above the EU average at 64.4 per cent in 2005.

Figure - Employment and unemployment rates in Estonia and in the EU-25, 2000/2005

	Estonia in 2000	Estonia in 2005	EU-25 in 2005
Employment rate – total	60.4%	64.4%	63.8%
Employment rate – male	64.3%	67.0%	71.3%
Employment rate – female	56.9%	62.1%	56.3%
Unemployment rate – total	12.8%	7.9%	8.7%
Unemployment rate – male	13.8%	8.8%	7.9%
Unemployment rate – female	11.8%	7.1%	9.8%

Source: European Commission (2007) *Employment in Europe 2005*.

Employment trends in hospital sector

The number of health care professionals in Estonia has decreased over the past decade. For example the number of doctors reduced by 11 per cent between 1995 and 2004. The number of doctors and nursing personnel has nevertheless remained unchanged in recent years (2002-2004).

Figure – the number of healthcare personnel in Estonia

	1995	2000	2001	2002	2003	2004
Doctors	4,832	4,233	4,137	4,268	4,277	4,312
- family doctors	104	448	557	701	803	818
Dentists	929	1,041	1,115	1,078	1,127	1,166
Nursing specialists and graduates of medical schools	11,416	9,916	9,777	10,028	10,300	10,057

GHK Consulting, 2007, on the basis of figures from the Ministry of Social Affairs

Structure and organisation of hospital sector and key recent reforms

The Estonian health system has seen a transformation since the country's independence. It has changed from a centralised and state-controlled health care delivery system to a decentralised one. The sector has also changed from a state-funded system to one based on health insurance contributions.

Organisational structure and management⁴²

Through the Ministry of Social Affairs and its agencies, the Estonian state is responsible for developing and implementing overall health policy, including public health policy, and for supervising health service quality and access. Recently, the role of county governors and municipal governments in health care policy has been reduced.

In 2001, the Estonian Health Insurance Fund (EHIF) attained its present status as a public independent legal body, of which main role is to act as an active purchasing agency. It is responsible for contracting health care providers, paying for health services, reimbursing pharmaceutical expenditure and paying for some sick leave and maternity benefits.

Since 2000, the Ministry of Social Affairs has carried out the general long-term planning of specialist care. The EHIF translates the plans into a shorter-term contracting policy. Responsibility for primary care planning is shared by the Ministry of Social Affairs at the national and county levels.

Health care delivery⁴³

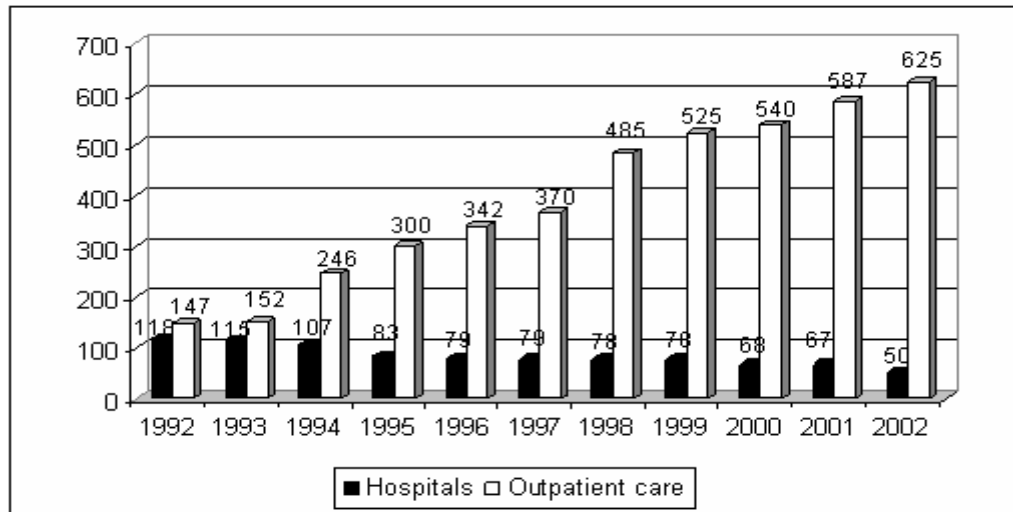
Primary care in Estonia is organised by family doctors, and their service includes diagnostic procedures, treatment of general illnesses, health counselling, health promotion and disease prevention. Patients need a family doctor's referral in order to see most specialists and to be admitted as non-emergency inpatients. All family doctors are private entrepreneurs or salaried employees of private companies restricted to providing only primary care services.

Specialist care in Estonia is divided into specialist care and inpatient care. Specialist care is provided by polyclinics, health centres, hospital outpatient departments (OPDs) and specialists practising independently. Some independent specialists, particularly dentists, gynaecologists, urologists, ophthalmologists and ear, nose and throat specialists, practise privately, but most other specialists work in hospital OPDs.

Inpatient acute care is provided by regional, central and general (or local) hospitals, as well as some specialist hospitals. All hospitals must be licensed by the Health Care Board and most are either limited liability companies owned by municipal governments, or foundations established by the state, municipalities or other public entities. Private hospitals only provide specific services such as gynaecology, obstetrics and cardiology. The number of hospitals (usually public) in Estonia has more than halved between 1992 and 2002; from 118 to just 50 hospitals in 2002. At the same time the number of outpatient care establishments (often private) has risen from 147 to 625. The Estonian hospitals are mainly owned by the state or municipalities (predominantly by the state) and there are seven different types of hospitals: regional, central, general, local, specialist, rehabilitation, and nursing hospitals.

⁴² European Observatory on Health Systems and Policies: Health Care Systems in Transition Estonia.

⁴³ European Observatory on Health Systems and Policies: Health Care Systems in Transition Estonia.

Figure – the number of hospitals in Estonia

Source: GHK Consulting, on the basis of information from the Ministry of Social Affairs, 2007.

Health care expenditure

The healthcare expenditure (as a share of GDP) is 3.4 percentage points below the average in the EU-25. In 2003 the expenditure stood at 4.2 per cent of GDP.

Funding

Most hospitals get their main income from public sector funds, primarily from the health insurance budget. The health insurance budget is part of the state budget. Health insurance revenue comes from the social tax that employers pay on employees' wages and other taxable income. The social tax is 33%, of which 13% is health insurance.

The health insurance budget is administered by the Estonian Health Insurance Fund (EHIF) that annually signs agreements with hospitals for the funding of treatment. On the basis of these agreements EHIF covers the cost of medical services provided to insured patients. Payments to the hospitals make up nearly half of the health insurance yearly budget which is altogether

Reforms

Three key reforms have affected the hospital sector in the past few years:

- Launch of the health insurance system;
- Introduction of the family practitioners system; and
- An on-going re-organisation of the hospital system.

Outline of system of industrial relations

*Main actors*⁴⁴

There are three main trade union confederations in Estonia:

- The Confederation of Estonian Trade Unions (*Eesti Ametiühingute Keskkliit – EAKL*) is the biggest, with 18 associated unions. It had about 47,500 members in 2002, down from 57,900 in 2000.

⁴⁴ EIRO: Industrial Relations in Estonia.

- The Employees Unions' Confederation TALO (*Eesti Teenistujate Ametiliitude Keskorganisatsioon*) had about 35,000 members in 2002, down from 40,000 in 2000.
- The Confederation of Food Producers and Rural Workers (ETMAKL) separated from EAKL in 1997 with some 9,600 workers and established a separate national centre.

The trade union density stood at about 17 per cent in 2000 and decreased to 15 per cent by 2002.

The only employers association recognised for the purpose of tripartite consultation is the Estonian Employers' Confederation (*Eesti Töandjate Keskliit, ETTK*). The membership of ETTK comprises of 31 branch organisations and 23 larger companies. It represents some 1,000 companies employing about 200,000 workers, a quarter of all employees.

Level of bargaining

Collective bargaining is mainly conducted at the company level in Estonia, though only about a quarter of all companies in Estonia have signed an agreement. There are sectoral agreements in state controlled industries and in the transport and health care sectors. The national level bargaining is usually tripartite.

Coverage rate

The coverage rate of collective agreements stands at around 22-28 per cent, which is one of the lowest rates in Europe. The weak development of social partnership is, primarily, due to the low coverage levels of social partner organisations as well as institutional and financial limitations.

Policy concertation

The tripartite Social and Economic Council with representatives of ETTK, EAKL, TALO, and the government has concluded national accords since 1992, notably on minimum wages, unemployment benefit, definition of the subsistence minimum, and the amount of personal income that should be free of tax⁴⁵.

Social partner organisations in the hospital sector

In the following sections we give information on active trade unions and employer's organisations in the Estonian health care sector.

Trade unions

The Estonian Medical Association (*Eesti Arstide Liit, EAL*)

The Estonian Medical Association aims to protect the professional and economic interests of some 2,878 doctors.

The Federation of Estonian Healthcare Professionals Unions (*Eesti Tervishoiutöötajate Ametiühingute Liit, ETTAL*)

The Federation of Estonian Healthcare Professionals Unions represents doctors, nurses, care assistants, professionals with university degrees and mid-ranking professional staff, kitchen personnel, drivers, cleaners, departmental secretaries, and customer service staff in the healthcare sector in Estonia. The union has 2,113 members and the union is a member of EPSU.

The Estonian Nurses Union (*Eesti Õdede Liit, EÕL*)

⁴⁵ EIRO: Industrial Relations in Estonia.

The Estonian Nurses Union, which is the largest trade union organisation in the healthcare sector, represents 3,800 nurses.

The Trade Union Association of Health Officers of Estonia (*Eesti Keskkastme Tervishoiutöötajate Kutseliit, EKTK*)

The Trade Union Association of Health Officers of Estonia organises nurses and other health officers. It has around 3600 member employed in hospitals.

Employers

There is one employers' organisation in the sector - the Estonian Hospitals Association (*Eesti Haiglate Liit, EHL*), which represents 19 major hospitals. The government is represented by the Ministry of Social Affairs.

Structure of collective bargaining and social dialogue in the hospital sector

The health sector is one of the few sectors in which sectoral bargaining takes place in Estonia; the company level bargaining predominates the Estonian industrial relations system. It is difficult to precisely define the system of collective bargaining in the health care sector as it is still evolving from one year to another and sectoral agreements are still a rather new concept in the country. But it can be stated that usually collective bargaining in the Estonian health sector takes place between the State (represented by the Ministry of Social Affairs), sectoral trade unions (the Federation of Estonian Healthcare Professionals Unions ETTAL, the Estonian Nurses Union EÕL, and the Estonian Medical Association) and the Estonian Hospitals Association EHL. These tripartite negotiations usually result in an agreement that determines the minimum wages for different occupations in the sector, covering employees in both public and private sectors. The sectoral agreements are usually valid for two years and all the local agreements must respect the conditions set out in the sectoral agreement. Other terms and conditions, apart from the minimum wages, are rarely discussed during the centralised bargaining rounds. Local agreements are usually signed by managers of individual hospitals and the trade unions. Local negotiations are carried out normally once a year.

The very first sectoral agreement was concluded in 1996 when one was signed to set the minimum wages for doctors and nurses in Estonian hospitals. After several years of local bargaining only, the second sectoral agreement was signed in 2003 setting the minimum wages for all different categories of workers in Estonian hospitals. Since then sectoral bargaining has taken place more frequently.

With regards to the latest agreement, on 25 January 2007 an agreement was reached between the state, employers and two trade unions to raise minimum wages in the health and social work sector by (on average) 25 per cent in 2007 and by another 20 per cent in 2008. The agreement, however, has not been signed by the Estonian Medical Union that represents over half of all the employed physicians in the country as they did not accept the offer made by the Estonian Hospitals Association. The situation remains unresolved.

The sectoral bargaining leaves room for local negotiations, which usually also only concern wages, rather than a wider set of terms and conditions.

Tripartite dialogue in other than wage related matters is weak. The three parties only come together to negotiate wages, though this year the trade union have pushed for further tripartite discussions on healthcare expenditure, which in their opinion is too low. Bi-partite collaboration is marginal too. Both sides, however, co-operate closely with universities and other training providers. Furthermore, the Ministry of Social Affairs has recently established an expert group to advice the development of the new Estonian Hospital Master Plan 2015. Furthermore, collective agreement at Tartu hospital was recommended as one of the most advanced forms of collective

agreements in Estonia. The bargaining has not only resulted in good wages, but has also included negotiations on qualifications and some other terms and conditions.

Interviews did not imply that any developments in this field (wider social dialogue) would take place in the foreseen future, in fact some parties questioned the need for further dialogue.

Key issues for the hospital sector and the sectoral labour market

According to the studies carried out for the European Observatory on Health Systems and Policies, the human resources in the Estonian hospital sector have been neglected in the past, and the quantity and quality of health care professionals is a key issue; underinvestment in health facilities and human resources has been a major source of cost savings and has resulted in low salaries and poor morale among doctors and nurses.

In this section of the report we further explore some of the challenges faced by the sector, as identified by the sectoral social partners and the government representatives during the consultation process for this study.

Staff shortage⁴⁶

The Estonian Nurses' Union highlighted a shortage of nurses in Estonia as one of the most acute problems facing the sector. A recent study by the Estonian Migration Foundation revealed that about 600 positions – corresponding to 2 per cent of all jobs in the healthcare sector - were vacant in 2005⁴⁷. According to the Ministry of Social Affairs, the labour shortage is particularly acute among doctors in remote rural regions, and among pathologists and anaesthesias. At the same time there are already more qualified family doctors than there are available positions.

The migration of healthcare workers is another cause of concern. The Estonian Medical Association has estimated that more than half of medical students start their first job outside of the Estonian health system. Norway, Finland, Ireland and the UK are popular destinations for young doctors.

According to the Federation of Estonian Healthcare Professionals the labour shortage is fuelled by the low wages in the sector and a lack of career advancement opportunities. The shortage affects general, county and central hospitals more than regional hospitals, which have traditionally been able to offer better wages than other hospitals⁴⁸. According to Statistics Estonia the salaries of doctors are about 1.5 times higher than the average wages in Estonia, while the salaries of nurses are at the average wage level and the salaries of caregivers are almost half the average wage level. The wages are similar in the public and the private health sector; no major disparity exists between these two sectors.

Competition and speed of reforms

According to the Ministry of Social Affairs one of the major problems for hospitals is the competition between them. This hampers the development of the healthcare system and results in an 'irrational' use of resources at times. The speed of reforms also affects the quality of care for patients as they are confused what kind of care is available at which hospital level. On the other hand there is political unwillingness to continue reforms since this implies cancellation of certain treatments in local hospitals and possibly some job losses.

⁴⁶ Information received from interviews with the Ministry of Social Affairs, Federation of Estonian Healthcare Professionals and publications of Praxis Centre for Policy Studies.

⁴⁷ Praxis Centre for Policy Studies.

⁴⁸ There is a hierarchy of hospitals where care hospitals are at the lowest level and regional hospitals at the highest. The higher in the hierarchy, the more varied and specific services the hospital provide.

FINLAND

Economic and labour market context⁴⁹

Finland is an industrialised nation with a GDP per capita higher than in the EU-25. During the early years of the current decade the average GDP growth only slightly exceeded the EU-25 average, but the annual GDP growth rate has been relative strong since 2004, particularly in comparison to many other old Member States. The overall employment rate is significantly above the European average. This is mainly as a result of high labour market participation of women of which employment rate was over 10 percentage points higher in 2005 in Finland and in the EU-25. The Finnish economy, nevertheless, remains fairly vulnerable to the fortunes of the ICT sector and the rates of male and youth unemployment remain above the EU-25 averages.

Figure - Employment and unemployment rates in Finland and in the EU-25, 2000/2005

	Finland in 2000	Finland in 2005	EU-25 in 2005
Employment rate – total	67.2%	68.4%	63.8%
Employment rate – male	70.1%	70.3%	71.3%
Employment rate – female	64.2%	66.5%	56.3%
Unemployment rate – total	9.8%	8.4%	8.7%
Unemployment rate – male	9.1%	8.2%	7.9%
Unemployment rate – female	10.6%	8.6%	9.8%

Source: European Commission (2007) *Employment in Europe 2005*.

The main socio-economic policy priorities are currently focussed on employment and promotion of entrepreneurship, an overhaul of Finland's municipal and public services structure, cutting taxes on labour to create more jobs, and beginning work on reforming what is currently a complex system of social benefits.

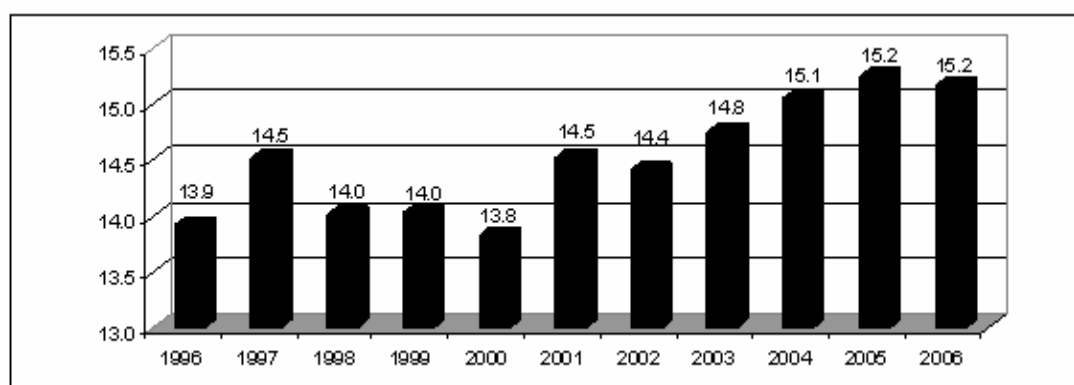
Employment in the hospital sector

The health and social sector is a rapidly expanding and dynamic sector. The number of employees in the sector has increased by around 70,000 – 80,000 over the past decade, and its share from total employment in the country has risen from 13.9 per cent in 1996 to 15.2 per cent in 2006 (see the graph below)⁵⁰.

⁴⁹ Statistical information based on data from European Commission (2007) *Employment in Europe 2006*.

⁵⁰ Based on figures from the Finnish National Statistics Office and Eurostat on employment in health and social care sector.

Figure - The share of employment in health and social sector from total employment



Source: Calculated from Eurostat (2007) figures for Health and Social sector employment (NACE N) and total employment (all NACE codes). Covers all age groups (15 years and over).

According to the Commission for Local Authorities the social and health sector employed over 330,000 individuals in 2004⁵¹. More recent statistics from the Finnish statistics office and Eurostat indicate that the sector employs today in the region of 370,000 workers. A considerable majority of these employees are working for health and social services delivered by local and sub-regional authorities. Around 80 per cent of workers in the health sector and in the region of 70 per cent of employees in the social sector are employed by the public sector.

The table below illustrates that just over half of the employees in the health and social service sector work in social services, while 47.6 per cent are employed in health services. The latter is also the best estimate of the number of workers in the hospital sector. The table below also shows that while both sectors have seen an increase in employees over the past decade (+23 per cent), the workforce of the social service sector has grown more rapidly than the workforce in the health services (hospitals and other health care). This is mainly down to the increase in private social care in Finland, though most social services still remain in the hands of public (local) authorities.

Figure - Breakdown of employment in health and social services, 1996 / 2006 (in thousands)

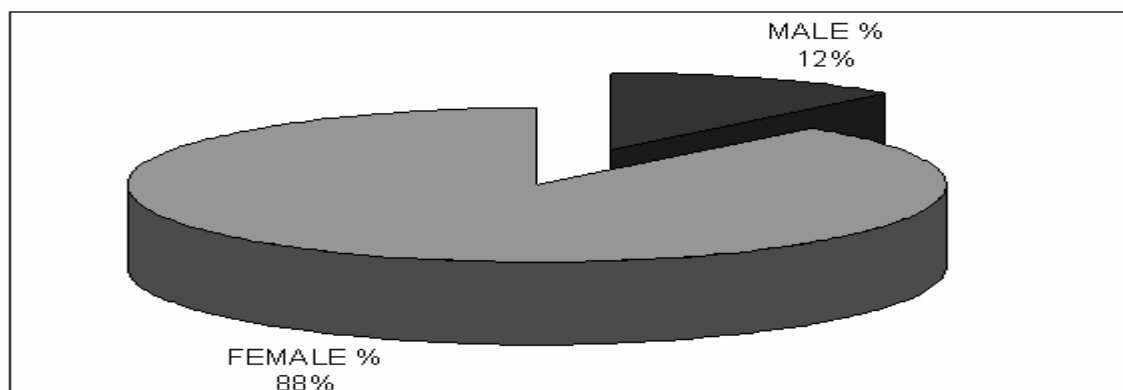
	1996	1998	2000	2002	2004	2006	Δchange (%)
Health services	157	159	164	167	177	177	+12.7
Social services	145	154	163	179	175	195	+34.5
Total	302	313	327	346	352	372	+23.2

Source: Information obtained and calculated from the data of the Finnish national statistics office, 2007

A significant majority (88 per cent) of employees in the health and social sector are female (see graph below). The hospital sector (health services) has a higher percentage of male employees than the social services. Around 15 per cent of the health care personnel are male, while the share of male workers in the social sector is just under 8 per cent⁵².

⁵¹ Commission for Local Authorities, 2007 (*Utinen 23.5.2007*)

⁵² Calculated from the statistics of the Finnish national statistics office (2007)

Figure – Breakdown of employment by gender, 2006

Source: Calculated from Eurostat (2007) figures for Health and Social sector employment in Finland (NACE N). Covers all age groups (15 years and over).

Structure and organisation of hospital sector and key recent reforms

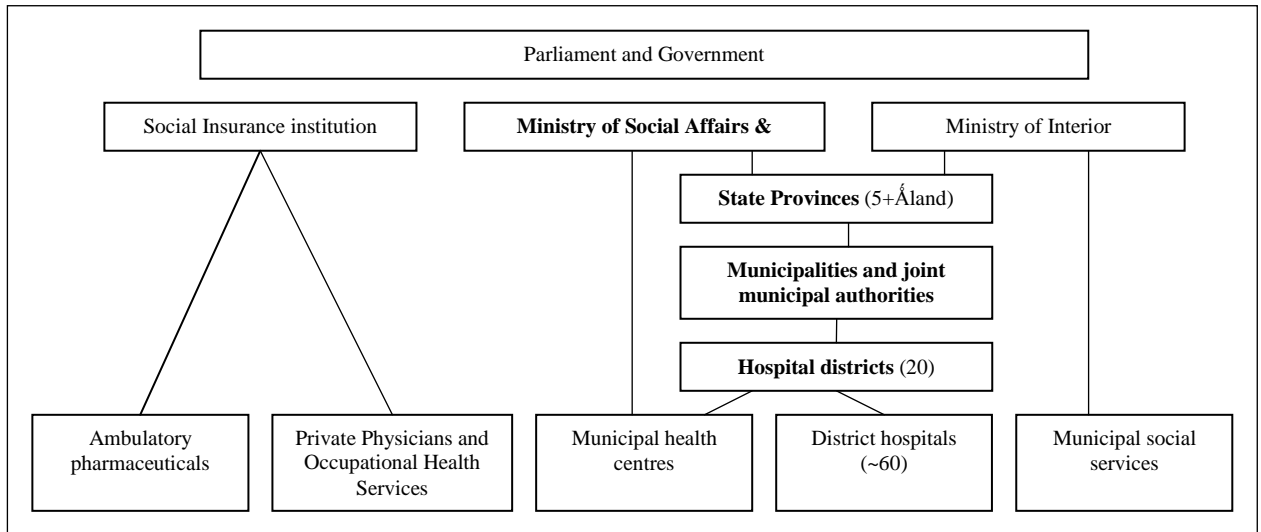
The organisation of the Finnish health system resembles those in other Nordic countries in that it offers universal coverage of a publicly funded health services paid for mainly out of general taxation⁵³. Furthermore, local governments play a leading role both in the financing and provision of care. However, the system has been more decentralised and more mixed in its funding than in other Nordic countries. Today the health system is seeing some intrinsic changes with the on-going public service restructuring that is leading to a creation of sub-regional entities with public service delivery capacities.

In this section we briefly outline the organisational and management structure for the health sector, hospitals in particular. This is followed by information on financing and expenditure, health care providers and information on key reforms.

Organisational structure and management

Central government and municipalities are the two main players in the organisation of health care in Finland. Municipalities are responsible for providing basic health services. Other key actors are the Social Insurance Institution KELA, provincial authorities and hospital districts. The following figure illustrates the management structure.

⁵³ OECD (2005) Organisation of the Finnish Health System.

Figure – Organisation and management of the Finnish health care system

Source: GHK Consulting, 2007, on the basis of information from Kuntaliitto (www.kunnat.net) and OECD (2005) Organisation of the Finnish Health System.

The **Ministry of Social Affairs and Health** directs and guides the development and policies of social protection, social welfare and health care. It defines the main course of social and health policy, prepares legislation and key reforms and steers their implementation, and handles the necessary links with the political decision-making process. Attached to the ministry is the Basic Security Council, which guarantees quality and equity in the provision of municipal health services. There are several agencies and institutions attached to the ministry, namely the National Research and Development Centre for Welfare and Health (STAKES).

There are 416 **municipalities** in Finland⁵⁴, which have been given the main lead in the financing, provision and management of health (and social) care⁵⁵. Municipalities can either provide health care services independently or join with neighbouring municipalities in joint municipal boards which maintain a joint health centre. A municipality can also buy-in health care services from other municipalities, non-governmental organisations or the private sector.

According to the Primary Health Care act, the responsibilities for municipalities include:

- Guidance in health matters and public health education, including maternity and child health care and family planning advice; medical examinations and screenings;
- Provision of medical treatment, including dental care, for local residents, and urgent outpatient care for all who happen to need it irrespective of residential criteria. Treatment of general illnesses is given at health care centres either in the form of outpatient care or at inpatient wards; home nursing services;
- School, student and occupational health care services;
- Provision of those mental health services which can appropriately be provided in health centres;
- Provision of local ambulance services.

⁵⁴ Kuntaliitto 09/08/2007 (www.kunnat.net)

⁵⁵ Key areas in social services include children's day care, care for the elderly and social work. Health care covers specialised hospital care, primary health care, dental care and environmental health care.

The country is divided into 20 **hospital districts** (plus Åland), which are federations of municipalities responsible for providing and coordinating specialised care within their area. Therefore they are critical in overcoming the efficiency and equity problems associated with the small scale of the main health care governing bodies, i.e. the municipalities⁵⁶. Each municipality must be member of a hospital district.

For the purposes of central government administration, Finland is divided into six provinces (including Åland). Each of these is headed by a **State Provincial Office**. The social and health departments of the State Provincial Offices are responsible for guidance and supervision of the social welfare and health care sector in their respective provinces⁵⁷. State Provincial Offices also handle complaints regarding health care personnel and implement various training and development projects.

Health care delivery

Specialised care (**secondary and tertiary care**) is provided in hospitals through outpatient and inpatient departments. The vast majority of hospitals in Finland are **publicly** owned and run. The Finnish municipalities - through hospital districts - run 5 university hospitals, 15 central hospitals and around 40 other smaller specialised hospitals. There are only a few **private hospitals**, providing less than 5 per cent of the hospital days in the country⁵⁸. **The third sector** plays a more marginal role. Services provided by NGOs complement the municipal services for small target groups, but primarily only in the field of specialist, social services.

As already mentioned, the municipalities are free to produce health and social services by themselves, to contract with other municipalities or to contract with the private sector for their provision. In principle, this freedom to outsource could lead to much diversity in methods of delivering services but, in practice, direct provision of services remains the dominant model⁵⁹. Looking at the health and social care provision in general, private and third sector organisations delivered just over a fifth of all social and health services in 2002 (17 per cent of health services and 24 per cent of social care)⁶⁰. The share of private provision in health care services rose by 2.5 percentage points between 1990 and 2002. During this time the private sector has strengthen its role especially in occupational health services. Private health care services are predominantly located in larger cities, and in addition to occupational health care, private providers deliver dental and specialist services, physiotherapy and rehabilitation. In 2003, there were 17,500 doctors in Finland. In the same year some 1,500 worked full-time as private doctors and 4,400 worked in a private surgery outside their regular working hours.

The role of third sector organisations has increased strongly in the delivery of social services, from 11.6 per cent in 1990 to 18.1 per cent in 2002.

With regards to the **primary health care**, this is largely speaking provided by the municipal health centres⁶¹. The 1972 Primary Health Care Act created a newly-built network of primary health care centres, within which multidisciplinary teams provide primary curative, preventive and public health services to their assigned populations. Legislation does not define in great detail how the services should be provided, and in most cases this is left to the discretion of the

⁵⁶ European Observatory on Health Care Systems (2002) Health Care Systems in Transition; HIT summary Finland.

⁵⁷ Sosiaali- ja terveystieteiden ministeriö (2004) Health care in Finland.

⁵⁸ Sosiaali- ja terveystieteiden ministeriö (2004) Health care in Finland.

⁵⁹ OECD (2005) Organisation of the Finnish Health System.

⁶⁰ Sosiaali- ja terveystieteiden ministeriö (2006) Sosiaali- ja terveystieteiden ministeriö 2006.

⁶¹ The following information is based on Sosiaali- ja terveystieteiden ministeriö (2004) Health care in Finland *and* European Observatory on Health Care Systems (2002) Health Care Systems in Transition; HIT summary Finland.

municipalities. There are approximately 270 health centres in the country, and the number of inhabitants per health centre doctor varies, averaging 1,500 to 2,000.

Health centres offer a wide variety of services: outpatient medical care, inpatient care, preventive services, dental care, maternity care, child health care, school health care, care for the elderly, family planning, physiotherapy and occupational health care. The in-patient departments of health centres work in a similar way than the in-patient hospital departments but they mainly cater for the elderly and chronically ill patients. A typical health centre has 30–60 beds. Patients need a referral for a specialist, with the exception of emergencies.

Health care expenditure

According to Eurostat, the health care expenditure accounted for 6.5 per cent of the country's gross domestic product (GDP) in 2003⁶². The figure is significantly below both the average for the EU-25 (7.6 per cent) and the EU-15 (7.7 per cent). The share of health care expenditure has remained stable with the figure for 1995 standing at 6.4 per cent.

Funding

The Finnish health care system is financed mainly through taxes; both the state and municipalities have the right to levy taxes. Public funding accounts for more than three quarters of total health expenditure (75.3 per cent). In 2002 about 43 per cent of the health care costs were financed by the municipalities, 17 per cent by the State (mainly through state subsidies), 16 per cent by the National Health Insurance (NHI) and about 24 per cent by private sources (households 20 per cent and other private bodies, such as insurance companies another 4 per cent)⁶³. Hospitals receive their revenue from municipalities according to the services used by their inhabitants.

In both absolute and relative terms there has been an overall increase in private financing, from 20.4 per cent of the total health expenditure in 1980 to 24.3 per cent in 2002⁶⁴. This is accounted for by increased user charges for municipal services, the abolition of tax deductions for drugs and other medical treatment costs and reductions in the NHI reimbursements for pharmaceuticals. Patient fees cover around nine per cent of public health care costs, though annual fees for an individual for public health care can not exceed €590⁶⁵.

Reforms

The health care reforms from the past few years and for the upcoming years have been focussed on securing the future of health care. In the beginning of the decade the Ministry of Social Affairs and Health announced that there had been growing problems in the operational framework for and geographical availability of services. For this reason, the Council of State initiated a national project – National Health Care Project - to ensure the future of health care on 13 September 2001. Based on the health-related needs of the population, the aim of the project was to ensure the availability, quality and sufficiency of care in the various parts of the country, irrespective of the residents' ability to pay.

According to a recent OECD assessment, the health service system is good and it is being developed in the right direction with projects like the National Health Care Project but the current

⁶² Eurostat (2007) Europe in Figures – Eurostat Yearbook 2006-2007.

⁶³ Ministry of Social Affairs and Health (2004) Health Care in Finland.

Grosse-Tebbe, S. & Figueras, J. (2005) Snapshots of Health Systems. European Observatory on Health Care Systems

⁶⁴ Grosse-Tebbe, S. & Figueras, J. (2005) Snapshots of Health Systems. European Observatory on Health Care Systems

⁶⁵ MISSOC: Health care in Finland.

action is not enough to ensure sustainable financing and the efficient use of resources in the longer term future.

To ensure the longer term sustainability of the health system, the government is undertaking an institutional reform aimed at redirecting the devolution of healthcare provision to inter-municipal and sub-regional entities. The aim is to take the advantage of the changes caused by ageing population to reorganise public services and improve efficiency. Restructuring of local authorities to create bigger intermediate entities means a transfer of the healthcare budget and service responsibilities from the municipal to the sub-regional level. New legislation on the re-organisation became effective in February 2007 (*Kunta- ja palvelurakennemuutoksen laki 167/2007*).

The OECD assessment on the Finnish health care warned that the institutional reform, is expected to face budgetary challenges for macro-economic reasons⁶⁶: *“With the likely reduction in revenue and increasing spending pressures, local government finances will be even further restricted. Local and sub-regional government employers that deliver public services will need to find additional resources, even while inputs are decreasing. Furthermore, at a macro-economic level, the reduction of the total labour force will necessarily lead to a diminishing public sector workforce, and so to decreasing public sector capacity. This is precisely why Finland has focussed its public sector ageing strategy on efficiency and productivity gains, in order to avoid deep reductions in service delivery.”*

Outline of system of industrial relations

The industrial relations in Finland are above all regulated by collective agreements, which regulate the minimum conditions for employment. Labour market relations are characterised by close cooperation between the state and the social partners. Almost all legislation concerning working life is based on a tripartite consensus. A distinctive feature of the Finnish system is a high trade union density and collective bargaining coverage. Also the membership in employers' associations is high.

In this section we briefly introduce the main labour market actors, outline the relationship between labour legislation and collective bargaining, describe the key features of the collective bargaining system, distinguish the differences between bargaining in private and public sectors and discuss the system of policy concertation.

Trade union density

Finland has one of the highest trade union density rates in Europe. On the basis of the European Social Survey the trade union density in Finland stood at around 76 per cent in 2003⁶⁷. According to a study carried out by the Finnish Ministry of Labour the density rate was in the region of 69 per cent in 2004, with women having a higher density rate (73 per cent) than men (65 per cent)⁶⁸. In the same year nearly 88 per cent of the public sector employees were trade union members. The public sector is followed by the manufacturing sector, which has a trade union density rate of around 86 per cent, and finally, by the private sector with a density rate of 49.5 per cent.

There are three main trade union confederations in Finland (SAK, STTK and AKAVA). Their organisation is based on occupational categories.

SAK, the Central Organisation of Finnish Trade Unions (*Suomen Ammattiliittojen Keskusjärjestö*), which was founded in 1907, is the biggest and oldest trade union confederation with over million

⁶⁶ OECD (2007) Ageing and the Public Service: Human Resource Challenges.

⁶⁷ European Commission (2006) *Industrial relations in Europe 2006*.

⁶⁸ Ahtiainen, L. (2006) *Palkansaajien järjestäytyminen Suomessa vuonna 2004*. Työministeriö.

members in private and public sectors. The confederation represents the interests of more than one million members (1,046,000) in 21 affiliated trade unions in industry, public, transport and private service sectors. Just under half of the members of SAK-affiliated unions work in manufacturing (44 per cent), about one third work in private services (34 per cent) and one quarter work in the public sector (22 per cent)⁶⁹.

STTK, the Finnish Confederation of Salaried Employees (*Toimihenkilökeskusjärjestö STTK*) represent in the region of 650,000 professional employees in 19 affiliated trade unions. These member unions organise employees in a wide range of sectors: industry, private services, local and regional government and the State.

AKAVA, the Confederation of Unions for Academic Professionals (*Korkeasti koulutettujen työmarkkinajärjestö*), represents in the region of 461,000 highly educated workers. It has 31 affiliates and a unionisation rate of over 70 per cent unionisation.

Employer organisation density

Estimates on the employers' organisation density rates vary from around 60 per cent⁷⁰ to 70 per cent⁷¹. The main employers' confederations are briefly introduced below, together with other key labour market organisations representing the interests of employers.

EK, the Confederation of Finnish Industries (*Elinkeinoelämän keskusliitto*), is the leading employers' confederation in Finland. It represents the entire private sector, both industry and services, and its member companies represent more than 70 percent of the GDP, and over 95 per cent of the export from Finland. EK has 35 different branch federations with a membership of 16,000 companies in all, which employ about 950,000 employees. SY, Federation of Finnish Enterprises (*Suomen Yrittäjät*), represents interests 90,000 companies, mainly small and medium-sized enterprises, but does not take part in collective bargaining.

KI, the Commission for Local Authority Employers (*Kunnallinen työmarkkinalaitos*), represents around 416 municipalities and 200 joint municipal authorities. These local authorities employ about 428 000 employees, a fifth of Finland's labour force.

VTML, the Office for the Government as Employer (*Valtion työmarkkinalaitos*), negotiates and concludes collective agreements for the 124,000 workers in different State departments and agencies.

KiSV, the Church of Finland Negotiating Commission (*Kirkon sopimusvaltuuskunta*), represents the Evangelical Lutheran Church of Finland as an employer and concludes collective agreements on behalf of the church and 548 parishes and federations of parishes. Collective agreements cover 21,400 officials and employees.

MTK, the Central Union of Agricultural Producers and Forest Owners, (*Maataloustuottajien ja metsänomistajien liitot*), represents 164 000 members. Its sister organisation, SLC, has 16,500 members and operates in Swedish-speaking areas. It negotiates agreements for 12,000 workers.

SY, Federation of Finnish Enterprises (*Suomen Yrittäjät*), represents interests 90,000 companies, mainly small and medium-sized enterprises, but does not take part in collective bargaining.

Labour laws vs collective bargaining

The main labour laws concerning are employment are the Employment Contracts Act, the Working Hours Act, Annual Holidays Act, Study Leave Act and the Act on the Protection of

⁶⁹ Information based on 2004/2005 figures – obtained from SAK.

⁷⁰ European Commission (2006) *Industrial relations in Europe 2006*.

⁷¹ The Confederation of Finnish Industries and EIRO (2006) *Finland – Industrial relations profile*.

Privacy in Working Life etc. Because the starting point for labour legislation has been the protection of employees, labour legislation includes mandatory or absolute provisions, which cannot be deviated from by any agreement to the disadvantage of an employee. On the other hand, labour legislation also includes provisions that can be altered with a collective agreement or contract (e.g. the provision regarding sick leave compensation and some provisions concerning working hours). In addition, the laws of labour legislation contain provisions that will become applicable only if nothing else has been agreed on.

Collective agreements have an important role in the Finnish system of determining the terms of employment relationships (pay and working time in particular). For example, there is no legislation to determine the minimum wage in Finland. In practice the minimum wage is the lowest wage of the sectoral collective agreements, hence the minimum wage varies from one sector to another.

To summarise, the terms of an employment relationship may in practice be determined by several different norms, such as the provisions of a law, collective agreement, employment contract or another agreement concluded at a workplace. The norm applied in each individual case is determined by the order of priority decreed by the legislation. Since both the provisions of laws and the stipulations of collective agreements have a minimum mandatory status, it is always possible to apply norms of a lower degree to agree on terms that are more favourable to the employee.

Level of bargaining

The collective bargaining system is characterised by multilevel bargaining, and there are five different types of collective agreements in Finland: incomes policy agreements, general agreements, sectoral agreements, company agreements and local (workplace) agreements. The collective agreements in practice cover the minimum wage and working hours but they can also include conditions for training, information and consultation, shop stewards, gender equity, job security etc. In the following we briefly describe the five different types of agreements, starting with the inter-sectoral agreements.

Inter-sectoral agreements

At the top level, the employees' confederations negotiate general and framework agreements with the central employers confederations, which normally become binding after they have been incorporated in collective agreements concluded by the federations.

There is a long tradition in Finland to regulate industrial relations by means of inter-sectoral collective agreements. Together with the government, the central confederations of workers and employers' organisations negotiate incomes policy agreements (*tulopoliittinen kokonaisratkaisu, TUPO*), covering not only wages but also employment and labour market policies and other social policy issues such as balanced work and family life, promotion of gender equality, social welfare and pension schemes, as well as taxation policies. The incomes policy agreements are signed on a bipartisan basis: by workers' and employers' representatives, but not by the state. The government does not have the power to give binding promises to the social partners, because parliament can veto government decisions. However, government representatives take part in the negotiation process, and incomes policy agreements reflect tripartite consensus. The government endorses the agreements by implementing the necessary policy measures. Such measures in recent years include holiday return bonuses, earning related unemployment benefits, shortened working hours as well as tax relief. Incomes policy agreements normally last two years. In addition to these issues, the recent agreements focused on macroeconomic issues such as measures to reduce unemployment or the maintenance of a low level of inflation.

The nature of income policy agreements is to create a framework for sectoral bargaining / agreements. The incomes policy agreements, however, do not always cover every sector as single federations may reject the agreement and try to reach a better one for their sector.

The current incomes policy agreement, which is valid until 30 September 2007, is being replaced by sector and union level agreements – instead of inter-sectoral income policy agreement. In April 2007 the influential Federation of Finnish Technology Industries announced that it would be taking a decentralised approach to the new round of bargaining. Later the prime minister announced that the conditions for a centralised agreement were absent.

In addition to collective agreements and contracts, the labour market organisations have concluded several general agreements / advisory agreements. The purpose of these agreements is to create consistent procedures for handling general matters regarding working life. As an example can be mentioned agreements on holiday pay, collection of union membership fees, shop steward agreement etc. Such agreements are valid until further notice.

Sectoral / industry level bargaining

After the central labour organisations have concluded the framework agreement (incomes policy agreement), unions and employers negotiate sectoral agreements. Rather than listing detailed measures, recent income policy agreements set out a broad economic and social policy framework, leaving room for initiatives and decisions at the workplace level.

If the central organisations are unwilling or unable to reach an agreement (as is the case in 2007), the trade union and employer confederations negotiate separate collective agreements for each industry or sector.

Local agreements

Local agreements of various types have gained importance in recent years. An industry-wide agreement may refer certain issues to be solved locally, or allow derogation from its contents by means of local agreements.

There are two different types of local agreement: company and workplace agreement. There are only a few company level agreements in Finland⁷², with workplace level agreements being much more common.

Bargaining coverage

The collective bargaining coverage rate in Finland - at around 90 per cent - is significantly above the European average of 66 per cent. The rate has remained at around 90 per cent for the last 10-15 years.

Bargaining in the public vs private sectors

The complete system of collective bargaining was created for the public sector in the early seventies with the 1970 collective bargaining contract legislation. Until then, the state and each municipality were able to determine individually the pay and other terms and conditions of civil servants. Today the system of collective bargaining is similar for both public and private sector workers. For example, labour market federations from both public and private sectors take part in the negotiations on the national income policy agreement, and sectoral and local agreements are concluded in both private and public sectors.

According to the Ministry of Labour, the range of issues settled in the public sector collective agreements resembles that of the private sector, though contractual rights are not exactly as wide as those of the private sector. The collective agreements include, for example, stipulations

⁷² According to information

regarding grounds for giving notice, which is not covered in the contracts of the public sector officials⁷³. Furthermore, a collective agreement in the public sector can not cover organisational matters, management or supervision of work.

Policy concertation

As already illustrated, social partners have an integral role in the national economic and social policy making. This is evident, first and foremost, with central trade unions and employer organisations having a right to independent negotiations on income policy agreements. The state is not directly involved in the negotiations and does not sign any part of the agreement. However, the government follows very closely the progress of the negotiations and often promises to adjust the tax scales or to pass new labour legislation in order to assist the social partners reach an agreement.

The Finnish social partners are also engaged in policy design, implementation and evaluation – particularly in the field of education, training, economic and employment - through participation in different working groups, committees and advisory bodies at national, sectoral, regional and local levels. Indeed, the participation of sectoral social partners in committees / working groups dealing with sector specific concerns and social policy matters is the norm, rather than exception. For example, at national level social partners are represented in national tripartite advisory bodies on education and training, the National Tripartite Council on labour and education policy, and tripartite sector committees. At regional level, labour and training policies are discussed on a tripartite basis at, for example, county boards (*maakuntaliittojen yhteistyöryhmät*), regional Employment and Economic Development Centres (*TE-keskus*), regional offices dealing with health at work (*työterveyslaitos*), work protection committees (*työsuojelulautakunta*) and labour force working committee (*työvoimatoimikunta*). Social partners also sit on governing boards of different national, regional and local institutes dealing with socio-economic and sector specific matters.

Social partner organisations in the hospital sector

Trade union density is exceptionally high in the Finnish health and social care sector. Nine out of ten employees are trade union members amounting to a density rate of around 90 per cent. An overwhelming majority of the trade union members, as well as employees in the health and social sector, are female.

In the following section we introduce all the sectoral trade unions (the first 7 unions are EPSU members) and provide information on the sectoral employer's organisations.

Employee representation

The Union of Health and Social Care Services / TEHY

TEHY (*Terveys- ja sosiaalialan koulutetun henkilöstön ammattijärjestö*) is the largest trade union for trained health care practitioners and social workers in Finland. It represents a total of 61,731 employed health care professionals, of which over half (32,353) work in Finnish hospitals. It has further 26,400 members working in other related sectors, and the total membership is over 124,000 (including 15,000 students). The employed members of the union constitute approximately a quarter (23.8 per cent) of the workers in the social and health sector.

The members of TEHY work in public and private hospitals, health centers, schools, laboratories, maternity and child care centers, nursing homes for the elderly, occupational health care clinics, kindergartens and rehabilitation centers. The main occupational categories are nurses, midwives, practical nurses, dental assistants/dental hygienists, practical children's nurses, emergency

⁷³ Ministry of Labour (2003) Industrial relations and labour legislation in Finland.

medical technicians and ambulance staff, practical mental health nurses, radiographers, medical laboratory technologists and physiotherapists.

Some 93 per cent of the TEHY members are female. Their average age is 40 and approximately 80 per cent work in the public sphere. Some 14.5 per cent of the members are covered by one of the private sector collective agreements.

Trade union for the public and welfare sectors / JHL

JHL (*Julkisten ja hyvinvointialojen liitto*) is the largest trade union in Finland with over 210,000 invoiced members in municipal and state sectors. They represent a range of different professions, including nurses, teachers, childminders, kindergarten teachers, prison guards, customs officers etc. Around 15,000 members work in the hospital sector.

Just over 70 per cent of the members are female, and 29 per cent men. Around 3,000 members are workers from abroad representing around 100 different nationalities, mainly Russian (800), Estonian (500) and Swedish (150).

The Federation of Salaried Employees PARDIA

PARDIA (*Palkansaajajärjestö Pardia ry*) is a trade union with a total of 70,000 members (of which 58,000 are invoiced members) and 21 member unions. It is the largest employee organisation representing the interests of governmental personnel. In fact, approximately 50 percent of all Finnish state employees are members of PARDIA.

The majority of the members work in governmental offices and institutions and some are employed by public utility companies and enterprises. Further breakdown reveals that approximately 27,000 members work in the field of Security; Technology and Information sector covers approximately 9,000 members; some 8,000 members work in the Higher Education, Research and Teaching sector; further 9,000 members work in the Administration and Welfare Service sector; the Financial sector covers approximately 6,000 members; and Pardia's Private sector covers approximately 5,000 members⁷⁴. Some 53 per cent of the members are male.

Only a fraction of the members work in the hospital sector (around 2,000), mainly indirectly through members working for the Ministry of Health and Social Affairs (*sosiaali- ja terveystieteiden ministeriö STM*), the National Research and Development Centre for Welfare and Health STAKES (*Sosiaali- ja terveystieteiden tutkimus- ja kehittämiskeskus STAKES*), National Product Control Agency for Welfare and Health (*Sosiaali- ja terveydenhuollon tuotevalvontakeskus STTV*), children's care homes, mental institutions, state specialist schools and holding centres for immigrants.

The Finnish Union of Practical Nurses (SuPer)

SuPer is one of the largest trade unions in the social welfare and healthcare sector. They have a total of 40,151 invoiced members of which 5,173 work in hospitals and a total of 13,076 members in the general health care sector. In total the union has 68,000 members, if students are also included.

Practical nurses (*perushoitajat ja lähihoitajat*) constitute the largest group of members.

Union of Professional Social Workers (Talentia)

The trade union Talentia promotes and protects the professional interests of over 18,000 social welfare professionals. It has a total of 8,000 invoiced members. Just over 840 members work in Finnish hospitals.

⁷⁴ Information of Pardia, 01/2007.

Central Union of Special Branches within Akava (AEK)

The Central Union of Special Branches within Akava (*Akavan Erityisalat*) represent 7,969 invoiced members from a wide variety of different sectors. Only small share of the members work in hospitals, for example, the members belonging to the Finnish Association of Occupational Therapists (*Suomen Toimintaterapeuttiliitto TOI*).

Bargaining Organisation for Technical and Basic Services (BOTBS)

Bargaining Organisation for Technical and Basic Services (*Tekniikan ja Peruspalveluiden Neuvottelujärjestö*) represents 15,000 invoiced members. The members work for municipalities and municipal federations in technical duties or as public health nurses (*terveydenhoitajat*).

The Finnish Medical Association, FMA

The Finnish Medical Association (*Lääkäriliitto*) represents more than 90 per cent of Finnish physicians. In the beginning of 2006 the Association had 20,294 members - 1,262 of whom were medical students.

The Federation of Special Service and Clerical Employees, ERTO

ERTO (*Erityisalojen Toimihenkilöliitto*) is an organisation of employees working in expert positions in the private service sector. The members represent a wide variety of fields, such as information technology, transportation and forwarding, advertising, market research, new media, health care and social services, financial management, physical exercise, culture, free-time activities and other special fields.

Two individual unions from the hospital sector unions are members of ERTO: Association of the employees of social services and health care organisations (*Sosiaali- ja Terveysalan Järjestöjen Työntekijät SOTT ry*) and Association of employees of private medical and health care centres (*Yksityisten lääkintä ja terveyspalvelulaitosten työntekijät ry (YLTT)*).

The Finnish Association of Occupational Health Nurses

The Finnish Association of Occupational Health Nurses (*Suomen Työterveyshoitajien liitto*) represents 2,000 occupational health nurses in Finland. The union is a member of AKAVA, the Confederation of Unions for Academic Professions in Finland.

Employer representation

The main employers' organisation in the hospital sector is the Commission for Local Authority Employers, which represents 416 municipalities and 200 joint municipal authorities. These local authorities employ about 428,000 employees, a fifth of Finland's employed labour force. In the private sector, the Private Health Services Association (*Terveyspalvelualan Liitto ry*) represents around 25 hospitals. In addition, the Employers's Association for Service Enterprises has 7 members in the sector.

Structure of collective bargaining and social dialogue in the hospital sector

The national income policy agreements establish the broad guidelines for bargaining at sectoral and local levels in the hospital sector. These central agreements are normally valid for two years and this centralised form of bargaining has been a predominant feature of the Finnish industrial relations system for the past two decades. The central income policy agreement was not renegotiated for the first time in decades in September 2007 when the last agreement came to an end, hence sectoral level is the highest level of bargaining for the next two-year period.

With regards to the **public** health sector, the terms and conditions of workers are negotiated under the sectoral bargaining framework for the local government sector. Different health sector

unions and their confederations negotiate with the Commission for Local Authority Employees and conclude five separate agreements for the local government sector. Five separate agreements are concluded in order to take into consideration the specific nature of different occupations within the sector.

The general collective agreement for municipal personnel (*Kunnallinen yleinen virka- ja työehtosopimus KVTES*) is the largest agreement within the local government sector. It covers in the region of 307,000 civil servants and other employees. The largest groups of employees of which terms and conditions are governed by this agreement are nurses, practical nurses, nursery nurses, cleaners and children's caretakers.

This agreement determines the terms for a large proportion of hospital sector workers, particularly nurses, practical nurses and cleaners. Though only one over-arching agreement is set for this group of employees, the main agreement includes several annexes, which often contain occupation specific conditions.

The collective agreement for physicians (*Kunnallinen lääkärien virkaehtosopimus LS*) covers a total of 14,000 doctors working in hospitals (7,500), municipal health centres (3,500), dental practices (2,500) and 500 vets.

The collective agreement for municipal hourly-paid personnel / TTES (*Kunnallinen tuntipalkkaisen henkilöstön työehtosopimus*) sets the wages and other terms for 16,000 temporary workers in the local government sector. It is not known how many people from the hospital sector belong to this agreement. Other two agreements are the collective agreement for teachers (OVTES) and the collective agreement for technical fields.

Labour market issues can also be negotiated at the local level and this form of bargaining has increased in recent years also in the health sector, for instance, as a consequence of new pay schemes (introduction of new performance-based health systems). There is indeed now scope for more local flexibility over the pay of individual workers, including doctors and nurses. Local agreements in the health sector can govern issues such as overtime, on-call compensation, holiday pay and compensation for work carried out in remote rural regions.

Wages of **private** sector health workers are determined under separate bargaining arrangements. There are three framework agreements for the private health care sector, which all private health care providers have to follow: private health care agreement, private social care agreement and private ambulance services agreement. As there is only a marginal number of private hospitals in Finland, the number of workers in the hospital sector affected by the private agreements is low. There are some important local agreements in the private health care sector, including one for the Finnish Red Cross.

Social dialogue in the sector is not only restricted to negotiations on wages and other terms and conditions of employment; regular meetings between the state, employers and employee representatives take place. The health care policy has been to a large extent based on a tripartite concertation. The representatives of trade unions stated that "*social dialogue in the sector has traditionally followed the principle of an on-going dialogue rather than a system, which brings employees and employers face-to-face only during bargaining rounds*". Both parties are consulted about legislative changes and they are also members of different national committees led by the Ministry of Social Affairs and Health (matters dealing with health, policy, legislation and provision) and the Ministry of Education (matters dealing with education and training in the sector).

Bipartite meetings between the Commission for Local Authorities and the trade unions are also regular. Bi-partite co-operation mainly takes place through working groups on topics that are often chosen during bargaining rounds. For example, during the most recent bargaining round

four different working groups were established of which aim is to create and renew recommendations and agreements on:

- Development of occupational safety and working environment;
- Education and training in the health sector;
- Procedures for measuring performance; and
- Other matters.

The Finnish Medical Association also emphasised that the representatives of the union meet on regular basis with heads of individual universities to discuss topical matters, including employment and education of the healthcare personnel. The union also has regular meetings (3-4 times a year) with the Commission for Local Authorities and head of medical studies at universities with medical faculties.

Co-operation between employers and employees in the health sector is further developed and formalised with the introduction of a new law on co-operation between employers and employees in the local government sector, including municipal health care. It was passed in April 2007. The purpose of the legislation is to further co-operation between employers and employees, to provide personnel with the opportunity to influence matters relating to their work and workplace, and to develop the operations of municipalities and quality of working conditions in municipal workplaces.

In practice the law means that employers must consult and discuss the following matters with employees and/or their representatives:

- Restructuring at a municipal level, joint-municipality level or national level that has implications for the workforce.
- Re-organisation of service delivery, which can have an effect on the workforce, e.g. decisions to outsource.
- Plans and reforms that concern personnel, personnel development and equal opportunities in employment.
- Redundancies or other changes in working arrangements that are caused by budgetary or economic reasons.

In addition, the law makes it a duty of local authorities to provide the personnel with information about the employment and economic situation of the authority, and forecasts of the situation in the future. Every quarter each authority also have to report on the number of temporary and part-time employees.

Key challenges for the hospital sector and responses provided by social dialogue

The Finnish health sector is performing relatively well but it is still facing a range of different challenges, including a significant labour shortage in certain locations and fields, challenges brought by an ageing population, and the challenge of managing the implementation of the new pay schemes and the organisational reform. Finally, the sector is currently undergoing one of the toughest bargaining rounds, which is having far-reaching effects on the sector as a whole.

In this section we discuss some of the challenges to employment in the Finnish hospital sector, and we also explore the role of social dialogue in responses to these challenges.

Labour shortage and ageing workforce

It has been estimated that approximately 12,000 more employees are needed to meet the increasing demand for social and health care services by the year 2010. Besides, about 49,000

to 55,000 employees in social welfare and health care services are likely to retire by 2010⁷⁵. The Committee on Estimation of Labour Demand in Social Welfare and Health Care has estimated that to meet this demand and fill the gaps created by retirements some 8,500 – 9,000 openings are needed per year in initial vocational training in social and health care from 2002 - 2010.

The shortage of personnel today is most acute⁷⁶:

- Among general practitioners working in municipal health centres. At the moment there is a shortage of around 400-500 GPs.
- Doctors in remote rural regions.
- Psychologists.
- Paediatricians.

Responses to the challenges and the role of social dialogue

The policy response to the challenge has been multi-dimensional, with some policies affecting the nation as a whole and others just the health and social sector:

- **To delay large-scale departures.** This has been enabled through the implementation of new national policies on retirement. In the late nineties Finland had one of the lowest average male retirements ages. Steps have been taken across the whole workforce to encourage older workers to defer their retirement age by altering the statutory, earnings-related pension scheme. A number of national schemes have also been implemented to address training needs of older workers (NOSTE) and health and safety of older workers (TYKES).
- **Increase study places for doctors.** To tackle the shortage of doctors, the annual medical school enrolment was increased from a low of around 350 in the mid-nineties to 600 in 2002 and by 2004 had reached 630. From 2003 more physicians were graduating than were retiring, and subsequently the Finnish Medical Association has stated that the shortage of doctors is now decreasing. Nurse training has also increased though there are still unfilled posts for practical nurses.
- **Increase study places in initial vocational education and polytechnic education** in the field of social and health care.
- **To improve attractiveness** of the health and social sector as well as public sector as an employer.
- In addition, there has been a significant influx of nurses returning from abroad to work in Finland again.

The Committee on Estimation of labour demand in social welfare and health sector has worked on a tripartite basis to estimate the extent of labour demand and the effect of large-scale departures on the labour market. Most of the responses have also been designed on a tripartite basis.

Labour migration to Finland is not seen by the social partners as a solution for the shortage because of language problems, though the number of foreign physicians living in Finland has slightly risen. In 2007 there were 360 foreign physicians working in Finland. Some physicians from other EU countries obtain a licence in Finland, but often choose not to work in Finland due to their family circumstances and/or poor Finnish language skills.

⁷⁵ OECD (2007) Ageing and the Public Service: Human Resource Challenges.

⁷⁶ Interviews with Lääkäriliitto and JHL.

Contrasting views on educational reforms in the health sector

Over the past decade the education system for both practical nurses as well as for physicians has undergone a reform. Prior to the reform of the nursing education, the training was focussed on producing specialist nurses; the field of specialisation was made at the start of the training. Today the specialisation comes at a much later stage. Many parties have been critical of this development, and for this reason the tripartite working groups on education and training in the health sector started to work to improve the education of practical nurses. For example, work experience periods have been extended.

The role of social partners in education and training of health care professionals

Social partners are engaged in education and training of health care professionals from the national to local level. With regards to the national level, the social partners from the health sector are represented in tripartite, sector-specific working groups on education and training policies and related laws. These working groups negotiate on matters such as the number of training places and the course content, though the relevant ministries are responsible for making the final decisions.

In relation to the local and regional level, the Finnish social partners are regular members of governing bodies and consultative committees of individual educational institutions. Social partners are also engaged in the competence-based qualification system, which is the framework for vocational education and training in the country. The VET system is based on a tripartite collaboration at national, regional and local levels. The tripartite qualification committees, appointed by the National Board of Education, define the competence based examinations. At local and regional level it is their role together with training providers to supervise the organisation of the tests and confirm approved qualifications. In practice this means that sectoral social partners are engaged in the design and deliver of VET in Finland. This also applies to the health and social sector, though the health sector to a lesser degree as for example doctors are educated in Finnish universities rather than within the VET system. But, for example, further VET qualifications for ambulance service personnel are provided within the VET system.

Further and on-going education of the health care personnel is another topical subject matter. Though a collective agreement the social partners in the health sector have agreed that further education of the health care personnel has two dimensions. First of all, each individual working in the health sector has a responsibility to ensure that they keep on updating their skills. And secondly, employers must provide opportunities for employees to take part in further education.

Example – a training agreement

A training agreement has been signed to safeguard the development of skills and competence of the employees in the health and social sector. Local authorities are legally bound to take care of the further training of their personnel.

Public authorities responsible for health care together with appropriate social partners are currently preparing a joint recommendation concerning the principles, practices and methods of continuing training in order to fulfil the requirements of health care of high quality.

Fixed term employment

According to the Ministry of Social Affairs and Health, the social and health care personnel in the municipal sector has increased in this decade by 8,700 persons. But only one in four of new employees have permanent jobs. Fixed term employment affects female workers proportionally more than male workers, with negative implications for individual pay increments, pay-dependent social security benefits, personnel training and annual leave.

The trade unions in the municipality sector have emphasised that the employment of women in temporary jobs over extended periods is one of the greatest obstacles to gender equality in Finnish workplaces.

A number of changes have been made to the employment legislation in order to cut down the share of temporary and fixed term employment in the municipal sector. Collective agreements have also tried to address this problem. The responses are explained below.

Addressing problems around fixed-term employment⁷⁷

The comprehensively redrafted Employment Contracts Act, which was the result of half a decade of tripartite negotiations, came into force in 2001. One of the aims of the reform was to curb the spread of fixed-term jobs and other forms of 'atypical' employment that had proliferated in the course of the 1990s. The new legislation prohibited employment of people on a fixed-term contract if they work on a continuous basis. The Act applies to all private sector and municipal sector workers.

In the three years that followed the adoption of the Employment Contracts Act, between 2001 and 2004, the share of fixed-term jobs in all employment came down by a mere 0.3 percentage points to 16.1 per cent. Young people and women in particular remained strongly affected. Furthermore, the proportion of fixed-term jobs in the public sector actually increased between 2001 and 2003 by 0.9 percentage points while their share in the private sector decreased.

The fundamental obstacle to increasing the number of permanently employed staff in the health sector is that it leads to rising costs. Temporary staff are paid lower wages and benefits than those with permanent contracts. Moreover, fixed-term workers are much easier and less costly to make redundant, which increases flexibility.

The recent introduction of a law on co-operation between municipal employers and employees makes it a duty of local authorities to report on the number of fixed-term and part-time employees. Fixed-term employment is also on the collective bargaining agenda, but a solution to this issue is yet to be found.

Addressing pay gap between men and women

The last incomes policy agreement (2005-2007) comprised a special municipal pay programme, which provided an increase of a few additional percentage points for nurses and teachers employed by municipalities.

During the most recent parliamentary election campaign (2007), the National Coalition Party (*Kokoomus*) – which secured the greatest number of votes in the election and subsequently is now the ruling party – further promoted the idea of the so-called 'equality income policy agreement', which envisaged considerable pay increases particular for nurses.

In the absence of central bargaining (as explained earlier in the report) there was a great pressure to address this issue during the bargaining round for the municipal sector. The Union of Health and Social Care Services (Tehy) promoted the introduction of a special pay programme, which would offer significant pay increases for health and social care professionals.

However, these demands were not welcomed by some of the other unions, such as the unions representing teachers and other female-dominated sectors. They wanted the increase to be more evenly spread among all municipal workers. They also claimed that the government had

⁷⁷ Aleksi Kuusisto, the Finnish Labour Institute for Economic Research.

promised these increases during the election, but their budgets on municipality services such as health care did not reflect their promises.

A collective agreement for the local government sector was finally signed in mid-October 2007. The social partners agreed to reduce gender pay gap in the municipal sector by 5 percentage points by 2015. Employers also agreed to increase the wages of health sector personnel by 12.7 per cent; however the Union of Health and Social Care Services (Tehy) demanded a 24 per cent increase. This has resulted in a record-breaking number of nurses handing in their notice, although this dispute has been settled since writing this report.

Re-organisation of the health sector service model

The on-going restructuring of the municipal health care aimed at redirecting the devolution of healthcare provision from local to inter-municipal and sub-regional entities is expected to have far reaching effects on the workforce, though the main aim is to ease the increasingly strained municipal economy. Trade union Tehy stated: *“The restructuring is going to have an effect on the rights, duties and locations of employees in the health care sector. It is essential that the new duties will mirror the education level and the rights of employees. With the physical expansion of the regions for which one single health care authority will be responsible, it must be ensured that the distances workers need to commute to work do not become unreasonable.”*

Other trade unions, JHL for example, have been concerned about the implications of the reform for the number of personnel in Finnish hospitals and health centres. For this reason they support the development of guidelines to govern the minimum number of personnel in different parts of the health sector.

Example – guidelines on the number of personnel required

The trade unions support the design of guidelines on the number of workers required to carry out work in different fields of the health sector, as a way of ensuring that cost-cutting measures do not end up placing too much pressure on the workforce. The Ministry of Social Affairs and Health has started some work in this field, together with the social partners, by providing recommendations on the number of personnel needed in elderly care.

These recommendations are voluntary in their nature, but still according to the trade unions a step forward, though they argue that the authorities with biggest problems in the elderly care are the ones which do not follow the guidelines.

To support development of new, more efficient working models that can cater bigger health care entities, the government launched the National Health Care Project to develop and test new working methods. The social partners have been engaged in the design and implementation of this project. At the same time the government also initiated a new, performance-based remuneration system.

Indeed, the pay scheme for the entire public sector has been undergoing a reform for a number of years now. The reform has been implemented with the help of collective agreements and pay-scheme development programmes. In theory, the pay is based on three separate components:

- A job-related component - pay depends on the demands of the job, the skills required and the local circumstances.
- A person-based component – pay depends on personal competencies and performance.
- A goal-sharing plan – individuals are paid for achieving their goals, which have been set in advance.

The application of the performance-related pay scheme in the local government sector (including hospitals) has been slow. In 2004 these pay schemes were applied by 8 per cent of all local government units.

FRANCE

Economic and labour market context

France has a high productivity per hour worked and a sophisticated social welfare system, but it also suffers from low labour force participation and high structural unemployment. This poor labour market performance contributes to a persistent budget deficit which is exacerbating, rather than alleviating, the fiscal pressures arising from ageing. GDP growth was 2% in 2007 (1.9 in 2006) and occupied population growth was 0.6% in 2007. Unemployment remains high, currently around 10%.⁷⁸

Employment rate (% population aged 15-64) in 2005 was 62.3 with a higher rate for men (67.7) than women (56.8).

Unemployment rate (% labour force 15+) was 9.8 in 2005 with rates being again gender differentiated: unemployment rates are higher for women (10.8) than for men (8.9).⁷⁹

Employment trends in hospital sector

There were approximately 1.6 million health care professionals in France in 2004, accounting for 6.2% of the working population. Nurses and nursing aides (*aides-soignants*) form the majority of these professionals (383 000 nurses and 377 000 nursing aides). France is currently facing a shortage of nurses, which might become more severe in the near future, given the ageing of the profession and the existence of recent employment laws restricting the working week to 35 hours (even in hospitals).

The number of doctors has risen rapidly in recent decades, but is now stable and should begin to decrease from 2006 onwards. Currently the number of doctors has stabilized, due to a policy reducing the number of students entering medicine. However, a significant decrease in doctors is forecast for the next ten years.⁸⁰

According to Eurostat figures (2006), employees in the health and social sector represent 12% of total workforce (all NACE branches) or 2.7 millions employees.

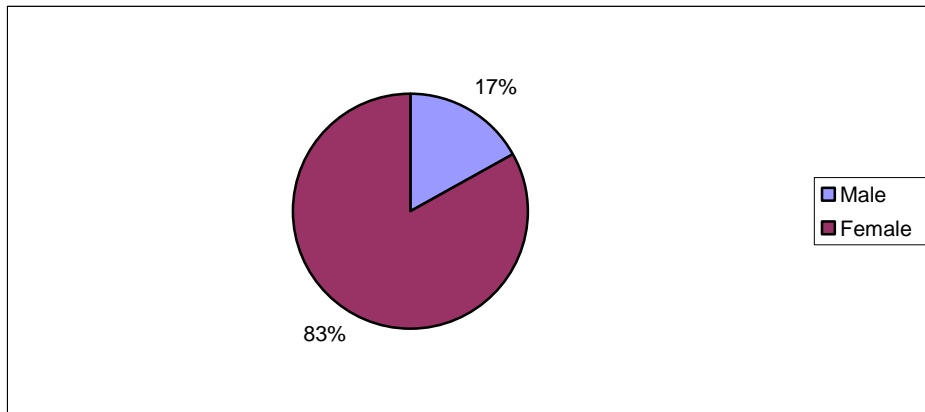
A breakdown of the figures by gender reveals that the vast majority of employees in this sector are women (83%), and that they belong to the age group 25-49 (69%). Employees above 50 years old represent a quarter of all employees in this sector.

⁷⁸ OECD, Economic Survey of France, 2005 <http://www.oecd.org/dataoecd/57/55/35006471.pdf>

⁷⁹ Country statistical profile 2007, OECD <http://stats.oecd.org/wbos/viewhtml.aspx?queryname=314&querytype=view&lang=en>

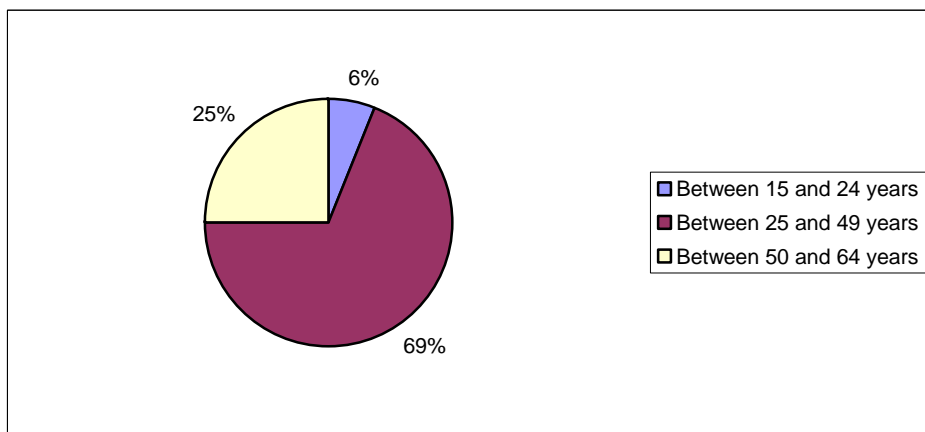
⁸⁰ Sandier S, Paris V, Polton D., Health care systems in transition: France. Copenhagen, WHO: European Observatory on Health Systems and Policies, 2004. <http://www.euro.who.int/document/e83126sum.pdf>

Figure 2 Employees in health and social sector broken down by sex –France 2006



Source: Eurostat

Figure 3 Employees by age groups in Health and social sector in France – 2006



Source: Eurostat

Structure and organisation of hospital sector and key recent reforms⁸¹

The French health care system is a mixed system combining elements of various organizational models:

- it lies between the Beveridge and Bismarck models, with health insurance funds and strong state intervention;
- it combines public and private health insurance, which finance the same services by the same providers for the same populations;
- it combines public and private care, including private for-profit hospitals;
- it is a publicly funded system characterized by freedom of choice and unrestricted access for patients and freedom of practice for professionals;

⁸¹ Sandier S, Paris V, Polton D., *Health care systems in transition: France*. Copenhagen, WHO: European Observatory on Health Systems and Policies, 2004. <http://www.euro.who.int/document/e83126sum.pdf>

- it is complex and pluralistic in its management, with co-management by the state and the health insurance funds.

Funding and expenditure

Total expenditure on health care in France was estimated at 9.5% of GDP in 2001. Public expenditure constituted 76% of total health expenditure in the same year.

The health care system provides comprehensive coverage to all residents and is mainly financed through statutory health insurance. The general scheme covers about 84% of the population (employees in commerce and industry and their families). The agricultural scheme covers farmers and their families (7.2% of the population). The scheme for self-employed people covers 5% of the population. Employers' and employees' contributions plus "general social contributions" (CSG: taxes on total income rather than salary) account for 87.8% of total health insurance revenue, with state subsidies and earmarked taxes making up the remainder. The CSG now accounts for a third of the health insurance funds' revenue.

Over the last few years voluntary health insurance (VHI) coverage has grown rapidly due to demand for better coverage and the continual reduction in the proportion of cost reimbursed by the statutory health insurance system. In 2000, complementary VHI covering statutory co-payments accounted for 12.4% of total health expenditure and covered about 85 of the population. VHI is provided by three types of organizations: mutual associations, provident associations and private for-profit commercial insurance companies.

Since 1996, the National Assembly approves an annual national ceiling for health insurance expenditure (ONDAM). Once the overall ceiling is set, the budget is divided into four sub-groups: private practice, public hospitals (divided among the regions), private for-profit hospitals and social care. Since the ONDAM was introduced, priority has been given to the social care sector.⁸²

The main health insurance scheme pays public hospitals through prospective global budgets, paid in monthly instalments by the main health insurance scheme.

For-profit hospitals are paid a fixed rate covering all costs except doctors, who are paid on a fee-for-service basis. Fees are specified in a contract between the doctor and the hospital, with the result that there is much variability in fees across doctors, specialties and hospitals.

Private not-for-profit hospitals can choose between the two systems of payment (public or for-profit). A reform currently underway aims to introduce an activity-linked reimbursement system and to harmonize the financing of the public and private sectors.

Organisational structure and management

The health care system is regulated by two main players: the state – the National Assembly, the government and ministries – and the statutory health insurance funds. The Juppé reform of 1996 clarified the roles of the state and insurance funds and reinforced the role of the region.

The Ministry of Health has recently been reorganized, with directorates responsible for health policy, hospital and health care, social security and financial matters and social policy. The Ministry also has directorates of health and social affairs at the local regional levels, most

⁸² L'Objectif national des dépenses de l'Assurance Maladie (O.N.D.A.M.) L'O.N.D.A.M. est l'objectif de prévision des dépenses de soins en ville et à l'hôpital voté chaque année par le Parlement. Il s'agit d'un mécanisme de régulation des dépenses de santé basé sur la définition d'objectifs quantifiés par profession de santé, obtenus à partir d'une évaluation médico-administrative négociée des prévisions des dépenses. Il est le budget prévisionnel des dépenses de soins en ville et à l'hôpital voté chaque année par le Parlement.

importantly the regional hospital agencies, the regional unions of the health insurance funds and the regional unions of self-employed doctors.

Regions apply national policies regulating the number of doctors and, to some extent, their specializations. This has led to a stable number of doctors and a decrease in regional disparities.

Hospitals are planned using a medical map (a quantitative tool) and the Regional Strategic Health Plan (a more qualitative approach). The medical map divides each region into health care sectors and psychiatric sectors. The French health care system is gradually becoming more decentralized to the regional level.

Providers

Primary and secondary ambulatory care

Self-employed doctors, dentists, medical auxiliaries and, to a lesser extent, salaried staff in hospitals deliver primary and secondary care.

Self-employed physicians provide the majority of outpatient and private hospital services. Patients pay direct fees for service and are then partially reimbursed by the statutory health insurance system. The national agreement between doctors and the funds specifies a negotiated tariff. Alternatively, from 1980 all doctors, but since 1990 only those with specific qualifications, have been able to join 'Sector 2' (currently about 24% of doctors) which allows them to charge higher tariffs. Doctors in public hospitals are paid on a salary basis, since 1986 they have been permitted to engage in part-time private practice within their hospitals as an incentive to remain in the public hospitals.

Doctors working in public hospitals are state employees who benefit from conditions of employment similar to those of civil servants.

The 2004 Health Insurance Reform modified the principles of care coordination in France by introducing in January 2005 a system of non compulsory coordinated care pathways for patients. It had three main features: introduction of a primary care doctor (preferred doctor scheme), initiation of capitation in ambulatory physician payment and reduction in patient's freedom of choice through financial incentives.

Secondary and tertiary inpatient care

Hospitals in France are either public (25%), private non-profit (33%) or private for-profit (40%). Within the public hospital system there are four levels: general, providing acute, follow up, rehabilitation and long-term care; regional, providing more highly specialized care and teaching facilities; local, providing health and social care functions; and psychiatric.

Public hospitals account for a quarter of all hospitals (1000 out of 4000). They are legally autonomous and manage their own budget. There are three levels of public hospital:

- 562 general hospitals (centres hospitaliers), providing a range of services covering acute care (medicine, surgery, obstetrics), follow-up care and rehabilitation and long-term care.
- 29 regional hospitals (centres hospitaliers régionaux), with a higher level of specialization and the technical capacity to treat more complex cases. Most of them are linked to a university and operate as teaching hospitals.
- 349 local hospitals;

Private hospitals fall into two categories: non-profit or for-profit. Public and private hospitals provide different types of services. While the private sector relies mostly on minor surgical

procedures, the public sector focuses more on emergency admissions, rehabilitation, long-term care and psychiatric treatment.

Reforms

The structural difficulties of the complex French system provide an impetus for reform. The main goals of current reform efforts include cost containment, improving management, public safety and equity.

The system's organizational structure makes it difficult to control expenditure and, although relatively high levels of expenditure on health have resulted in patient satisfaction and good health outcomes, cost containment remains a permanent policy goal. However, during the late 1990s concerns for equity led to a major reform (CMU) aimed at removing financial barriers to access but which went against the general trend of cost containment.⁸³

In 2003 the government decided to introduce a case-mix based prospective payment system for financing hospitals. The new payment system is being implemented progressively in the public sector (public and private not for profit hospitals) as of January 2004. The part of the activities paid by the case-mix instrument will increase gradually each year: 10% in 2004, 25% in 2005, 50% in 2008 and so on. The Ministry of Health will decide the pace of the transition taking into account the problems encountered during the implementation process. It has been announced that by 2012 100% of the hospital activity will be paid by the new system.⁸⁴

Private hospitals on the other hand are being paid entirely by the new case-mix based system, as of March 1, 2005. However, a transition period is allowed where 'national prices' will be adjusted for each provider taking into account its own historical costs/prices. The objective is to harmonise the prices for all the providers before 2012.

The introduction of the new DRG (Diagnostic-Related Group) based payment system was part of the government's (elected in 2002) hospital reform plan 'Hospital 2007' which aims to reinforce public hospitals' autonomy and efficiency. Introduction of case-mix based payment is one leg of this reform while the other leg 'new management' aims to modernise hospital administration and facilitate self-governance in public hospitals.⁸⁵

In May 2004 the conservative government proposed a series of reforms to raise revenue and reduce expenditure, purportedly to save €15 billion by 2007. The government proposed the introduction of several changes: raise health care levies on firms; reduce waste and over consumption (particularly of pharmaceuticals); reduce reimbursement of expensive pharmaceuticals; prevent national health insurance card fraud; establish a computerized, personal medical record accessible by any French health care professional to prevent patients from 'shopping around'; and continue to move towards gatekeeping.⁸⁶ The French health system is institutionally complex leading to tensions between the state, the health insurance funds and providers.

The 2004 Health Insurance Reform modified the principles of care coordination in France by introducing in January 2005 a system of non compulsory coordinated care pathways for patients.

⁸³ In this respect, the 1999 Universal Health Coverage Act (CMU) has been a major reform. The equity objective has prevailed over cost containment, as this reform explicitly aims to increase access and, consequently, health care expenditure, for people on low incomes.

⁸⁴ Snapshots of health systems, World Health Organization 2005, on behalf of the European Observatory on Health Systems and Policies, <http://www.euro.who.int/document/e87303.pdf>

⁸⁵ Zeynep Or., 'Hospital payment reform', Health Policy Monitor, March 2005. Available at <http://www.hpm.org/survey/fr/a5/4>

⁸⁶

It had three main features: introduction of a primary care doctor (preferred doctor scheme), initiation of capitation in ambulatory physician payment and reduction in patient's freedom of choice through financial incentives. Ultimately this reform is a first attempt to introduce some rationalization in the system through gate keeping. This long term objective cannot be evaluated yet. Currently, the reform has increased the level of complexity in the system through interlinked payment schemes.⁸⁷

In parallel, the reform requires the introduction of electronic personal medical records (dossier médical personnel, DMP) in order to keep track of all patient contacts with the health care system. The DMP will include medical data both from health professionals and hospitals and will be accessible through the internet. The electronic files will be hosted by selected internet providers approved by the government.⁸⁸

Outline of system of industrial relations⁸⁹

Industrial relations in France are still contentious and fragmented. As a result, the social partners find it difficult to determine and expand their powers within the economic system. Their difficulty is reinforced by a continuous and growing weakness of the trade union movement.

Main actors

Trade unions

Membership is quite low: union density has fallen to 8%⁹⁰. This is lower than the EU average (25%). Trade union presence in the workplace is high in large companies, but very low in small ones. The highest membership rates are in the public sector.

The unions are mostly organised on a sector or branch level and grouped in several confederations. There are five main union confederations with membership across the entire economy (CGT, CFDT, CGT-FO, CFTC, and CFE-CGC), all considered representative at national level. This status automatically gives them rights to negotiate, nominate candidates for elections, and have seats in some of the social security bodies, which are directed by the social partners.

There are also other union confederations, which have significant influence but do not have this status at national level. These so called autonomous unions are organised in the more reformist UNSA and the G10, which forms a kind of cartel with the more radical, anti-establishment SUD.

For most of the post-war period, the trade union movement has been ideologically divided between the communist-inspired and militant CGT and the more left-reformist CFDT. Recently the trade union movement has had a sharp decline not only in membership, but also in influence. As a consequence of this weakness, the movement has organisational and financial problems.

Regarding workplace representation, about 65% of employees declare to have a trade union representation or similar body at the workplace, a high proportion compared to the European average (53%).⁹¹

⁸⁷ Paul Dourgnon 'Preferred doctor reform', Health Policy Monitor, October 2006.

Available at <http://www.hpm.org/survey/fr/a8/2>

⁸⁸ Chantal Cases, Philippe Le Fur, 'Electronic medical records', Health Policy Monitor, October 2006.

Available at <http://www.hpm.org/survey/fr/a8/3>

⁸⁹ France industrial relations profile, EIRO <http://www.eurofound.europa.eu/eiro/country/France.html>

⁹⁰ Year 2004; data from DARES/INSEE, Source: Enquêtes permanentes sur les conditions de vie et ménages

⁹¹ European Social Survey, year: 2002-2003

Representation on most issues is provided by two separate elected bodies:

- Employee delegates (délégués du personnel)
- Works councils, either at company level (comité d'entreprise) or at plant level (comité d'établissement)

Since 1968, trade union rights have been recognised in companies and trade unions have been entitled to appoint delegates (délégués syndicaux), who have the power to negotiate and sign collective agreements at company level – a power the other bodies do not have.

Employers

In contrast with the employee's side, employer organisational density is quite high: 78% compared with 58% for the EU average.⁹² Three out of four employers are member of an employer organisation.

The MEDEF, the main employer association, is a multi-layered confederation of sector and territorial organisations bringing together companies with more than 10 employees. MEDEF directly organises 87 federations that cover some 600 associations and 165 regional organisations. There is no direct company membership at the confederation level. MEDEF was founded in 1998 and succeeds the former CNPF.

SMEs are represented by the CGPME, and self-employed artisans by the UPA. These two organisations played a significant part in reducing working time in small and very small companies in 2002.

Level of bargaining

Negotiations can be carried out at all levels of economic activity, provided that some recognised actors take part.

The lower bargaining levels are the more frequently used. The traditional level has long been the **branch**, certainly for negotiating collective agreements of general significance. Sector bargaining covers only SMEs. Many larger companies have a company agreement. Regional-level bargaining is rare, but some sectors (metalworking and construction) engage in local and regional bargaining.

Some agreements, often framework ones, can be reached at **national** level. After a decline in multi-sector bargaining in the 1970s and 1980s, it was relaunched in the 1990s, although on a limited level and concentrating on specific topics (vocational training, employment measures).

More recently, a significant movement towards negotiating **company-level** agreements started in the area of wages and reduced working time. The 2004 Fillon law encourages this move towards company-level negotiation by approving derogation agreements. A decentralised bargaining system has developed in which companies enjoy greater autonomy from both labour legislation and collective agreements. The employer confederation has promoted this trend energetically. The industrial relations agenda shifted to a large extent from wages to employment and production issues, reflecting more the agenda of employers than of employees and unions.

Coverage rate

Collective bargaining coverage is very high. About 90% employees are covered by a collective agreement. This is because agreements are easily extended to entire sectors and/or to different geographical regions or other economic sectors. The government can extend agreements at the request of one of the bargaining partners. It has historically been used to improve the working

⁹² Year 2003 Administrative data reported by Medef

conditions. As a consequence, companies that are not members of an employer association that signed an agreement are covered by a sector-level agreement once it has been extended by the government.

Collective agreements cover issues such as:

- collectively agreed pay increase
- Working time in relation to flexibility issues, working time arrangements, shift work etc: sector and company-level negotiations have been carried out on working time to ensure compliance with 35 hours from 2000-2004.
- some minimum wages agreed through collective bargaining (sector-level)
- Vocational training: in September 2003 social partners signed a national inter-sector agreement on lifelong access to training.
- Gender equality issues since 2000 (national agreement in 2004 to reduce gender pay gap and career development, integrated into company-level agreements)

Minimum wage (SMIC) covering all employees (cross-sector) and statutory working time (35 hours) are determined by legislation.

Policy concertation

The main **tripartite** bodies through which employer and trade union confederations can hope to influence government policy-making are purely consultative: the **Economic and Social Council (ESC)** and the **Planning Commissions**. Both are made up of representatives of employer and trade union confederations, as well as other interest groups such as consumers, and qualified individuals nominated by the government. This consultation remains underdeveloped, and is essentially limited to the state testing the strength of opposition to its policies. France must be characterised as a low concertation country.

Consultation (of a non-binding nature) runs high only in periods of big social reforms, for instance the pension reforms of 2003 and the health insurance reforms in 2004.

Nevertheless, both industrial relations camps are still heavily involved in the management of certain social security provisions (public health insurance, unemployment benefits, social welfare boards). The social partners also play a central role in the supplementary private health insurance system (mutuelles) and pension plans. They are involved in the system of vocational training. The national system of policy concertation is complemented by a tripartite social dialogue in development at the regional or local level.

However, French business has in the recent decade increasingly criticised these forms of tripartism. Therefore, MEDEF currently has a policy of selective disengagement and withdrawal from these joint steering roles.

The features described produce a discordant industrial relations atmosphere. Because of the lack of coordination between the state and the social partners, between the trade unions and employer associations, and between the different union confederations, strikes are frequent.

A lot of the strikes are in the public sector and especially in public transport. Another feature of the strike pattern is the growing importance of wider employment issues as motives: working time, restructuring, and downsizing.

Social partner organisations in the hospital sector

Trade unions

Trade unions look after the interests of different professional groups. Union representation is very fragmented, not only due to the existence of different professions, but also as a result of differences in status, for example between salaried and self-employed professionals. Furthermore, health care professionals can often choose from more than one union.

Workplace elections of employee representatives in public hospitals confirmed the dominance of the CGT trade unions, while CFDT recorded a loss of support as well as FO. These three trade unions are still the most popular trade unions in the sector. SUD and UNSA are gradually increasing their support.

The three main trade unions are:

❖ **Fédération Santé Sociaux – CFDT**

The Federation covers the health, social and medico-social sector. It takes part in collective bargaining in the private sector and in the hospital civil service.

The union sits in various bodies such as the Conseil supérieur du travail social, the Conseil supérieur de la fonction publique hospitalière, the Conseil supérieur des hôpitaux etc. It is also represented in 'organismes paritaires' or bodies with equal representation on both sides. CFDT is a member of CISL (Confédération Internationale des Syndicats Libres) and ETUC.

❖ **CGT Santé**

Fédération CGT de la Santé et de l'Action Sociale was founded in 1895. In the last few years it has become the first trade union in the hospital sector with 56,000 members today.

❖ **FSPSS-FO**

The « Fédération des personnels des Services Publics et des Services de santé » was founded in 1948 and has 30,000 invoiced members. It is the third most important trade union in the hospital sector.

❖ **UNSA**

UNSA organises managerial staff and has a total of 10,000 members (not clear how many of them are in the hospital sector).

❖ **CFTC- SSS**

CFTC Santé-services sociaux). It unionises both public and private health, socio-medical and social service sectors.

❖ **CFE-CGC**

CFE-CGC de la santé, de la médecine et de l'action sociale). It unionises professional and managerial staffs in both public and private health, socio-medical and social service sectors.

❖ **SUD**

The national health and social service workers' federation (Fédération nationale SUD Santé sociaux), unionises both public and private health, socio-medical and social service sectors. It does not participate in national sectoral bargaining in the private sector.

❖ **SNCH**

The national union of hospital managers ([Syndicat national des cadres hospitaliers](#), SNCH). It unionises managerial staff in public sector hospitals.

Medical profession

The tendency of medical representation in France is a tendency to fragmentation due to the existence of a large number of unions. Professional organisations represent specific professions (such as the Syndicat des Radiologues hospitaliers or the Union Syndicale de la Psychiatrie. The main organisations are:

- CMH - Coordination médicale hospitalière
- CHG - Confédération des Hôpitaux Généraux
- SNAM-HP - Syndicat National des Médecins des Hôpitaux Publics
- SNAM - Syndicat National des Médecins, Chirurgiens, Spécialistes et Biologistes des Hôpitaux Publics
- INPH - Intersyndicat National des Praticiens Hospitaliers
- Intersyndicat de praticiens hospitaliers

Employers

❖ **Fédération Hospitalière de France (FHF)**

French Hospital Federation represents all public hospitals, with more than more than 2000 undertakings (1000 public hospitals and 1000 specialised medical structures). It was created in 1924.

FHF represents hospital employers in key national committees preparing or taking decisions about all issues concerning public health care. It is represented in a number of consultation bodies. All legislative texts related to the hospital civil service are discussed with FHF.

At the national level, FHF appoint representatives in high profile Commissions : the Conseil Supérieur des Hôpitaux, Conseil Supérieur de la Fonction Publique Hospitalière, Commissions Nationales et Régionales de l'Organisation Sanitaire et Sociale etc. FHF is playing an important role in all public hospital issues by issuing positions (budget, health professionals, international issues, health care services 'delivery and so forth). It is the main interlocutor of the government on these issues.

FHF represents hospitals' employers in *paritaire* institutions such as the national association for professional training and development of competences and qualifications (Association pour la Formation permanente des personnels hospitaliers), or the 'Comité de gestion des Oeuvres sociales' which aims at developing social policies for improving economic conditions of professionals, pension's funds etc.

At the European and international level, FHF is a member of IHF (International Hospital Federation). It is also a member of HOPE (European Hospital and Healthcare Federation and CEEP.

❖ **FHP - Fédération de l'Hospitalisation Privée**

FHP is the equivalent of the FHF in private hospitals. It represents 1250 private undertakings, and is organised in regional and specialised trade unions (*Syndicats Régionaux* and *Syndicats de Spécialités*). It is the interlocutor of the government in the discussions on the reform of the private sector.

❖ **FEHAP - Fédération des établissements hospitaliers et d'assistance privés**

The federation of private hospital and assistance covers health, socio-medical and social services establishments in the private non-profitmaking sector.

Structure of collective bargaining and social dialogue in the hospital sector

Public hospitals

In France, workers in public hospitals are civil servants. Therefore, national agreements are negotiated by Department of Health or Social Security or for some negotiations by other departments (E.g. Treasury).

Workers in public hospitals benefit from the status of the civil service, which means that the terms and conditions of employment (salary, grades, career scales etc) are centrally determined according to different 'corps' such as the 'corps infirmier' for nurses.

Consequently there is no collective bargaining in public hospitals. The provisions attached to the 'status' of civil servants are determined by the Ministry of Health together with the Ministry of Finance. Salary increase for instance are determined in relation to the 'point indiciaire', meaning that regularly (usually every year) the government can decide to increase the 'point indiciaire'. This is usually the case when a new government comes into power. Decisions taken for the civil service in general are then transposed and adapted to the three 'civil services': state civil service, territorial civil service and hospital civil services.

Regarding the role of trade unions, negotiations take place between the Ministry and the different categories of workers (e.g. nurses).

Employer organisations have no influence on the determination of the terms and conditions of employment. However a broader social dialogue exists on issues such as training, on a more informal level. Recently an agreement has been reached on the career advancement and lifelong learning. It is now possible for hospital staff with low qualifications to take up training (e.g. leading to a nurse qualification for instance), while continuing receiving most of their salaries. This new scheme is one example of a constructive social dialogue to address the challenge of the shortage of qualified staff.

Private sector

In private hospitals wages and working conditions are determined by collective bargaining between social partners (bipartite).

The most recent collective agreement on terms and working conditions in the hospital sector was signed in October 2006 at the national level. At the national level, agreements concern mostly salaries and work conditions. Agreements at the workplace level are related to work condition and work organisation (working time), profit-sharing and participation.

Branch agreements are often negotiated in the private not-for-profit sector. Agreements on salaries also have to be accredited by the Ministry.

Negotiations take place annually for salaries. There is no regularity for the other issues. On the issue of training, a branch agreement was concluded in February 2007: the agreement is related to the implementation of lifelong learning in private hospitals. It was signed by three trade unions and the FHP. It is now in the process of being extended by the Ministry of Labour. In particular it creates a new form of training contract.

In general social dialogue is limited to the collective bargaining process and there is no strong dialogue between social partners outside collective bargaining.

A **National Health Conference** takes place once a year to propose priorities and suggest policy directions to the government and parliament. From 2002, the conference is also responsible for monitoring respect for patients' rights.

The conference is made up of representatives from health care professionals' organizations and health care institutions. In the future, patients' organizations will also be represented in the conference.

Key issues for the hospital sector and the sectoral labour market

Staff retention and shortage of qualified staff

Nowadays, hospitals complain about pressures on staff: the implementation of the EU Working Time Directive for physicians and the enforcement of the French '35 hours law' for other members of staff increased staff pressure already observed in some hospitals. Lack of sufficient personnel has been cited as one of the causes of the high mortality observed in the particularly hot summer of 2003 and unions representing hospital staff fear new pressures with the onset of winter epidemics.⁹³

The CGT also stresses the fact that the implementation of the 35 hours in the private sector increased the shortage of staff and worsened the work conditions. This is partly due to the fact that recruitment of new staff to limit the effect of the reduction of working time has not really taken place. The priority has been given to the reduction of spending, with a diminution of the number of beds and the supply of services in general, along with a diminution of working time. However the demand for health services has constantly increased. Another problem is the *numerus clausus* and quotas, in particular in nurse schools, which limit the number of new entrants in the profession.

One of the consequences of the shortage of qualified staff is the *transfert de competences* or the fact that auxiliary nurses increasingly tend to perform medical acts that are normally performed by nurses. This 'role slippage' takes place mostly informally. Trade unions denounce a situation which is only a short-term solution to shortage of nurse and presents a real problem in terms of the definition of tasks in relation to the relevant qualifications and the corresponding salary.

The shortage of nurses is becoming worse, due to various factors such as the ageing population and the strenuous work conditions. Recently a new scheme has been set up to address the shortage of qualified staff. An agreement has been reached between employers (FHF) and trade unions in public hospitals on career advancement and lifelong learning. It is now possible for hospital staff with low qualifications to take up training (e.g. leading to a nurse qualification for instance), while continuing receiving most of their salaries.

In the private sector, the FHP stresses the fact that the medical profession is going through a serious crisis, particularly in the freelance professions. This is partly due to issues of salaries, constraints related to working times and the 'judicialisation' of the sector (with the increasing number of trials). The FHP opened a concertation process with the trade unions to discuss of the issues of the *numerus clausus*, and the development of statistical tools on the demography of the medical profession to address the sector's needs.

⁹³ Sandier S, Paris V, Polton D., *Health care systems in transition: France*. Copenhagen, WHO: European Observatory on Health Systems and Policies, 2004. <http://www.euro.who.int/document/e83126sum.pdf>

The FHP is favourable to a better remuneration of doctors in the private sector, and to a fairer system of insurance to enable doctors to subscribe to insurance schemes which are more and more expensive to the increasing number of trials.⁹⁴

In 2006 several unions representing doctors called for strike action. The FHP also called on private clinics to close their doors, reflecting the growing tension about the level of remuneration of doctors. The great majority of doctors working in private hospitals are self-employed and their remuneration is provided by the consultation fees that are paid by patients. This corresponds to a tariff fixed by the health insurance fund, and only doctors in the 'sector 2' category are authorised to impose surplus fees.

This issue is also pointed out by trade unions. The CFDT Santé Sociaux stresses that salaries have a very low progression over time, whereas work conditions are very difficult. In addition they are lower in the private sector.

Cost containment: the funding of medical establishments

Since January 2006 private clinics have been funded on the basis of 'rates per activity' (Tarification à l'activité or T2A), as opposed to the system of 'global budget' prevailing in the past. Regional hospital agencies (ARH) distributed the budgets to hospitals mainly based on historical costs. The change is part of the 2002 government's hospital reform plan 'Hospital 2007' which aims to reinforce public hospitals' autonomy and efficiency. This means that hospitals are remunerated according to their level of activity (with a specific cost attached to each treatment). The proportion of this type of funding is to be increased for public and non-profit making establishments. It has been gradually introduced in public hospitals and now represents about 50% of the funding. In the long term it should represent 100% of the funding, to achieve a gradual convergence of the conditions under which hospital care is dispensed and financed in public and private sector.

The fragile financial status of these establishments has led to the decision to introduce the T2A. However the new financing system is controversial. The debate revolves around the issue of increased efficiency in public hospitals and making gains by increasing competition between public hospitals and private clinics. Some experts consider that the T2A does not take into consideration the social aspects of different kinds of treatment, which public hospitals also have to deal with. The issue is the comparative 'costs' between public hospitals and private clinics.⁹⁵

Another issue of concern is the construction of the 'MIGAC budgets' for public hospitals to finance the education, research activity and other 'public missions'. Both public and private sector expressed concern as to the future size of this budget. The private sector fears that this budget would be used as a mechanism to cover actual efficiency deficits of public hospitals, while public sector has doubts about underestimating the value of their 'public mission'.

According to the FHP (federation of private hospitals) the implementation of the transparency and management of costs to private as well as public hospitals is a good thing. It advocates a conception of the hospital as an enterprise, which promotes a more efficient budget management.⁹⁶

Convergence of financing systems is also on the agenda of the new government. One of the measures featuring in Nicola Sarkozy's programme is the full implementation of the T2A for 2012 with a convergence public/ private.

⁹⁴ Plate-forme 2007 – Propositions pour un nouveau projet hospitalier , FHP 2007

⁹⁵ Disputes over funding and pay issues in public and private hospitals, EIRO 12.12.2006
<http://www.eurofound.europa.eu/eiro/2006/10/articles/fr0610029i.html>

⁹⁶ Plate-forme 2007 – Propositions pour un nouveau projet hospitalier , FHP 2007

Hospital management: the New Governance system

The new governance system has been set up in public hospitals since 2006 and aims to give more autonomy to medical staff over managerial decisions. It is also part of the 'Hospital 2007' plan which aims to reinforce public hospitals' autonomy and efficiency. This 'new management' aims to modernise hospital administration and facilitate self-governance in public hospitals. It consists in the creation of centres of activity (*pôle d'activités*) or large medical departments, to decentralise the management of hospitals and organise their medical activities in a more efficient way. Doctors and medical staff are actively involved in these poles and associated to the decision making process, so as to encourage a more committed and responsible attitude towards the functioning of their department. These centres, under the responsibility of a doctor, enjoy organisational and administrative autonomy, being subject to an internal contract with the hospital management.

GERMANY

Economic and labour market context

Germany's GDP per capita is well above the average of the EU-25 (110.2% in 2006), although the gap narrowed over the last two decades. Economic growth seems to have rebounded from its sluggish, near-recession period between 2001 and 2005. GDP rose at 2.8% in 2006, and a steady growth of around 2.4-2.5 is expected for the next two years. This loosely corresponds to the average of the EU-25. This recent improvement in the figures is primarily explained by a stronger export performance (exports rose at 9.4% in 2006, and will maintain a relatively high pace at 6-7%).

Table: Key economic indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
GDP per capita in PPS (EU-25 = 100)	111.7	110.0	108.5	112.5	111.1	109.9	110.2
Real GDP growth rate (%)	3.2	1.2	0.0	-0.2	1.2	0.9	2.8

Source: Eurostat

Employment

The German level of employment has been traditionally high, significantly above EU-average. Following a slight decline in the years with slow economic growth (2002-2004), the situation on the labour market improved strongly in 2005, and primarily in 2006, when the employment rate reached 67.2% (the corresponding figure was 64.7 for the EU-25). Altogether, more than 37 million people were employed in 2006.

Table: Key employment indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005*	2006
Number of people employed (annual average, in thousands)*	36,466	36,573	36,289	35,925	35,841	36,354	37,190
- male	20,469	20,423	20,097	19,797	19,723	19,963	20,345
- female	15,998	16,150	16,192	16,128	16,118	16,391	16,845
Employment rate (percentage)	65.6	65.8	65.4	65.0	65.0	65.4	67.2
- male	72.9	72.8	71.8	70.9	70.8	71.3	72.8
- female	58.1	58.7	58.9	58.9	59.2	59.6	61.5

Source: Eurostat, * Eurostat LFS, break in series at 2005

The favourable employment situation is to a large extent the consequence of relatively high female participation, which hit 61.5% in 2006 (the EU average was 57.3). The share of working men is also higher, but the difference is much smaller (72.8% in Germany, against the European 72.0%). This means that the gender gap in employment is less elaborate in Germany than in Europe in general (one should especially note the high share of working female population in the eastern part of the country).

Unemployment

Mainly as a result of increased outsourcing activities in the industry, as well as lay-offs in the public sector, unemployment in Germany has become a major concern. Despite recent economic recovery, the figure still stood at 8.4%, higher than the average of the EU-25 (7.9%). The explanation for the rising level of unemployment is given by the boom in the activity rate of the population. Actually, recent social security reforms (Hartz-IV) aimed at creating and

strengthening the incentives to work had a major impact on the willingness to participate on the labour market. Continued fight against undeclared work may be a further reason.

Table: Key unemployment indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Unemployment rate	7.2	7.4	8.2	9.0	9.5	9.5	8.4
- male	6.0	6.3	7.1	8.2	8.7	8.8	7.7
- female	8.7	8.9	9.4	10.1	10.5	10.3	9.2

Source: Eurostat

Both men and women could benefit from new jobs recently created, the unemployment rate of both genders decreased in a similar ratio.

Employment trends in hospital sector

Employment in the sector has increased steadily, both among men and women, although female employment clearly predominates.

Table: Employment in the health and social work sector (NACE N), 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Number of people employed in the health and social work sector (annual average, in thousands)	3606.3	3674.8	3749.7	3912.7	4022.3	4058.3	4187.2
- male	836.4	848.8	873.9	897.5	942.4	940.3	986.4
- female	2769.9	2826	2875.8	3015.3	3079.9	3118	3200.8
Employment in the health and social sector, as share of total employment (percentage)	9.9	10.1	10.3	10.9	11.3	11.2	11.3

Source: Eurostat LFS

Table 5: Employment in the health and social work sector (NACE N), broken down by age (percentage), 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Between 15 and 24 years	12.4	13.0	12.8	12.4	12.0	11.9	11.9
Between 25 and 49 years	68.6	66.8	65.7	66.1	65.7	65.2	64.3
Between 50 and 64 years	18.4	19.7	20.8	20.8	21.6	22.1	22.8
Over 65 years	0.6	0.6	0.7	0.7	0.7	0.8	1.0

Source: Eurostat LFS

Funding and expenditure

Table: Health care expenditure, key figures, 2000-2005

	2000	2001	2002	2003	2004	2005
Total health expenditure as percentage of GDP	10.6	10.8	10.9	11.1	10.9	..
Total health expenditure, PPP\$ per capita	2,674	2,772	2,912	3,001	3,052	..
Public sector expenditure as percentage of total health expenditure	78.6	78.4	78.6	78.2	78.1	..

Source: WHO-HFA estimates

Table: Key indicators of inpatient care, 2000-2005

	2000	2001	2002	2003	2004	2005
Total inpatient expenditure as percentage of total health expenditure	35.8	35.2	35.1	34.7	..	..
Expenditure on inpatient care, PPP\$ per capita	956	980	1,023	1,044	..	..
Public inpatient expenditure as percentage of total inpatient expenditure	83.6	83.1	83.1	83	..	..
Number of hospitals	3,635	3,628	3,564	3,513	3,460	3,409
Number of hospital beds (in thousands)	749.5	741.9	731.9	721.7	707.8	698.3

Source: WHO-HFA database

Provision of health care

There are three main categories of hospitals in Germany: the municipal hospitals (around 50%), hospitals run by churches/religious organisations (around 5%), and private hospitals (almost 50%). In addition to the municipal hospitals, there are a limited number of other public sector hospitals. Those being part of universities are owned by the Länder (which own the universities), e.g. Hessen has two of them. The Germany army also has hospital(s).

Municipal hospitals are grouped into 16 provincial ("Länder") employer associations, which are members of a national umbrella organisation.

Two large private chains are prominent in the private sector, both have been active in the privatisation process:

Rhön-Klinikum AG (45 hospitals, more than 14,000 beds)

Helios Kliniken GmbH (58 hospitals, 15,800 beds)

Outline of system of industrial relations

Social dialogue and collective bargaining have a long tradition in Germany. The constitution provides that employers and employees are autonomous in signing collective agreements ("Tarifautonomie"), the government does not interfere (it only participates in its role as employer).

Collective bargaining takes place at national, regional, local and workplace level. The main level of bargaining continues to be the national sectoral level. In recent years, there has been a tendency for "opening clauses" to be introduced in collective agreements allowing for greater local determination and deviation from national framework agreements on particular issues to provide greater flexibility.

At national level, BDA (Bundesverband Deutscher Arbeitgeber) represents employer organisations at cross sectoral level and DGB (Deutscher Gewerkschaftsbund) the employee side at cross sectoral level.

Social partner organisations in the hospital sector

Employer side

- The Association of Municipal Employers (VKA – Verband Kommunaler Arbeitgeber) is a large multi-sectoral association of public sector employers at local level (including also utilities, savings banks, etc.). It represents employers with 2 million employees. This

includes 650 hospitals with a total of 440 000. VKA is a member of HOSPEEM and CEEP.

- Tarifgemeinschaft deutscher Länder (TdL) is the employers' association of the German Länder and represents all federal states with the exception of Berlin and Hessen.
- Bundesverband Deutscher Privatkliniken e.V. is the Federal Association of German private hospitals and has 460 member companies.

The charity organisations of the Catholic Church named [CARITAS](#), as well as the charity organisation of the Protestant church named [Diakonie](#) operate hospitals. However, these organisations are regulated by church law. Therefore, they are not part of collective bargaining.

Employee side

The employee side is represented by the following trade unions:

- The public services union Ver.di has 2.2 million members. Ver.di represents the majority of hospital sector staff and until 2005 also negotiated on behalf of doctors. However, as the union only counted among 1000 doctors among its membership, representativity was called into question and doctors represented by the Marburger Bund (see below) felt that doctors' interests were not well represented as the often achieved lower salary increases than nurses and auxiliary staff.
- bbb Tarifunion represents civil servants working in a limited number of state run hospital sector organisations.
- Marburger Bund is a relatively new player in the formalised bargaining process, which it has participated in since 2005, although the organisation itself has a longer history. It represents public sector hospital doctors (i.e.110,000 out of 145,000 hospital doctors, but not the self-employed doctors).
- Gewerkschaft Öffentlicher Dienst und Dienstleistungen (GOED) is a Christian Public Service Workers' Union
- Gewerkschaft für Beschäftigte im Gesundheitswesen (GIB) is a general health sector employees' union

Structure of collective bargaining and social dialogue in the hospital sector

Collective agreements are signed with the Länder for the hospitals run by them and with the employers association for the municipalities for the majority of hospitals which are run at this level. The only collective agreements negotiated at federal level in the sector are for doctors in the military. Collective bargaining usually takes place on an annual basis.

Of the 16 provincial employer associations, only 14 take part in the co-ordinated collective bargaining process. The Länder Berlin and Hessen left the "Tarifgemeinschaft" completely. Hamburg withdrew its own hospitals from the bargaining - these are basically university hospitals and psychiatric hospitals. There are slight differences between Länder (university and psychiatric hospitals) and municipal hospitals in terms of working time, workload, night shifts, on call time, and payment conditions (2-3% difference). The deals brokered are binding for member hospitals. They also have an impact on private sector and church hospitals' wage agreements.

Church hospitals cannot be forced into negotiations with trade unions by law. They also have the right to opt out from certain rules, e.g. the rigid rules of the working time directive. They are not derogated from the directive as such, but they can formulate their own guidelines

("Arbeitsvertragrichtlinien"). Other examples are exemptions from laws respecting individual rights: Catholic hospitals may decline the employment of divorced people. Their obligation to conduct abortion may differ from other hospitals'.

There is basically no legal difference in the negotiations with private hospitals and state associations, but the level is different. In the private sector, the negotiations usually take place at workplace level. Rhön-Klinikum leaves negotiations to individual hospitals (only issuing guidelines), but Helios Kliniken negotiates contract for the whole chain.

Key issues for the hospital sector and the sectoral labour market in particular

One of the most controversially discussed issues in recent years has been the transformation of the hospital financing system. This is led by the Ministry of Health and is intended to the implementation of a "diagnosis related group" system and continues to be debated. The reform started some 10 years ago and entered into its second phase in 2004. The cut-off date will be 2009. Discussions on reforms have involved the social partners. Prior to the reform hospitals negotiated with the insurance companies on the basis of input financing justified by performance. In future, hospital budgets (revenues) will be independent from wages, and other resources. This will have an effect on wage negotiations as wages have a significant impact on budgets. It has been argued that new financing measures may bring concentration. Some smaller, rural hospitals will be in danger and might not all survive. This process of concentration is already under way: 10% of hospitals have been closed in recent years, reducing bed capacity by 20%. At the same time, the number of hospital patients has increased by 20%, which was achieved by reducing the length of hospital stays. The new financing system (and resulting greater budgetary stringency) is likely to adversely affect wage negotiations for nurses and ancillary staff. As there are pockets of doctor shortage in Germany, this group is likely to be less affected by this trend.

Another key challenge is a rapidly progressing process of privatisation. Private hospital provision currently makes up 15-20% of the market and this is likely to grow. Nurses and auxiliary staff may be afraid to transfer to the private sector as their wages could be adversely affected. This is less of an issue for doctors.

Hospitals are mostly dealing with the financing reform now. But other issues being discussed are part of collective bargaining are:

- The impact of the working time directive and particularly the SIMAP and Jaeger on-call provisions;
- Health and safety in the workplace
- ageing workforce. It is estimated that there will be a lack of well trained specialists within 10-15 years.
- recruitment and retention. There is a small but significant trend for German doctors (particularly from the northern parts of Germany) to emigrate to Sweden, Norway or the UK. In some regions, this has already led to a shortage of doctors. At the same time staff from the "new" Member States are coming to Germany and this is welcomed, but better measures must be taken to integrate them into workplaces and society.
- for some employees, according to Marburger Bund, the diversity of hospitals presents difficulties. A good surgeon has to work in different hospitals which often have different regimes pointing to the necessity to harmonise working hours, holiday, overtime payment, on call time
- A recent collective agreement included provisions on the training and qualification requirements of doctors and other staff

- Aggressive behaviour in hospitals (either by staff or patients). This is currently only an issue at local level and has not yet entered the debate at national level

GREECE

Economic and labour market context

Services make up the largest and fastest-growing sector of the Greek economy, but remittances from transport (mainly shipping) are growing, and actually exceeded tourism receipts in 2004.

The Greek economy is estimated to have grown by 3.6 per cent in 2005 and similar growth rates are projected through 2007. Nevertheless, the employment rate was below the EU-wide average and the unemployment rate above the EU-average in 2005. Unemployment is particularly common among women and people under 27.

Figure 1 - Employment and unemployment rates in Greece and in the EU-25, 2000/2005

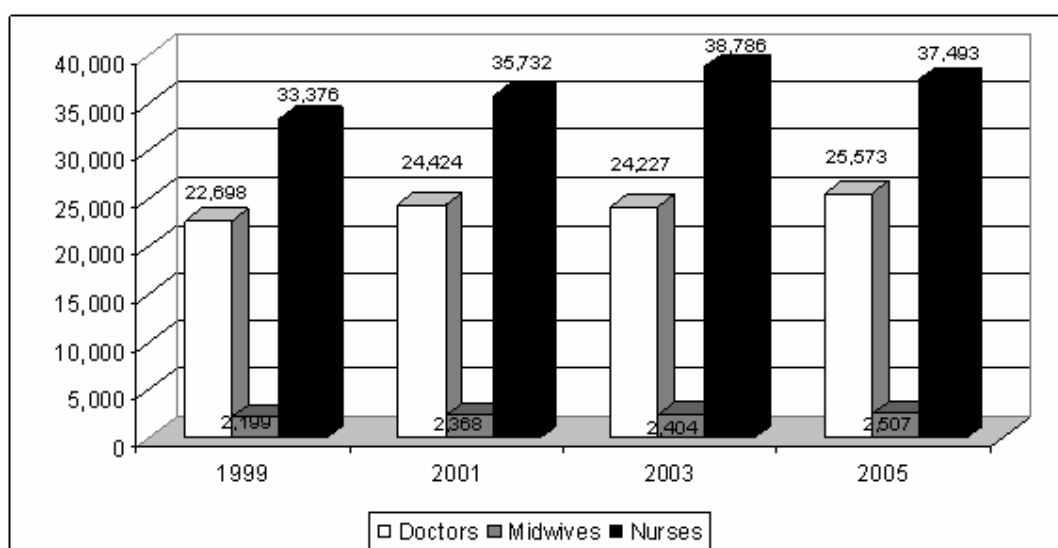
	Greece in 2000	Greece in 2005	EU-25 in 2005
Employment rate – total	56.5%	60.1%	63.8%
Employment rate – male	71.5%	74.2%	71.3%
Employment rate – female	41.7%	46.1%	56.3%
Unemployment rate – total	11.3%	9.8%	8.7%
Unemployment rate – male	7.5%	6.1%	7.9%
Unemployment rate – female	17.2%	15.3%	9.8%

Source: European Commission (2007) *Employment in Europe 2005*.

Employment trends in hospital sector

The number of health sector workers rose from around 34,000 in 1999 to just under 37,500 in 2005. This represents a growth of 13 per cent. The number of doctors has increased by 13 per cent, midwives by 14 per cent and nurses by 12 per cent.

Figure 2 – Employment in the Greek health sector, 1999 - 2005



Source: Information obtained and calculated from the data of the Greek national statistics office, 2007

Structure and organisation of hospital sector and key recent reforms

The Greek National Health System (ESY) was established in 1983 under the law 1397/1983. The public health system provides free or low cost health care for those who contribute to the Greek social security.

Organisational structure and management

The overall responsibility for the provision of health care and the development of a national health policy lies with the Ministry of Health & Welfare. It is also responsible for primary health centres, hospitals, social centres for children and the elderly, as well as regional distribution of health and welfare services⁹⁷. The main thrust of the national healthcare system reform plan initiated by the previous government was the decentralisation of services to a series of regional health systems. Consequently the health reform of 2001 introduced 17 Regional Health Authorities (PESYs) to be responsible for the service delivery (this reform is still ongoing).

The Ministry of Labour and Social Affairs is responsible for the organisation and administration of social insurance services.

Health care delivery

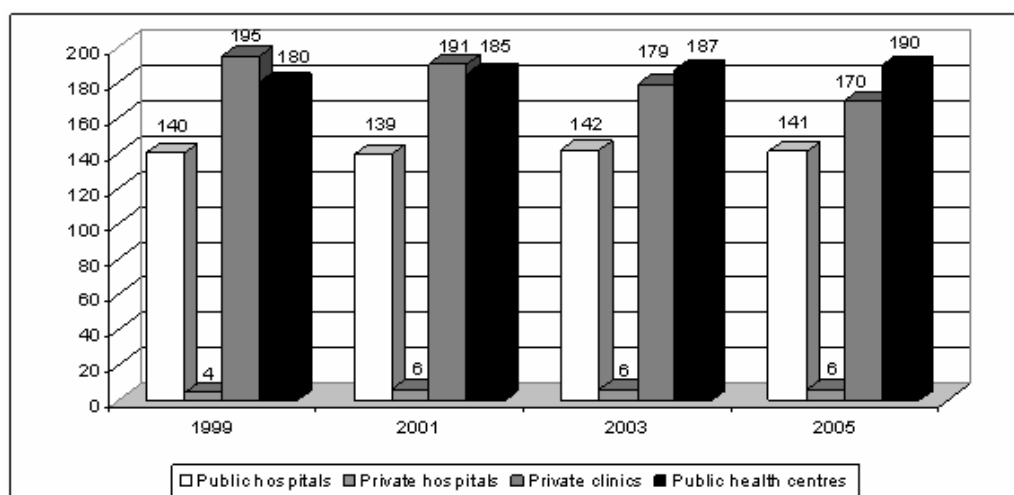
The country is divided into health regions, and each region provides three different types of health services:

- Primary care is provided by general hospitals and 190 health centres, which are mainly located in rural areas.
- Secondary is provided by general (181) or specialist (123) hospitals (plus 13 combined hospitals).
- Some 23 hospitals provide tertiary care.

Public and private health care systems operate alongside each other, although public health facilities are limited in some areas, particularly on the Greek islands. Transfers from provincial and island hospitals to hospitals in Athens or other major hospitals (e.g. the University Hospital at Ionnina) are common.

Though the public and private health sectors complement one and another, the number of private establishments has gone down since 1999. In 2005 there were 6 private hospitals and 170 private clinics. The number of public health centres went up from 180 to 190 between 1999 and 2005, and the number of public hospitals increased from 140 to 141.

Figure3 – the number of health care establishments, 1999 - 2005



Source: Information obtained and calculated from the data of the Greek national statistics office, 2007

⁹⁷ Local authorities (52 districts) play only a limited role in the administration of hospitals and rural health centres.

Health care expenditure

According to the Eurostat data, the health care expenditure (as a share of GDP) remains below the EU average in Greece, even though it has increased by nearly a percentage point over the past decade. The expenditure stood at 5.6 per cent of GDP in 1995 but rose to 6.7 per cent by 2003. The 2005 budget included a 14.5 per cent increase in spending on healthcare and social services (in local currency terms).

Funding

Health care in Greece is funded mainly through the central government budget (general taxation), the numerous state insurance funds (employers' and employees' contributions) and private insurance schemes.

Private hospitals are primarily financed by the social insurance funds through contractual agreements or by the patients themselves, should they choose a private hospital or clinic instead of a public one.

Reforms

Since the establishment of the National Health System several reforms have taken place. Issues such as hospital management, the introduction of general practitioners, primary health care networks, the management of biomedical technology, decentralisation of the system and quality assessment have however never been fully implemented and remain on the reform agenda.

The current reform agenda focuses on:

- unification of numerous social insurance funds;
- regional expansion of primary health care through the establishment of family practitioners (GPs);
- implementation of several public health and mental health initiatives;
- creation of regional directorates; and
- improving management capacity in hospitals (professional managers).

System of industrial relations⁹⁸*Background*

Before the nineties there was considerable tension between social partners. Consequently social dialogue was practically non-existent and the system of collective bargaining relied mainly on compulsory arbitration⁹⁹. The implementation of new legislation in 1990 (1876/1990) created an effective, new legal framework for bargaining. It removed state interventionism and established dialogue between employer and employee organisations as the regulatory means of collective bargaining and settling of industrial disputes. The Mediation and Arbitration Service (OMED), established in 1992, operates as an independent, non-profit organisation to provide objective and reliable mediation and arbitration services, aimed at achieving collective labour agreements. The establishment and operation of OMED was the cornerstone of the new collective industrial relations system replacing the state interventionism of the dispute-resolution regime.

Main actors

The Greek trade unions are represented by two confederations:

⁹⁸ EIRO: Industrial relations profile Greece.

⁹⁹ Koukoules, 1997

- The Greek General Confederation of Labour (GSEE) which represents all trade unions in the private sphere (62 unions and 75 labour centres with a total of 450,000 members working in the private sector).
- The Confederation of Public Servants (ADEDY) which brings together all the trade unions of public administration. It represents 1,264 first-level unions that are organised in 52 federations representing a total of 240,709 members.

Employers are represented at national level by three major confederations:

- The Federation of Greek Industries (SEB) represents the industrial sector.
- The National Confederation of Greek Commerce (ESEE) represents mainly the commerce sector.
- The General Confederation of Professional Craftsmen and Small Manufacturers of Greece (GSEBEE) represents the interests of handicraft professionals and small manufacturing companies.

Level of bargaining

Bargaining takes place at national, sectoral, occupational and company levels (private sector):

- The National General Collective Agreement (EGSSE) sets the minimum wages for workers all over the country and is signed by GSEE on the one side and SEB, GSEBEE, and ESEE on the other.
- The sectoral or industry collective agreements cover employees in related industries and are normally signed by industry federations and trade unions.
- The national and regional/local occupational agreements cover employees engaged in a specific occupation or profession at the national or local level, and are signed by employer federations and occupational trade unions.
- The company level agreements cover the employees of a single company and are signed by trade unions and the management.

Wage bargaining both at national and sectoral levels is of great importance. The duration of collective agreements is usually two years.

Coverage rate

According to the European Social Survey the trade union density declined to just 20 per cent in 2004. The density remains higher in the public sphere than in the private sector. The organisation rate of employers was stood at 70 per cent in 2004.

The coverage rate of collective bargaining was 65 per cent in 2002, which is very close to the EU average. Between 2000 and 2004 the number of collective agreements however declined.

Policy concertation

The Economic and Social Committee (OKE – or also known as ESC) is the main tripartite discussion forum in Greece representing employers, employees and a third category (farmers, independent professions, local government, and consumers).

As a way of further strengthening social dialogue in the country, a new framework law “Social dialogue for the promotion of employment and social protection and other provisions” (3144/2003) was introduced in 2003¹⁰⁰. In accordance with the new law, two new national tripartite committees were set up: the National Employment Committee and the National

¹⁰⁰ Christofi, K. (2003) Collective bargaining in Greece.

Social Security Committee. The purpose of the National Employment Committee is to promote social dialogue within the context of employment policy making in the country, and the aim of the latter is to use social dialogue as a tool to combat poverty and social exclusion.

Social partner organisations in the hospital sector

The Confederation of Public Servants (ADEDY) represents a total of 40,000 workers in the Greek public sector. Some 15,000 of their members work in the hospital sector.

Of individual trade unions in the hospital sector, the most important ones are the Association of Hospital Doctors of Athens and Piraeus (EINAP), the Pan Hellenic Federation of Public Hospital Employees (POEDIN) and the Federation of Hellenic Hospital Physicians' Unions (OENGE). OSNIE is the most important organisation representing workers in the private health care sector.

In the public sector, the employers' role is performed by the state and there is no specific employers' organisation. In the private sector, employers organisation are split between specialisms (psychiatry, general hospitals etc) and region.

Structure of collective bargaining and social dialogue in the hospital sector

Social dialogue in the hospital sector is in its infancy in Greece. A legislative settlement recognising the right of trade unions in the public sector to engage in collective bargaining was adopted only in August 1999. Until then, even though civil servants used to have the right to organise in trade unions and to strike, they did not have the right to collective bargaining and the signing of collective labour agreements. The new legislation recognises the right to bargaining, not for pay issues (which are excluded from the collective bargaining process), but for education and training, health and safety, mobility, and trade union rights.

As the health system is operated by the state, these rules also apply to the hospital sector. The number of medical and paramedical staff, their distribution (amongst the various specialities available in each hospital) *and* their salaries are currently dictated by the Ministry of Health.

Bargaining on other issues (than wages) remains limited too. According to the tripartite Economic and Social Council *"the institutional deficit on the one hand, the lack of a 'culture of dialogue' in the public sector on the other, as well as the 'addiction' of state power to the imposition of one-sided decisions, have driven the collective bargaining between the government and the ADEDY to failure for two years running."*

Bargaining in private hospitals takes place at local level.

Key issues for the hospital sector and the sectoral labour market

Rural health centres in Greece are experiencing an acute shortage of doctors – caused by the relatively low wages and difficult living conditions in these areas of the country. As a result of the shortage, patients from rural regions are rushing to the hospital emergency services in bigger cities, thereby overloading the hospital system.

The lack of co-operation between the various areas of the health service has resulted in an inefficient distribution of healthcare personnel. Some hospitals have a large surplus of specialist doctors but there is a significant shortage of general practitioners (GP) and qualified nurses.

In order to address this situation, the State has introduced the following measures:

- giving hospital administrations greater management flexibility through their budgets (in terms of the distribution of resources, in particular);
- appointing professional administrators from the private sector to the management teams of public hospitals; and

- classifying patients according to their diagnosis and starting to review the salaries of doctors working in hospitals under a system in which they could benefit from a combination of a fixed salary together with an element of productivity-related pay based on the number of patients treated.

HUNGARY

Economic and labour market context

Economic growth in Hungary has been steady over the 1997-2005 period, amounting to an average of 4.5%, fuelled first by domestic demand and then by exports. Due to the recent fiscal tightening, however, the pace of growth has started to slow and fall significantly behind other new Member States in Central and Eastern Europe. Preliminary data show that GDP only grew by 3.9% in 2006, the lowest level amongst the new Member States, and a further slowdown to around 2.5-3% is projected for 2007 and 2008. This is a result of weaker household and government consumption, while exports will remain relatively strong. The Hungarian economy, as well as the standards of living, is however catching up with the average of the European Union. GDP per capita (in Purchasing Power Standard) reached 63.5 percent of the EU-25.

Table: Key economic indicators, 2000-2006

	2000	2001	2002	2003	2004	2005	2006
GDP per capita in PPS (EU-25 = 100)	53.9	56.8	59.0	60.8	61.3	62.5	63.5
Real GDP growth rate (%)	5.2*	4.1	4.4	4.2	4.8	4.1	4.0

Source: Eurostat, * KSH data

Employment

Economic growth brought only a moderate growth in employment in recent years. Following a considerable expansion from 1997 to 2000, the overall employment rate only rose by 1 percentage point from 2000 onwards, and reached 57.3% in 2006, which is still way behind the EU-25 average of 64.7%. The number of people employed amounted to 3,930 thousand, of which 788 thousand (or 20%) were employed in the public sector. The low level of employment is a consequence of the weak economic activity in Hungary, which is closely linked to the low effective age of retirement, and the boom in tertiary education, as well as a substantial informal sector, which does not appear in the official labour market statistics.

Table: Key employment indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Number of people employed (in thousands)	3,807	3,859	3,867	3,924	3,894	3,901	3,930
- male	2,092	2,111	2,111	2,130	2,117	2,116	2,137
- female	1,715	1,748	1,757	1,793	1,777	1,785	1,793
Employment rate (percentage)	56.3	56.2	56.2	57.0	56.8	56.9	57.3
- male	63.1	62.9	62.9	63.5	63.1	63.1	63.8
- female	49.7	49.8	49.8	50.9	50.7	51.0	51.1

Source: Eurostat

The gender employment gap in Hungary is traditionally slightly smaller than in the old EU Member States. Male employment rate was 63.8% in 2006, while the female employment rate was 51.1%. The gap narrowed a little in the last six years, as female employment figures improved at a higher margin, thanks to some degree to increases in public sector employment. But announced budget cuts and downsizing in the public sector will likely widen the employment gap again in the coming years.

Unemployment

The unemployment rate fell sharply from 9.6% to 5.7% between 1997 and 2001, but the trend has been reversed since. The figure for 2006 was still relatively low at 7.5%, close to the EU average. This recent rise in unemployment is however paired with slightly improving employment figures, leading to the conclusion that some increase in employment originates in previously undeclared work that was so far not included in the national statistics.

Table: Key unemployment indicators, 2000-2006

Indicator	2000	2001	2002	2003	2004	2005	2006
Unemployment rate	6.4	5.7	5.8	5.9	6.1	7.2	7.5
- male	7.0	6.3	6.2	6.1	6.1	7.0	7.2
- female	5.6	5.0	5.4	5.6	6.1	7.4	7.8

Source: Eurostat

Statistics show that women were hit harder by job losses. While female unemployment has been traditionally lower than the male rate, this changed in 2005, with the figure for women surpassing that of men. Female unemployment reached 7.8% in 2006, and male unemployment amounted to 7.2%. This change in unemployment patterns is explained by the fact that recent job losses occurred mostly in the public sector and in certain manufacturing branches, where women's employment played a greater role.

Employment trends in hospital sector

Employment in the health sector, as the sector being mostly affected by job cuts in the public sector, declined by almost 7% in the last three years – from its peak of 147.7 thousands in 2003 to 137.8 thousands in 2006.

Table: Employment in the health and social work sector (NACE N), 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Number of people employed in the health and social work sector (annual average, in thousands)	248.1	240.5	242.5	270.5	271.8	263.7	272.8
- male	61	54.7	56.6	62.6	61.6	57.6	59.5
- female	187.1	185.8	185.9	207.8	210.2	206.1	213.3
Employment in the health and social sector, as share of total employment (percentage)	6.5	6.2	6.3	6.9	7.0	6.8	6.9

Source: Eurostat LFS

Some critics – including trade union EDDSZ – however expressed concerns as regards of the reliability of the above numbers, stating that it is not entirely clear what health sector jobs they include or omit. They suggest that certain forms of (auxiliary) employment like hospital maintenance and ICT have not been taken into account in the statistics.

The large majority of employees in the health sector are women, but up-to-date gender-disaggregated data does not seem accessible, despite the integration of gender-related data into statistical reporting templates healthcare institutions.

Table: Employment in the health and social work sector (NACE N), broken down by age (percentage), 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Between 15 and 24 years	10.8	7.7	6.8	5.3	4.7	4.3	3.0
Between 25 and 49 years	66.2	70.1	66.5	67.1	67.9	65.0	65.7

Between 50 and 64 years	22.0	21.7	25.5	26.8	26.3	29.5	30.0
Over 65 years	1.0	..	1.2	..	1.0	1.2	1.2

Source: Eurostat LFS

Structure and organisation of hospital sector and key recent reforms

Health expenditure in Hungary amounted to 8.4 of GDP in 2004, according to WHO estimates¹⁰¹, which is a major increase against the estimated 7.1% in 2000 (OECD Health Division statistics indicate with 8% a slightly lower value for 2004). This is lower than the 9.3% average of the old Member States, but significantly higher than the 6.6% of the EU-12. The dynamic increase in health expenditure was mostly a result of rising labour cost and pharmaceutical expenditure, but it will decrease again, following recent fiscal restriction.

Table: Health care expenditure, key figures, 2000-2005

Indicator	2000	2001	2002	2003	2004	2005
Total health expenditure as percentage of GDP	7.1	7.4	7.8	8.4	8.4	..
Total health expenditure, PPP\$ per capita	856	975	1,115	1,259	1,323	..
Public sector expenditure as percentage of total health expenditure	70.7	69	70.2	72.4	71.8	..

Source: WHO-HFA estimates

In 2004, 72% of the expenditure was covered from public resources, while private resources accounted for 28% of health expenditure, but the latter's share is increasing.

The Hungarian system of financing healthcare is based on statutory national health insurance, with contributions collected by the Tax and Financial Control Administration¹⁰² as the national tax office (TFCA), and forwarded to the National Health Insurance Fund¹⁰³ (NHIF). As a general rule, employers pay 8%, and employees 7% of gross salaries from 1 January 2007. This is complemented by complex rules on employer lump sum payments, and different payment obligations for self-employed, companies in a flat-rate taxation scheme, people engaged in economic activities supplementing e.g. their pension payments, and for certain capital income.

The Fund's revenues are made up to over 90% by the contributions as described above. Its expenditures account for about 80-85% of public expenditure. The rest of health costs is borne by the national and local governments. This includes e.g. government grants and local matching funds for capital investment expenditure, which accounted for 6% of total health expenditure in 2001. The majority of healthcare institutions, especially inpatient care facilities are owned by local governments (the smaller by municipalities, the larger, with specialist departments by counties), others by the central state or public universities.

Table: Key indicators of inpatient care, 2000-2005

Indicator	2000	2001	2002	2003	2004	2005
Total inpatient expenditure as percentage of total health expenditure	29.3	28.1	29	..	..	..
Expenditure on inpatient care, PPP\$ per capita	251	273	323	..	..	..

¹⁰¹ WHO Regional Office for Europe, European health for all database,(HFA-DB), May 2007. <http://www.euro.who.int/hfadb>

¹⁰² "Adó- és Pénzügyi Ellenőrzési Hivatal"

¹⁰³ "Egészségbiztosítási Alap"

Public inpatient expenditure as percentage of total inpatient expenditure	88.6	88.3	89	..	..	..
Number of hospitals	173	173	175	175	179	180
Number of hospital beds	82,663	80,057	79,752	79,368	79,114	79,226

Source: WHO-HFA database

Private expenditure came predominantly in the form of out-of-pocket payments (89% in 2004¹⁰⁴). This includes co-payments (mostly for medicines, but also prostheses, hotel services, specialist care if referral by the home doctor has been bypassed, etc.) and fees for private service providers.

The rest of private expenditure is mostly covered by companies and charity organisations. Complementary private health insurance (PHI) is present in Hungary, but still plays a minor role. Its share in health expenditure was below 1% in 2000-2001, according to the European Observatory for Health Systems and Policies¹⁰⁵, but its significance is increasing.

Data on resource allocation show a dominant share of medical goods, accounting for 36% of total health expenditure in 2000.

The Health Insurance Fund has local branches which contract with providers and reimburse them according to national, uniform rules.

The benefit package is comprehensive. Certain special services, such as high-cost, high-tech interventions and public health and emergency ambulance services, are financed (and delivered) by the central government.

Many structural reforms have been implemented against the background of 4 years of economic recession and 8 years of tough cost-containment policies. These have included the introduction of a purchaser-provider split in social health insurance structures, the introduction of new prospective and performance-oriented payment methods, as well as a reduction in and geographical reallocation of inpatient capacity. The new model is functioning, but the tight expenditure control policies have come to create substantial tensions in the system.

Outline of system of industrial relations

The industrial relations system is characterised by tripartite bargaining for public sector workers and largely local level bargaining in the private sector.

Social partner organisations in the hospital sector

Trade unions

- The Democratic Union of Health Care Employees (Egészségügyi és Szociális Ágazatban Dolgozók Demokratikus Szakszervezete, EDDSZ) is the oldest trade union in the sector with around 25000 members in the sector. EDDSZ is a member of EPSU.
- LIGA Health Federation (LIGA Egészségügyi Szövetség) has members in a number of public health institutions and has around 1300 members in the sector.
- Federation of Hungarian Physicians (Magyar Orvosok Szövetsége, MOSZ) represents around 8000 physicians with employee status.

¹⁰⁴ WHO HFA-DB

¹⁰⁵ The OECD Health Division estimated a mere 0.2% for 2000

- Trade Union of Defence Employees (Honvédségi Dolgozók Szakszervezete, HODOSZ) and Trade Union of Hungarian Railwaymen (Vasutasok Szakszervezete, VSZ) represent all types of employees in the separate healthcare system of the army and the railway and have 240 and 125 members respectively.
- The Medical Universities' Trade Union Federation (Orvosegyetemek Szakszervezeti Szövetsége) represents employees in hospitals belonging to four universities.

Employers

The Hungarian Hospital Association (Magyar Kórhákszövetség, MKSZ) represents approximately 140 hospitals employing around 70000 staff and is a member of HOPE.

Structure of collective bargaining and social dialogue in the hospital sector

For all public employees (including the vast majority of health employees) annual wage agreements are regularly concluded in the Public Service Interest Reconciliation Council (Közszolgálati Érdekegyeztető Tanács, KÉT). The latter is a tripartite body involving employer, government and trade union representation. There is no multi-sector agreement in the private sector; only 95 single employer agreements.

Key issues for the hospital sector and the sectoral labour market in particular

Key issues include staff recruitment and retention and the perceived lack of adequate hospital sector funding.

IRELAND

Economic and Labour Market Context

The GDP growth rate was 0.2 for the period 2006-2007 (GDP was 4.9 and 5.1 in 2006 and 2007 respectively). In 2005, the overall employment rate for 15-64 year olds was reported as 62.5%. When broken down by gender the employment rate in 2005 rested at 76.1% for males and 49.0% for females. In 2005, the overall unemployment was 4.3% for those aged over 15 years. When broken down by gender the unemployment rate, was reported as 4.6 for males and 4.0 for females¹⁰⁶.

Employment Trends in the Hospital Sector

The Health Service Executive (HSE) employs 100,000 people. It directly employs 65,000 staff and a further 35,000 are employed in voluntary hospitals and bodies funded by the HSE. The majority of its employees are frontline, delivering patient care¹⁰⁷.

Table: National Hospitals Office Staffing Levels

Type of staff	Number	Percentage
Nursing	19,321	39%
General support services	7,628	16%
Management and Administration	7,552	15%
Health and social care professionals	5,604	11%
Medical and dental care	5,528	11%
Other patient and client care	3,704	8%

Source: National HSE Employee Handbook, January 2007

Table: Primary, Community and Continuing Care Staffing Levels

Type of staff	Number	Percentage
Nursing	15,744	32%
Other patient and client care	9,549	20%
Health and social care professionals	8,198	17%
General support services	7,466	15%
Management and administration	6,482	13%
Medical and dental	1,617	3%

Source: National HSE Employee Handbook, January 2007

Structure and organisation of hospital sector and key recent reforms

Funding and Expenditure

Approximately 78% of hospital sector funding derives from public sources. A further 8.5% of funding is sourced through private insurance arrangements. The remaining percentage is what individuals pay in 'out-of-pocket' expenses. These include, for example, the fees non-general medical card holders have to pay for general practitioner and other therapy services.

Eligibility to health services is divided up into two categories. These are:

¹⁰⁶ Employment in Europe Report 2006, statistical annexes for all
http://ec.europa.eu/employment_social/employment_analysis/eie/eie2006_annex_en.pdf

¹⁰⁷ Health Service Executive Factfile,
<http://www.hse.ie/en/FactFileHome/HealthServices/HSEStaffFiguresandinformation/>

- Category 1 – individuals qualify to avail all services without charge and
- Category 2 – subject to prescribed charges

The majority of public funding comes from funds raised through general taxation.

The health care budget has increased rapidly from €3.7 billion in 1997 to €12 billion in 2007. The budget is now managed by the the Health Service Executive (HSE).

Organisational Structure and Management

The HSE was established in January 2005 and is responsible for providing health and personal social services for the Republic of Ireland. It provides an enormous range of services in hospitals and in communities throughout the country.

Establishment of the HSE is a recent and significant change in the provision of health care services in Ireland. Its objectives were introduced in the Health Act 2004. Prior to its formation health care services were delivered through a complex structure of ten regional Health Boards, the Eastern Regional Health Authority and other organisations and agencies.

The HSE organisational model is designed to put patients at the centre of service delivery. Health and Personal Social Services are divided into three service delivery units;

- Population Health – promotes and protects the health of the total population.
- Primary, Community and Continuing Care – delivers personal and social care in the community and other settings.
- National Hospitals Office (NHO) – provides acute hospital and ambulatory services.

Population Health is a Directorate and has overarching responsibility for maintaining health in Ireland. It provides knowledge, information and evidence to support corporate decision making and strategic planning in response to identified needs. Approximately 700 people work in this Directorate.

Primary, Community and Continuing Care is delivered through 32 Local Health Offices.

The National Hospitals Office (NHO) has responsibility for the strategic management of acute hospitals. Hospital services are delivered through eight hospital networks. An annual service provision arrangement is entered into by the NHO and each of the eight networks.

Providers

Primary and ambulatory care

General Practitioners, nurses, midwives, health care assistants, home helps, physiotherapists, occupational therapists and administrative personnel comprise the central primary care services in Ireland. A wider range of health care services are also provided under the primary care remit.

Estimates for 2007 suggest that each Primary Care Team (PCT) will provide services to populations of between 4,000 and 10,000. When using services from the wider Primary and Social Care network, PCTs provide services to populations of between 30,000 and 50,000.

Secondary and tertiary care

Hospitals in Ireland are either public or private-for-profit. HSE is responsible for 52 acute care public hospitals nationally¹⁰⁸.

¹⁰⁸ Introduction to the HSE <http://www.hse.ie/en/AbouttheHSE/FiletoUpload.6145.en.pdf>

Outline system of industrial relations¹⁰⁹.

Traditionally the industrial relations system in Ireland has been described as 'voluntarism'. This refers to a system of minimum legal intervention rather than an absence of government intervention in collective bargaining how voluntarism is often understood in mainland Europe.

Up until the 1980s the industrial relations system was very similar to the UK. Changes in UK industrial relations legislation introduced differences between the two systems.

The Irish industrial relations system is immunities-based rather than rights-based legal system. For example, immunities available to trade unions for actions that would otherwise be illegal in common law. To complement such immunities the Labour Court, non-legalistic resolution institution was introduced.

A number of reforms have taken place over last 40 years. Most notable are the changes providing greater protection to individual employees. This is the result of internal discussions, such as in cases of unfair dismissal and in response to EU developments, on issues such as gender equality.

Greater legality now surrounds the industrial relations system, although, voluntarism remains the norm and intact. Such legalities are still quite limited, for example, the system does not involve kind of restrictions on industrial action in place in UK. Additionally the introduction of the Industrial Relations Act 1990 in Ireland has made it more difficult for employers to gain injunctions in the event of industrial action.

The most significant changes to have occurred over the past 20 years are in the area of collective bargaining and social dialogue. Since 1987 six centralised agreements/social pacts have been negotiated. The first, the Programme for National Recovery was introduced in response to the fiscal crisis in 1980's. Five subsequent agreements established an institutionalised multipartite system of social partnership extending into fields of economic and social policy.

This is a national-level partnership and involves combination of consultation and negotiation with employer organisations, farmer representatives, trade unions, the government and a community and social pillar.

More recently the industrial relations system has been characterised as conforming to a competitive or liberal corporatism model. This has been accompanied by rapid economic growth and a significant decrease in absolute poverty, alongside other factors.

Main actors

There are a range of trade union organisations within Ireland. There are two nursing organisations, plus a further two unions which represent nurses and one organisation representing hospital consultants. There are 60 unions in the largest confederation, which is regarded as strong. In total there are 633,000 adult members; equivalent to 20% of the adult population.

Trade unions

The Irish Congress of Trade Unions (ICTU) is the main trade union confederation. Its remit covers both the Republic of Ireland and Northern Ireland. It has an important role at national-level relations with the government and employers' organisations, although, it is more a grouping of independent unions than a confederation that directs its affiliated unions.

¹⁰⁹ European Observatory on Industrial Relations, EIRO
http://www.eurofound.europa.eu/eiro/country/ireland_2.htm

Differences in current total union membership figures have been reported. Nevertheless, all statistical sources report a drop in trade union density between 1980 and 2004 – from 61% to 43% respectively. The decline is greatest in the private sector, where density is reported at 21-23%.

Contrasting to the decline in density, absolute union membership has increased from 474,450 in 1990 to 653,433 in 2004¹¹⁰.

To engage in collective bargaining trade unions must hold a negotiation licence, issued under the Industrial Relations Act 1941. Some public services, such as the police and the army are prohibited from joining trade unions. They have representative organisations that actively engage in collective bargaining but are exempt from holding a negotiation licence.

Employers'

As reported in 2004, there are 11 employer organisations representing over 11,000 member companies. It is also a requirement for employers' organisations to hold a negotiation licence.

The Irish Business Employers Confederation (IBEC) is the largest employers' organisation confederation. It is the overarching for business groups and sectoral associations and has the dual tasks of a handling industrial relations and promoting business generally.

Due to estimates ranging from 35% to 67%, it is not possible to say how many individuals work in work in companies that are members of an employers' organisation.

Collective Bargaining

The Irish Constitution protects the right to form and join trade unions. This excludes an obligation on employers to recognise or to negotiate with any trade union.

Generally collective agreements are not legal enforced and are binding in honour only. Such agreements are not widely breached. Typically state institutions take the terms of the agreements on board when settling any disputes. Terms and conditions of collective agreements gain legal status as they are incorporated into individuals' employment contracts.

Collective agreements can be registered with the Labour Court, giving them legal status. This provision is rarely used and is confined to collective agreements covering specialist issues such as pensions. Additionally, it is possible to have a registered agreement that covers an entire industry. Again, this is not widely used.

The Sustaining Progress agreement¹¹¹ has introduced a range of pay policing mechanisms. A pay assessor service has been established to investigate employers' inability to pay claims. Cases can be referred to the Labour Court for a binding recommendation, although they are not legally binding.

Growth and developments in individual employment law had to changes regarding collective agreements. This has resulted in a move from a bargaining-based to a rights-based system for resolving individual disputes. A lot of what took place under collective bargaining is now dealt with by individual employment law.

In some areas it is still common practice for trade unions to negotiate using collective bargaining. This is most notable in cases of collective redundancies where unions regularly negotiate terms better than the statutory average of two weeks pay per year of service.

¹¹⁰ Department of Enterprise, Trade and Employment

¹¹¹ Sustaining Progress: Social Partnership agreement 2003 – 2005
<http://www.ictu.ie/html/publications/other/Sustaining%20Progress.pdf>

Level of Bargaining

Ireland has a highly centralised bargaining system – the result of national agreements. Although, the agreements are negotiated centrally, they are not applied at the same level. Generally, industry level bargaining is not featured in collective bargaining, excluding the construction sector¹¹².

Away from national agreements, negotiations normally take place at an organisational level, between trade unions and employers. In such discussions, individual employers are usually represented by an employers' organisation. Any subsequent agreements are normally applied at a local level.

Coverage rate

As national agreements do not have a legal effect and are not applied nationally, it is not possible to provide a collective bargaining coverage rate. One method of illustrating coverage is to link it with trade union density. This is reported as a medium density rate, between 40 and 60%¹¹³.

On the surface this figure appears lower than other western European countries. However, in cases of disputes on wages or terms of employment it is general practice for the Labour Court to recommend the application of a national agreement.

It was explained that attempts have been made to extend national social partnerships at a company level. Substantial funding has been made available to mainstream cooperative industrial relations.

Workplace representation

Differences in opinion surround figures of workforce representation. The European Social Survey¹¹⁴ reports 53% of employees' state they are represented by a trade union or similar organisation, although the basis for this figure is considered unclear. It is discussed that this figure is much higher than any other estimates for union density.

In the state-owned sector there is provision for sub-board level participation. Examples of such participation in the private sector are patchy. A few work-councils type of structures have been established. However, these are few and far between with employees either represented through unions or not at all. This means that employees do not have automatic rights to information and consultation. Such rights are only available under certain circumstances such as collective redundancies or changes of ownership.

Legislation relevant to EU directives referring to employee consultation is being enacted. Discussions suggest that they are being implemented in a modest way. Efforts have been made to create a system of workplace-partnership to sit alongside the national partnership system.

The National Centre for Partnership and Performance has been set up to stimulate mainstreaming efforts in this area¹¹⁵. It aims facilitate workplace change through increased partnership working, creating a better quality of life for employers and employees.

¹¹² EIRO, http://eurofound.europa.eu/eiro/country_index.html

¹¹³ Industrial Relations in Europe Report, http://ec.europa.eu/employment_social/social_dialogue/docs/ir_report2006_en.pdf

¹¹⁴ European Social Survey <http://www.europeansocialsurvey.org/>

¹¹⁵ National Centre for Partnership and Performance <http://www.ncpp.ie/default.asp>

Board-level representation exists only in small number of state-owned companies or former state companies that have been privatised.

Policy concentration

Long-term policies are reported as a key benefit of a highly centralised system. Economic and social policy making has seen focus of involvement from the government, employers, trade unions and consultative groups. There are three consultative bodies:

- National Economic and Social Council
- National Economic and Social Forum and,
- National Centre for Partnership and Performance.

Such bodies are referred to as part of the social corporatist structure, created to integrate social and economic objectives.

More recently representation of the community and voluntary sector has been added to the collective bargaining process. This has helped to complement macro-level negotiations on economic strategy by expanding the range of working groups, advisory committees and forums.

An example of this policy concentration has been the tax-wage trade off. This involved progressive reductions in personal taxation in return for moderation in wage increases. Additionally there have been reductions in corporate taxes to 12.5%. Such measures have reduced the cost of labour and made Ireland attractive to foreign investment.

Social Partner Organisations in the Hospital Sector

Trade unions

Trade unions promote and look after the interests of a range of professional sectors. Union membership is strongest within the public sector. This has resulted in fragmented membership, with some sectors represented more than others. Additionally, health care professionals have an array of unions to choose from.

Trade unions:

- **SIPTU**

The Social, Industrial, Professional and Technical Union (SIPTU) is the largest trade union with over 250,000 members. Classified as a general union it has members in many different sectors. As well as participating in bargaining with employers it campaigns at a national and local level.

It represents staff from the public and private health care services in all professional fields. It sits on various bodies including the Health Services Staff Panel.

- **IMPACT**

IMPACT has 55,000 members. The majority of its members work in public sector occupations, although it also represents the voluntary and community sector and some private sector organisations in the telecommunications and aviation companies. It also sits on the Health Services Staff Panel.

- **INO**

The Irish Nurses Organisation (INO) has 35,000 members and represents nurses and midwives. It was founded in 1919 and is the fifth largest trade union in Ireland. It also sits on the Health Services Staff Panel.

- **PNA**

The Psychiatric Nurses' Association has around 5000 members in the sector.

- **IMO**

The Irish Medical Organisation represents around 8500 doctors.

- **IHCA**

The Irish Hospital Consultants' Association speaks on behalf of 1800 consultants.

The blue collar unions UNITE and TEEU (Technical, Engineering and Electrical Union) together represent a further 2200 workers in the sector.

Employers

- **HSE – Employers Agency**

Public sector health care service employers are represented by the HSE Employers Agency. Hospitals and health care services in the private sector are represented by the Irish Business Employers' Confederation (IBEC).

The HSE – Employers Agency is the representative body for health service employers. It is a statutory agency and promotes the improved use of human resources within health care services. In cases of industrial relations it supports and represents employers.

It represents employers on issues such as pay and employment conditions for all types of employees. Where relevant it supports employers on local issues and works in partnership with trade unions.

State institutions as facilitators

Historically, the government has not intervened in the collective bargaining system. It acts as a facilitator, bringing in third parties to help settle disputes. Two main resolution bodies deal with collective disputes. These are:

- **The Labour Relations Commission**

The Labour Relations Commission is the main state institution. Its functions include providing conciliation, mediatory and advisory services. A rights commissioner service is also provided. This deals with both individual employment law and industrial relations disputes.

- **The Labour Court**

Membership of the Labour Court is drawn from industrial relations practitioners. Use of the Labour Court is generally optional and its proceedings are non-legalistic. Its main purpose is to make recommendations for settling disputes and it is generally used as a last resort. Generally, its recommendations are non-binding, although recently attempts have been made to introduce binding negotiation.

Structure of Collective Bargaining and Social Dialogue in the Hospital Sector

Collective bargaining in the hospital sector takes place at a **national** level. Negotiations of terms and conditions of staff are generally **tripartite**, involving the government.

Depending upon the issue under review, negotiations in the hospital sector take place at different intervals and at different levels. For example, discussions regarding general pay and conditions – such as cost of living increases - are determined after consultation with social partners.

Negotiations regarding general pay, regarding rises in line with inflations take place every 18 months. Other issues are negotiated every four years. This would include any salary scale revisions.

A Public Service Benchmarking Body takes place every four years. Employer and employee representatives from all public services – health care, fire, the police and other public bodies – discuss salary grade revisions and working conditions.

In addition to regulating terms and conditions for employees, social dialogue between employers and trade unions takes place on other key issues. The National Joint Council discusses human resource issues, such as flexible working and worklife balance. This has been rolled out in the hospital sector.

Key issues for the Hospital Sector and the Sectoral Labour Market in particular

Working with the private sector

The Health Strategy proposed that a significant proportion of hospital services will be provided by the private sector in the future. Government incentives will be introduced to attract private providers to improve facilities. A greater degree of public services will be procured from the private sector.

There are around 2,500 private beds in public hospitals. This programme aims to transfer up to 1000 of these beds to private facilities on the same site over the next five years. An increased amount of public beds will become free, increasing capacity for public patients.

Social partner agreements

Towards 2016 – a ten year social partnership agreement¹¹⁶ – will impact on the negotiation of terms and conditions in the hospital sector. A key objective of this paper is support the relationship between social policy and the economy, notably through the involvement of employers and social partners.

Included in this agreement are a wide range of policies aimed at improving public services and workplace relations. Trade unions, employers and employees are expected to make active and responsible contributions regarding employment rights. As part of efforts to improve communications social partners will be invited to include their knowledge and networks in the design of new programmes.

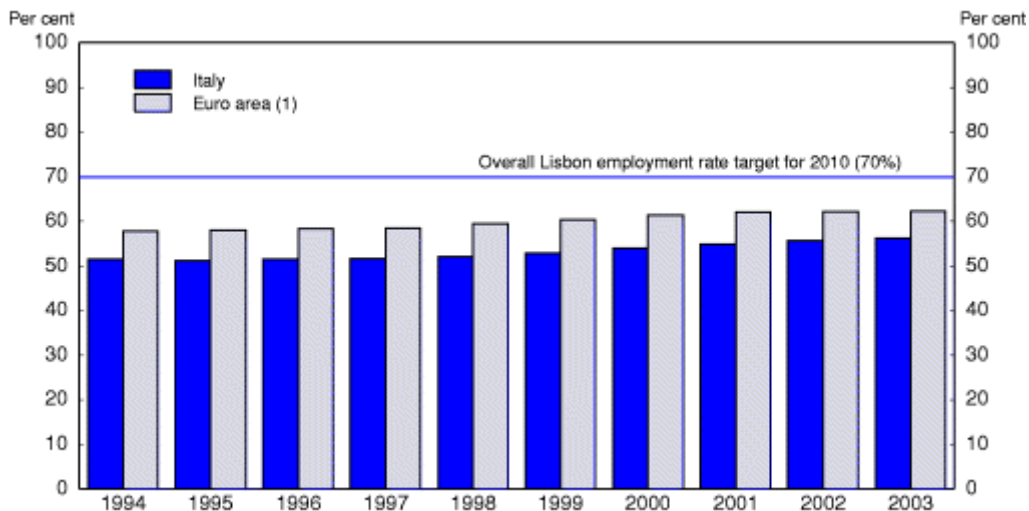
¹¹⁶ Towards 2016 – A ten year social partnership agreement
http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ireland_rd01_en.pdf

ITALY

Economic and labour market data

Although employment has risen substantially since the late 1990s, and unemployment rates have fallen, overall employment rates in Italy remain low, as do participation rates. The overall participation rate for those of working age is 63%, compared with an EU average of close to 70% (and a US figure of 75%). As in most countries, participation rates for prime-age males are well above 90%, but the figure drops to barely over 30% in Italy for males over 60 years old. Female participation rates are low by international comparison at all ages. Less than 50% of women are in the labour force compared with an EU average of 60%. And as in other southern European countries, part-time employment of women accounts for a relatively low proportion of their total employment. Participation rates of women and older males are lower than the EU average even in the prosperous Italian regions that experience chronic labour shortages.

Employment rates¹¹⁷



Between 1995 and 2004, Italian GDP grew by 1.6% per year on average, compared to 2% for the euro area. During that period the growth of productivity per person employed was also below the euro area average. In spite of low growth, robust job creation in recent years has contributed to a fall in the unemployment rate to 8% in 2004, below the EU average. At the same time, the employment rate, at 57.6% (2004).¹¹⁸

The overall unemployment in Italy was 8.7% in 2003 versus 6.5% for the Eur-A. The rate among men was 6.7%; among women it was 11.6%. Unemployment among people 15–24 years old may differ from national averages: in 2001 in Italy it was 25% for males and 32% for females. Ninety-three percent of unemployed people had secondary education or less (80%

¹¹⁷ http://www.oecd.org/document/26/0,2340,en_33873108_33873516_34737882_1_1_1_1,00.html

¹¹⁸ http://ec.europa.eu/growthandjobs/pdf/2006_annual_report_italy_en.pdf

had secondary level and 13% had primary level). Sixty-two percent of those unemployed had been so for 12 months or more.¹¹⁹

Structure and organisation of hospital sector and key recent reforms

Italy's health care system is a regionally based national health service that provides universal coverage free of charge at the point of service. The system is organized at three levels: national, regional and local. The national level is responsible for ensuring the general objectives and fundamental principles of the national health care system. Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefit package through a network of population-based health management organizations (local health units) and public and private accredited hospitals.

The main central institution is the Ministry of Health, which manages the National Health Fund. Until 2001, the Ministry of Health, through its departments and services, ensured five different functions:

- health care planning;
- health care financing;
- framework regulation;
- monitoring; and
- general governance of the National Institutes for Scientific Research (IRCCS – Istituti di Ricovero e Cura a Carattere Scientifico).

The ministry draws on the input of other ministries, namely: the Ministry of Social Affairs (to ensure coordination between health and social services); the Ministry of the Treasury (which participates in setting the health care budget and provides support and control over financing health care services). Since 1992, the regional level (regional governments and parliaments) is in charge of legislation, management and regional planning of health care services, as well as for monitoring the quality and efficiency of local health units (LHUs), and public and private hospitals. Starting in 1998, they are also responsible for pursuing the leading national objectives posed by the National Health Plan.

At the local level, LHUs are responsible for assessing needs and for providing comprehensive care. Regions define their organizational structure and monitor their operation. Services are territorially structured in four layers:

- public hospital trusts, which provide highly specialized tertiary hospital care, have the status of quasi-independent public agencies, and fall under the direct responsibility of regional health departments;
- secondary hospitals, organized and managed at the level of LHUs;
- primary care, ambulatory specialist medicine, residential and day care, which are organized at the level of health districts;
- health prevention and promotion programmes, which operate within public health divisions.

National Institutes for Scientific Research and private accredited providers (responsible for ambulatory, hospital and diagnosis services financed by the NHS) complete the network of providers operating at the local level since 1992.

¹¹⁹ http://www.euro.who.int/eprise/main/who/progs/chhita/demographic/20050131_1

Health care provision

Primary health care is provided by general practitioners and paediatricians, who are independent contractors of the NHS. They act as gatekeepers to secondary care.

Local health units are in charge of protecting and promoting public health mainly through disease prevention (especially immunization), health promotion and food control.

Specialized services are provided either directly by local health units or through contracted-out public (61%) and private (mainly not-for-profit) facilities accredited by local health units.

Health care financing and Expenditure

In general, welfare expenditure as a proportion of GDP was slightly lower than the EU average in 1999. Italy ranks first in expenditure for old-age pensions and survivorship annuities, has an intermediate-to-low position for health care expenditure and is markedly above average in the subsidies allocated to families with children, housing, unemployed people and socially disadvantaged people.

In 1999, the total health care expenditure (public and private) was about €85 000 million, with public expenditure of about €58 000 million (67% of the total) and private expenditure €27 000 million (33%). In 1960, health care expenditure was 82% public and 18% private. Expenditure as a proportion of GDP increased steadily until 1993: from 3.9% in 1960 to 6.6% in 1978 – when the NHS was established – to 8.1% in 1990, peaking in 1993 (8.6%), declining to 8.0% in 1995 and then stabilizing at 8.4% from 1997 to 1999.

Trends in health care expenditure, 1980–1999, selected years¹²⁰

	1980	1985	1990	1995	1996	1997	1998	1999
Health care expenditure (thousand of millions of 1995 euros)	43.7	48.4	67.3	72.9	74.6	79.9	84.0	85.5
Health care expenditure as a % of GDP	7.0	7.1	8.1	8.0	8.1	8.4	8.4	8.4
Public expenditure as a % of total	80.5	77.2	78.1	67.7	67.8	68.0	68.0	67.0

The sources of public health care financing

Until 1998, the relative shares of taxes and payroll contributions remained unchanged. In particular, financing from general taxation decreased from 41% in 1990 to 38% in 1998 and then, the following year, increased to 46%; while the contribution from payroll tax (which was replaced by the IRAP and the regional IRPEF in 1998) remained about constant at 53% and decreased to 44% in 1999. The somehow odd trends in the main two sources of funding in 1999 was reversed in 2000, when funding from IRAP and the regional IRPEF increased again to 53% and general taxation decreased to 38%.

¹²⁰ <http://www.euro.who.int/document/E73096sum.pdf>

Sources of public health care financing, thousands of million euros, 1990–1999, selected years¹²¹

Source of financing	1990		1995		1997		1998		1999	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
General taxation	17.1	41	20.1	42	19.9	39	20.0	37	24.9	46
Payroll taxes ^a	22.6	54	24.3	51	26.6	52	28.4	53	26.0	44
Contributions from autonomous regions	0.5	1	1.6	3	2.8	5	2.9	5	3.0	6
Local health unit revenue	1.2	3	1.9	4	2.2	4	2.5	5	2.2	4

Source: Ministry of Treasury and Budget (11,12).

^a IRAP and the regional IRPEF from 1998.

Health care reforms

During the last quarter of the 20th century, Italy has experienced three main waves of reforms. The first, in 1978, instituted a National Health Service aimed at providing all Italian citizens with free access to extended public health care services and financed by taxation.

Decentralization of the health care system: The decentralization of the health care system has been a key issue in the development of the NHS since its inception in 1978, and especially during the last decade. The 1978 reform defined an integrated, centralized system in which a few specific administrative responsibilities were allocated to the regional and local levels. The central and regional governments had clashed since 1978 about financing and jurisdiction. Following a process of informal expansion of regional power, Legislative Decree 502/1992 started an explicit, formal process of devolving political power and fiscal authority to regions. This process provided the regional health departments more autonomy in policy-making,

During 1992–1993, within the context of a profound national political and financial crisis, the government launched the second health care reform. The latter aimed at establishing an internal market similar to the British model, and a parallel process of political and financial devolution to regions. The internal market reforms envisaged delegating significant managerial autonomy to hospitals and LHUs, and introducing a partial split between purchasing and providing functions.

Market competition was promoted by introducing fee-for-service financing for inpatient and ambulatory care. In addition, civil law replaced public law in regulating the basic organizational framework of tertiary hospitals and LHUs. Finally, health service charts were created to safeguard citizens' rights in public services and a package of performance indicators and other quality promoting measures was established. However, there were several deviations from this internal market model, namely the perverse incentives that fostered hospital activity and expenditure; the rebound of the regional debt; the sluggish implementation of the internal market reforms in the less developed regions; and an incomplete separation between providers and purchasers, as exemplified by the dual role of LHUs.

The third wave of reforms actually consisted of two kinds of reforms: the first was aimed at establishing fiscal federalism (launched in 1997 and further elaborated in 2000) and the second contained the National Health Plan for 1998–2000 and the subsequent 1999 NHS reform. The fiscal federalism reform aimed at clarifying accountability by transferring to regions full responsibility for providing a basic benefit package under a balanced budget.

¹²¹ <http://www.euro.who.int/document/E73096sum.pdf>

During the transition period, total regional autonomy in allocating funds among different functions is contingent upon implementation of the monitoring system defined by the central government.

The introduction of fiscal federalism has been surrounded by considerable debate. Its advocates expect that it will promote political transparency and financial responsibility. Its critics point to the following potential dangers. As the tax base is unevenly distributed across the country, large equalization transfers will be needed, which might reduce the effective political autonomy of the less affluent regions. In addition, to obtain equivalent cash increases, low-income regions will have to raise tax rates more than high-income regions, which may hinder private investment.

Finally, higher reliance on indirect taxes would make overall health financing more regressive.

The push towards federalism also led to increasing awareness of the potential negative effects of devolution on interregional differences. To address this, the National Health Plan (NHP) for 1998–2000 and the 1999 reforms launched four sets of regulatory measures aimed at developing mechanisms to guarantee equity of access and treatment across Italy.

Low levels of citizen satisfaction have remained as one of the most enduring problems of the NHS throughout the different waves of reform. Despite significant progress, Italy was still markedly below the EU average in overall satisfaction in the mid- to late 1990s. The main areas of concern in the late 1990s were the administrative services of LHUs, emergency care and specialist outpatient care. In addition, problems of access and high co-payments also account for the low average satisfaction levels, which, in addition, differ markedly across the north-south divide.

Outline of system of industrial relations

The total union membership, in 2004 has reached 11,589,000 persons or 23% of the adult population¹²². In Italy the union density rate is still higher among male workers than among female workers.

The (weighted) average employer rate of organisation is approximately 55 to 60% in the EU. In other words, on average a considerable majority of private sector employees in the EU-25 work in a company which is a member of an employers' organisation.

Compared to that, the Italian has a middle-range density rate of employers' organisations with an average rate of 50%.

Collective agreements are seen as private law and have only a legally binding effect between the stipulating parties and their members. However, although judges are not legally obliged to apply the (pay) standards of contracts; they do so for reasons of fairness.

Collective bargaining in the public sector in Italy is more centralised at national level than is the case for the private sector. One of the reforms of the public sector in Italy is the 1992 ACT (421/92), which is meant to create a more unified framework for collective bargaining. Pay, contracts of employment and working conditions will no longer be legally regulated but will be regulated through collective agreements (pay negotiations still take place at the central level) as in the private sector.

Collective negotiations are conducted at three different levels. First the umbrella organisations negotiate at the central level the standard conditions and rules which apply to everyone in the public sector. The next bargaining level is the national sectoral level, where more specific

¹²² However, the data of autonomous unions not included.

questions relating to employment are dealt with (the public sector is divided into nine sectors of which health and hospitals is one). The final bargaining level takes place at regional or 'azienda' level (which covers a certain number of hospitals in a territorial authority) on issues which have been expressly reserved for this level.

For the public sector pay conditions are conducted every two years on a central level, while framework agreements covering conditions of employment are negotiated every four years.

Collective bargaining exists at inter-sectoral and it is also quite common within enterprises. However, the dominant level of collective bargaining is the sectoral one.

In Italy a long-lasting disagreement – both in academic circles and among the social partners – shows the difficulty of intervening in formalising the role of decentralised agreements. In the 2001 'White Paper' presented by the newly elected centre-right administration it was suggested that national agreements should be reduced in their scope, in order to liberalise recourse to decentralised bargaining. Once more, as previously underlined, the practice of collective bargaining is going into a different direction from the one shown by the government. A nationwide agreement signed in 2004 by the main confederations, covering the artisan sector confirmed the role of national collective agreements and indicated a wider scope for decentralised agreements, not only at the company level, but also within certain territorial areas, in order to redistribute productivity and fill the gap between planned and current inflation.

In Italy collective agreements can intervene in crucial matters, according to the new legislation on agency work provided for in the 2003 Decree reforming the labour market. For open ended contracts intervening between the user company and the agency, collective agreements can expand the list of activities indicated in art. 20 of the Decree, namely cases in which there can be recourse to agency work. This empowers the contracting parties beyond the letter of the law, allowing a wider recourse to agency work. They can also indicate quantitative limits for agency workers to be required by user companies and specify training obligations, financed by a special fund into which employers are bound to pay their contribution.

Tensions between public relevance and private means of collective bargaining Italy offers an interesting example in the law regulating collective bargaining in the public sector. Unlike in the private sector, where it all depends on voluntary sources, the legislature intervened in the public sector with a strong emphasis on rationalising decentralised bargaining and setting limits to the same.

Social partner organisations in the hospital sector

Employers

ARAN is a cross sectoral employers' organisation covering the public administration (11 different public sectors). Aran has worked as an employer organisation since 1994. In total, 368 hospitals (of medium and big size) are members of the organisation. Aran is a member of the CEEP, an organisation which operates at EU level.

As far as bargaining is concerned, ARAN has been mandated (from the regions) to participate in discussions with trade union representative concerning the negotiation of wages and other terms and conditions of labour relations. The consultations with trade unions are undertaken at national level.

Private non-religious hospital and care facilities are represented by:

Associazione Italiana Ospedalità Privata, AIOP (Italian Association of Private Hospitalisation, AIOP)

The private religious establishments are represented by:

Associazione Religiosa Istituti Sociosanitari, ARIS (Association of Religious Sociomedical Institutions).

Trade unions

- Federazione Lavoratori Funzione Pubblica Cgil, FP CGIL represents around 82000 employees in the sector.
- Federazione dei Lavoratori Funzione Pubblica Cisl, FP CISL (Public Function Cisl) organises round 140000 workers in the sector.
- Federazione Cisl Medici (Federation of Medics, Cisl Medici) represents around 7800 doctors.
- Uil Federazione Poteri Locali, UIL F.P.L. (Federation of Local institutions, UIL FPL) represents nearly 100,000 medical and non-medical employees.
- Federazione Italiana Autonoma Lavoratori Sanità, FIALS (The Italian Autonomous Federation Health Workers, FIALS) organises around 40,000 workers in the sector.
- Federazione Sindacati Indipendenti Sanità, FSI Sanità (Independent Trade Union Health Federation, FSI Sanità)
- Unione Generale del Lavoro Sanità, UGL Sanità (the General Union of Work – Health Sector, UGL Sanità)
- Confederazione Italiana Veterinari e Medici della Prevenzione, CIVEMP (Italian Confederation of Veterinary Surgeons and Preventative Medics, CIVEMP)
- Federazione sindacale medici dirigenti, FESMED (Trade Union Federation of Medical Managers, FESMED) has around 7000 members in the sector.
- Unione medici specialisti dirigenti, UMSPED (Union of Medical Specialist Managers, UMSPED)
- Coordinamento Italiano dei Medici Ospedalieri – Associazione Sindacale dei Medici Dirigenti, CIMO-ASMD (Italian Coordination of Hospital Medics-Trade Union Association of Medical Managers, CIMO-ASMD) has 13,000 members in the sector.
- Associazione medici Dirigenti, ANAAO ASSOMED (Association of Medical Managers, ANAAO ASSOMED) has around 18,000 members.
- Associazione Nazionale Primari Ospedalieri, ANPO (The National Association of Head Physicians of Hospitals, ANPO)
- For the non-medical managers in the public hospital structures, the trade union organisations are:
- Sindacato Italiano Dirigenti Servizio Sanitario, SIDir.S.S, (Italian Trade Union of Health Service Managers, SIDir.S:S).
- Associazione Unitaria Psicologi Italiani, AUPI, (United Association of Italian Psychologists, AUPI).
- Sindacato Nazionale Farmacisti Dirigenti del SSN, Si.Na.F.O, (National Trade Union of Chemist Managers of the SSN, Si.Na.F.O).
- Sindacato Nazionale Dirigenti Sanitari del Servizio Sanitario Nazionale (SSN) e delle Agenzie Regionali per la Prevenzione Ambientale (ARPA), SDS SNABI (National

Trade Union of Health Managers of the National Health Service – SSN - and the Regional Agencies for Environmental Prevention - ARPA, SDS SNABI).

- Confederazione dei sindacati dei funzionari direttivi, dirigenti e delle elevate professionalità della funzione pubblica - Sanità, CONFEDIR SANITA' (Confederation of the Trade Unions of Directive Officials, Managers and High Professionality in the Public Function – Health, CONFEDIR SANITA').
- Confederazione Italiana Medici Ospedalità Privata, CIMOP (Italian Confederation Private Hospital Medics, CIMOP)

Collective bargaining in the sector

Collective bargaining largely takes place at national and local level, although there is also some regional bargaining. Five national collective agreements are negotiated in the hospital sector:

National Collective Agreement	Bargaining Parties Unions	Bargaining Parties Employer associations	Employees*
Employees of the National Health Service	Aran	Fp Cgil, Fps Cisl, Fpl Uil, Fsi, Fials	570,000
Medical and veterinary managers of the National Health Service	Aran	Fp Cgil Medici, Cisl Medici, Fpl Uil Medici, Civemp, Fesmed, Umsted, Cimo Asmd, Anaa Assomed, Anpo	110,000
Non-medical managers	Aran	Fp Cgil, Fps Cisl, Fpl Uil, Sidirss, Sinafo, Aupi, Confedir Sanità, Snabi Sds	25,000
Medical employees of nursing homes, Private Institutions of Hospitalisation and Scientific Care and private Rehabilitation Centres and Nursing Homes	Aiop, Aris, Fondazione Don C. Gnocchi	Cimop	30,000
Employees of the health structures associated with the Aiop, Aris and Fondazione Don C. Gnocchi	Aiop, Aris, Fondazione Don C. Gnocchi	Fp Cgil, Fps Cisl, Fpl Uil	110,000

**These figures include workers of the hospital division together with the workers of other divisions*

Source: European Foundation representativity study – report on Italy

There is no legal basis for social dialogue in Italy. Social dialogue takes place when the government decide that it is necessary.

The key challenges facing the hospital sector are:

- Change the mentality of the labour force by fostering the managerial skills of the doctors
- Enhance the reform process

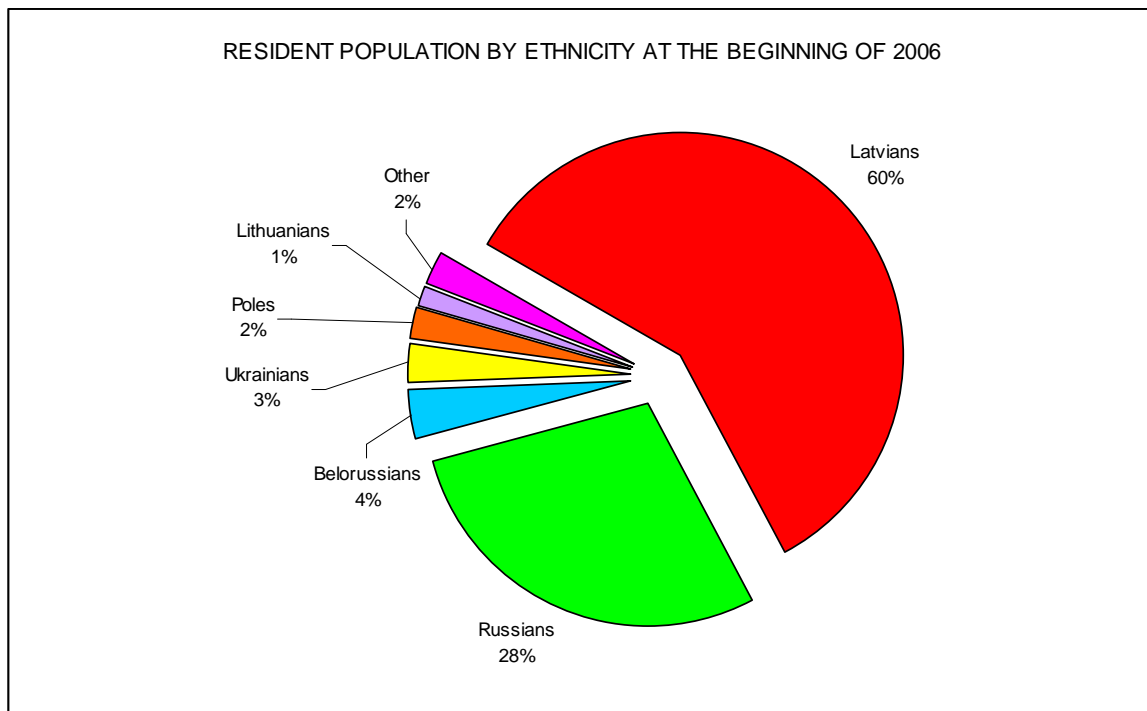
- Tackle the shortage of nurses and the ageing of the labour force
- Develop the enrolment of the labour force in training programmes (to acquire new skills for ex IT skills)
- Develop new flexible forms of work especially for older workers
- Foster internal mobility

LATVIA

Economic and labour market context

Latvia regained its independence from the former Soviet Union in 1991 and joined the European Union on May 1, 2004. It has been a member of NATO since March 29, 2004. Latvia had an estimated population of 2.35 million in 2000, down by over 10% since 1992. The last statistical data available indicates a further decrease of the Latvian population to 2.27123 million (3%) by May 2007. Latvia's economic activity is concentrated near the capital, Riga, where more than one-third of the population lives.¹²⁴ Trends in life expectancy are similar to those in other eastern European countries: 65.6 years for males and 77.4 for females. Economic reforms and stabilization have contributed to a trend of increasing life expectancy in recent years.

Chart: Resident population by ethnicity in Latvia



At the beginning of 2006, the “ethnic Latvians” represented 60% of the total population and accounted for only 42.4% of the people living in the capital region. The “ethnic Russians” were the biggest minority in Riga representing 42.3% of its population¹²⁵. This ethnic divide placed in the context of the country’s Soviet past, socio-economic problems and decreasing population is continuing to provide grounds for social controversy and unrest within the country.

Regardless of the recent increase in birth rate the trend of depopulation in Latvia continues. In the course of the next five to seven years those born during 90’s will enter the labour market.

¹²³ Central Statistical Bureau of Latvia (CSB) <http://www.csb.gov.lv/?lng=en>

¹²⁴ Riga had a population of 727 578 in the beginning of 2006.

¹²⁵ Central Statistical Bureau of Latvia

As the birth rate during this decade was particularly low, the country is expected to have serious labour shortages. The biggest decrease is expected among the working population (aged 15 to 74), which will diminish by 15% in comparison to 2005 and is estimated down to 1.6 million by 2020. Furthermore, according to the projections of the Bank of Latvia, 200,000 economically active inhabitants will gradually leave the country by 2015 using the possibilities offered by the increasing labour mobility within the EU. These trends, due to the economic situation and problems in the local labour market, will further decrease the offer of the labour in Latvia¹²⁶.

Latvia - population change components by year			
	Total		
	Population increase/decrease	Natural increase	Net migration
1990	9 979	3 106	-13 085
1991	-15 161	-116	-15 045
1992	-57 325	-3 851	-53 474
1993	-44 771	-12 438	-32 333
1994	-40 324	-17 501	-22 823
1995	-31 049	-17 336	-13 713
1996	-24 619	-14 538	-10 081
1997	-24 123	-14 703	-9 420
1998	-21 541	-15 790	-5 751
1999	-17 533	-13 448	-4 085
2000	-17 461	-11 957	-5 504
2001	-18 486	-13 327	-5 159
2002	-14 288	-12 454	-1 834
2003	-12 277	-11 431	-846
2004	-12 769	-11 690	-1 079
2005	-11 844	-11 280	-564

Source: Central Statistical Bureau of Latvia

In the post-independence years the services sector was expanding rapidly – its share of GDP growing from 48% in 1992 to 64% in the first nine months of 1998. Factors behind this growth have been the rapid expansion in transport and communications, financial services growth, and growth and modernization of the trade sector. The private sector share in the economy grew from near zero in the late 1980s to 63% in 1997, accounting for 67% of employment the same year¹²⁷.

Presently the country is characterised by considerable economic growth, inflation and emigration of economically active population. In 2007 the annual growth of real GDP was 7.6 per cent. Inflation was 7.3% in 2004. Consumer prices grew by 7% in 2005, 6% in 2006 and further by 3% in the first five month of 2007¹²⁸. In 2005 63.3% of the population aged 15-64

¹²⁶ Ivars Indāns. "Ārvalstu darbaspēks Latvijā – scenāriji, iespējas, riski."

<http://www.politika.lv/index.php?id=10026>

¹²⁷ Health Care Systems in Transition. Latvia 2001. <http://www.euro.who.int/document/e72467.pdf>

¹²⁸ Central Statistical Bureau of Latvia

was employed - 67.6% of men and 59.3% of women respectively. The unemployment rate (% labour force 15+) in the same year was 8.9% - 9.1% for men and 8.7% for women¹²⁹.

Employment trends in hospital sector

It is hard to estimate a precise share of the employment in the health sector as a part of the total employment, as there are quite a few professional groups (mostly support personnel – e.g. sanitarians, drivers, institution staff, etc.) that do not appear in the available statistics but are counted under the legislation as a part of the health system. If taken together the professionals listed in the Table below would account for 2.17% of all Latvian economically active population in 2006.

Number of persons in some health sector professions at the end of the year 2006	
Physicians of all specialities	8 341
Residents and apprentices	420
Specialists with higher medical professional education	379
Nurses with higher education	593
Medical personnel with secondary medical education	14 751

Source: Central Statistical Bureau of Latvia

Similarly, it is hard to estimate an approximate number of workers in the hospital sector. However, the table below provides some idea about the number of employees in some significant professions in this sector. Again it has to be noted that no data concerning the size of the employment in the hospital sector as a whole is accessible.

Physicians by speciality at the end of the year													
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total employment (000)	1 083	970	952	993	991	973	944	965	987	997	1 008	1 024	1 126
PHYSICIANS - TOTAL	8 682	8 399	8 627	8 395	7 964	8 041	8 134	7 744	7 921	7 883	8 087	8 207	8 341
Internists (therapeutists)	1 452	1 149	1 045	968	876	642	607	552	540	548	427	423	412
General surgeons	759	724	702	687	656	632	633	599	613	623	638	652	645
Gynecologists	495	480	475	465	444	457	465	441	458	446	458	480	469
Pediatricians	902	789	759	699	619	487	390	357	339	329	261	243	241
Ophthalmologists	222	212	201	205	193	200	195	191	198	198	223	222	229
Otolaryngologists	191	181	176	171	165	167	170	161	165	160	158	162	160
Neurologists	264	274	252	260	250	238	236	215	231	235	237	247	253
Psychiatrists and narcologists	334	356	363	340	342	331	312	298	346	321	336	349	364
Phthisiopulmonary specialists	146	145	130	122	153	148	142	129	146	129	133	137	131
Dermatologists and venerologists	116	112	120	112	113	115	115	112	112	108	111	115	126
Radiographers and radiologists	296	303	311	306	298	289	278	265	280	279	279	277	280
Rehabilitation and sports physicians	106	106	139	120	110	91	89	76	77	84	81	97	100

¹²⁹ Employment in Europe Report 2006. Statistical annexes.

http://ec.europa.eu/employment_social/employment_analysis/eie/eie2006_annex_en.pdf

Dentists	939	931	1 185	1 111	1 064	1 164	1 278	1 245	1 268	1 287	1 390	1 450	1 561
Specialists in oncology	86	89	88	79	80	78	86	81	80	79	86	82	78
Anesthesiologists and reanimation specialists	370	374	357	362	350	346	358	349	345	356	368	371	370
General practitioners	76	186	302	391	489	801	966	970	1 027	1 050	1 231	1 274	1 283

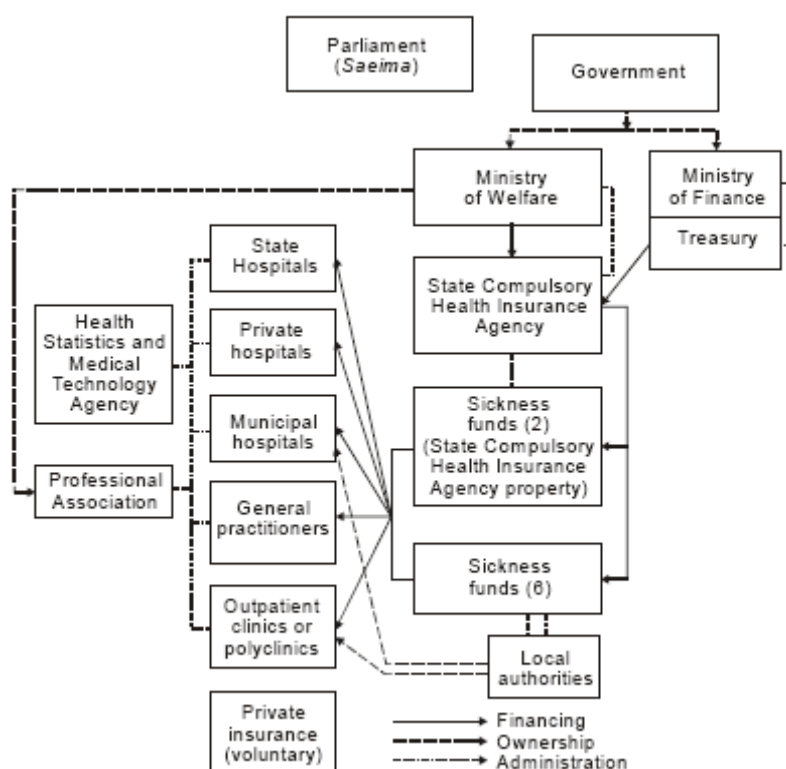
Source: Central Statistical Bureau of Latvia

Structure and organisation of hospital sector and key recent reforms

In 1993 the Ministry of Welfare was created by uniting Ministries of Health, Labour and Social Welfare. The same year, the enactment of the Law on Local Governments marked a major shift toward decentralisation by significantly expanding the roles of local governments in both financing and provision of health care services. Specialized services remained under the responsibility of the state. However a re-centralisation of financing which took place in 1997 limited the role of local governments to provision only. At that time, the 32 local account funds were merged in eight regional sickness funds, which took on the responsibility of distributing state funds for health care.

The State Compulsory Health Insurance Agency (SCHIA) was established in 1998. It is operating under the jurisdiction of the Ministry of Welfare. SCHIA receives the tax-financed budget allocation for health care and distributes it to the eight regional funds, which in turn allocate between primary and secondary care. The Agency also directly finances tertiary care and special state health care programmes. The regional funds use the money received from the SCHIA to purchase health care for their respective populations on the basis of contractual agreements.

Organizational chart of the health care system¹³⁰:



¹³⁰ Health Care Systems in Transition. Latvia 2001. <http://www.euro.who.int/document/e72467.pdf>

The provision of healthcare by public and private institutions is regulated by a legislative framework, including the laws “On Medical Care” (1997) and “On Physicians’ Practice” (1997). A separate law “The Basic Care Programme” established a range of primary and secondary care services included in statutory provision. Several public institutions as well as departments in the Ministry of Welfare, are responsible for management and regulation of specific activities in the health care system¹³¹.

Funding and expenditure

Health care expenditure – defined here as expenditure on sickness/ healthcare according to the European system of integrated social protection statistics (ESSPROS) – as a part of GDP is relatively low in Latvia. According to Eurostat the EU-25 average share of GDP for health care in 2003 was 7.6 %¹³². In 2003 expenditures higher than 8 % were recorded in Germany, France, the Netherlands and Sweden, while the Baltic States, Cyprus and Poland spent less than 4 % of GDP on healthcare. The share of the GDP allocated to health in Latvia was slowly diminishing during nineties - it was 4,75% in 1996 and 3,71%. It was on the level of 3.2% during 2002 and 2003 and seems to be slightly rising since 2004.

Expenditure on healthcare – Latvia				
	% of GDP			
	2002	2003	2004	2005
Health	3.2	3.2	4.0	3.8

Source: Central Statistical Bureau of Latvia

Latvian social security system consists of the following components:

1. Social insurance.
2. Health-care.
3. State social benefits.
4. Social assistance.

State social insurance is organised as a single work-based, contribution financed system, mandatory for all employees and self-employed persons as well as assimilated categories of individuals, and open to residents who fall outside this scope. It covers the risks of old-age, death, incapacity for work, maternity, labour accidents and professional diseases and unemployment. The personal scope of application, financing and organisation of social insurance is determined by the law „On State Social Insurance“, while several other laws deal with the specific schemes.

The Latvian health-care system is tax-financed with patients’ co-payments. It grants all residents access to a defined minimum range of health-care services. At the moment, various aspects of health-care are regulated by a series of laws and regulations of the Cabinet of Ministers. Basic principles of state social benefits and social assistance are regulated by the law „On Social Assistance“.

State social benefits include family benefits and some other payments. They are tax-financed and available to all residents who meet the specified criteria.

Social assistance includes means-tested benefits in cash and in kind, provided by municipalities and state to persons who cannot support themselves and lack sufficient support from other individuals.

¹³¹ HiT summary Latvia. <http://www.euro.who.int/document/Obs/LTVsum2003.pdf>

¹³² http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-CD-06-001-03/EN/KS-CD-06-001-03-EN.PDF

The social protection system in Latvia is supervised by the Ministry of Welfare. The ministry is headed by the minister, who is politically responsible. The administrative work of the ministry is supervised by a state secretary who is a civil servant. The ministry consists of the following departments: the Department of Social Insurance, Social Assistance, Labour, Health, Environmental Health, Pharmacy, Social Policy Development, European and Legal Issues, Financing and Budget Department and the Administrative Department.

The State Revenue Service is responsible for the social insurance contribution collection. The Social Assistance Fund is performing the administrative and financial management functions of providers of state-run social assistance services. Another area of the activities of the Social Assistance Fund is to accumulate information about social services provided, in order to monitor and improve the system. The whole amount of resources allocated to health care are channelled to the State Compulsory Health Insurance Agency (SCHIA), which distributes it among territorial sickness funds¹³³.

Since 1997 public funds are channelled to health care institutions via the insurance system in two ways: the total budget for health care is divided into the state budget, which is managed by Ministry of Welfare, and local government budgets (also financed from central government revenues), which were administered by district-level and city governments through their corresponding territorial sickness funds. Thus the financial resources are used to finance two programmes in health care as follows:

- The Basic Care Programme (primary and secondary health care) financed from local government budgets through a budget administered by each of the eight territorial sickness funds. This is financed by the Special Health Care Budget (the earmarked amount consisting of 28.4% of personal income tax) plus subsidies (block grants) from the state budget. These funds are managed by the SCHIA which distributes them to the eight regional sickness funds. These in turn purchase services from providers on a contractual basis.
- The state programme for health care financed from the state budget, through central government revenues. The funds are transferred to the SCHIA, which directly pays providers for their services, which include tertiary care, specialized treatment of tuberculosis, the treatment of mental illness, oncology services and other services provided in state-owned hospitals.

The Latvian health care system is based on the contract model: regional sickness funds make contracts with health care institutions and pay for the costs incurred in these institutions. The regulations of the Cabinet of Ministers define standards for medical equipment, personnel and qualifications that must be met for certification of an institution, preference is given to hospitals with more advanced material equipment and certification¹³⁴.

Health care delivery system

As illustrated by the data on the number of health care institutions in the table below, Latvia is moving away from the public provision of Secondary and tertiary care towards a system which concentrates most of the health care services provisions in the Primary care. The number of hospitals has fallen in the recent years (down to 56% in 2006 in comparison to 1990), simultaneously seeing the increase in the number institutions providing outpatient services (see Table 3.), while the number of doctors has remained relatively stable since mid-nineties. Also the number of hospitalised persons has remained relatively stable during the past 16 years (see Table 5.) although the time they spent in hospitals and the number of beds has diminished considerably.

¹³³ http://ec.europa.eu/employment_social/social_protection/docs/latvia_final.pdf

¹³⁴ <http://www.euro.who.int/document/e72467.pdf>

Number of hospital sector institutions at the end of the year				
	Hospitals	Health care institutions providing outpatient services - total	medical assistant's-obstetrician's aid posts	other outpatient health institutions
1997	156	1 127	407	75
2000	142	1 892	342	95
2003	131	2 757	263	392
2006	106	3 183	246	559

Source: Central Statistical Bureau of Latvia

Thus the primary health care system is consolidating. In 1999 the ratio of family doctors against the total number of primary care doctors was 42%; at the end of 2000 it had already reached 49%¹³⁵. The percentage of general practitioners in comparison to the number of all physicians has grown from 1% in 1994 to 15% in 2006¹³⁶.

Primary care services

Until 1990, primary health care in cities and large towns was provided in polyclinics, while in rural areas it was provided by local internists and nurses or feldshers (doctor assistants). In 1992, the Ministry of Welfare approved a model of Primary health care (PHC) based on the establishment of single or joint family doctor practices staffed by general practitioners and nurses or doctors' assistants. The establishment of private practices with primary care doctors as independent contractors was favoured. Implementation of this model is as yet far from complete. In the interim period, patients may make their first contact with health services in various outpatient institutions: polyclinics; hospital emergency clinics or ambulatory emergency clinics; doctorates; feldsher points; and health points.

The specialty of general practice was established in 1991, and the number of certified GPs has increased sharply due to retraining courses which became available since 1992. Efforts to support development of primary health care have led to a system of remuneration of PHC physicians involving mixed capitation. This includes a capitation amount that is partly remuneration for primary care practitioners, partly compensation for certain costs (for example, PHC nurse) and partly payment for services of specialists to whom patients are referred. This arrangement was prompted by the hope that it would contribute to keeping service delivery as much as possible in the primary care sector. However it has met with several difficulties including resistance by patients who often feel deprived of essential secondary services.

Other problems in the PHC sector include difficulties in setting up independent practices, and uncertainties about their legal basis, inadequate cooperation among primary, secondary and tertiary care, inadequate physician qualifications for the development of primary care, and problems of access to care in rural areas.

Public health services

The Health Promotion Centre under the Department of Environmental Health of the Ministry of Welfare organizes health promotion. The Latvian Infectious Diseases Centre and State Sexually Transmitted and Skin Diseases Centre are responsible for infectious and communicable disease control. Professional disease registration and observation are coordinated by the Professional Diseases and Radiation Medical Centre. Primary care

¹³⁵ http://ec.europa.eu/employment_social/social_protection/docs/latvia_final.pdf

¹³⁶ Central Statistical Bureau of Latvia

doctors and school physicians are responsible for immunization. Preventive services (basic health education, cervical smears, etc.) are delivered by primary care providers. In 1997 the State Sanitary Inspection was established for the purpose of monitoring environmental health.

There are seven youth health centres working on youth reproductive health care and education. Public health services are hampered by a lack of coordination at the state level. Often different institutions work on the same problems, without knowing what colleagues have already achieved.

There are three categories of hospitals in Latvia: state (accountable to the Ministry of Welfare), municipal and private. Hospitals are overwhelmingly public, with municipalities controlling roughly half. All specialized hospitals are concentrated in Riga. Hospitals usually have the status of non-profit organizations or stock companies, frequently employee-owned. Directors' decisions, however, must be ratified by regional sickness funds with which the hospitals are contracted. The director or head doctor of each municipal hospital organizes the hospital's activities according to the local authority's health care development plan.

In 1997, inpatient (and outpatient) health care institution certification was initiated. Since 1990, there has been a remarkable decrease in the number of beds, which fell from 141.0 beds per 100.000 population to 87.3 beds in 2006, representing a 48% drop.

Total of hospital beds, annual average									
	Per 100,000 population								
	1990	1992	1994	1996	1998	2000	2002	2004	2006
Beds	141.0	130.8	121.5	141.0	130.8	121.5	104.9	96.6	87.3

Source: Central Statistical Bureau of Latvia

The hospitalization rate remained constant over this period at around 21–23 per 100 population. However, the average length of stay decreased from 17.3 days in 1990 to 9.3 days in 2006.

Hospitalisation										
	1990	1992	1994	1996	1998	2000	2002	2004	2006	
Number of hospitals	188	176	170	158	150	142	129	119	106	
Number of hospitalised persons, thsd	578.6	522.7	536.5	522.1	540.1	524.5	476.4	488.5	529.1	
Number of hospitalised persons per 1,000 population	217	200	213	212	224	221	204	211	231	
Bed days, thsd.	10 034	9 179	8 845	7 559	6 757	6 011	5 225	5 171	5 111	
Average length of stay (days)	17.3	17.6	16.5	14.4	12.5	11.4	10.6	10.4	9.3	
Bed turnover	16.2	15.2	17.1	19.6	23.5	25.4	26.3	27.3	...	

Source: Central Statistical Bureau of Latvia

Key aspects of reform in last 5 years

Apart from the decentralisation during nineties and a shift towards PHC discussed above, the two most prominent aspects concerning the health and hospital sectors have been privatisation and problems with the retention of health care staff and remuneration.

The private sector

The private sector in Latvia includes institutions that have been privatized, namely many polyclinics and almost all dental practices and pharmacies, as well as some independent primary care practices which emerged following efforts in recent years to develop this form of institutional setting for primary health care. Private providers contract with sickness funds to

provide services which are specified in the Basic Care Programme. In addition, they may offer services on a private basis. The full range of primary health care services is available through private provision (i.e. through private, out-of-pocket payments). Services provided mainly in the private sector include certain advanced diagnostic services, spa treatment and psychotherapy. The private (non-statutory) system offers high quality and freedom of choice for the patient but is financially out of reach for much of the population.

A much smaller proportion of hospitals is privately owned (7 in 1998, 10 in 1999¹³⁷ and 11 in 2002). In 2002, 129 secondary and tertiary care hospitals provided 18,143 beds, amounting to 77 beds per 10,000 inhabitants. Only 11 hospitals were privately owned. The central government controlled 42 and the municipalities 74 hospitals. The remaining two hospitals were public joint-stock companies¹³⁸.

Human resources in the hospital sector

The available statistics indicate that the number of physicians has fallen significantly in the period from 1990 until 2001 (down by 38%), the year that marks a reverse in this trend (8% increase by 2006). However, the number of health care apprentices and residents is decreasing since 1999 and so is the number of medical personnel with secondary education (down to 52% in 2006 in comparison with 1990). Reasons for falling staff numbers include the declining numbers of hospitals and hospital beds and low salaries and prestige for medical professionals. The ratio of nurses to doctors is quite low and this is expected to have a negative impact on the development of PHC teams¹³⁹.

Like other transition countries, Latvia is witnessing a reduction in the number of hospitals. The number of hospitals has fallen in Latvia from 188 in 1990 to 106 in 2006 (down by 82). While the number of hospitalised persons has remained relatively constant, on average in 2006 they spend twice as little time in hospitals as they used to in 1990. In accordance with the so called 'Master plan', Latvia's health investment programme planned to reduce the number of local hospitals from 132 in 2000 to 60 in 2007 hoping to obtain efficiency gains by providing more specialised care in fewer institutions. Although the Master plan has not been officially adopted so far, a further restructuring of health care institutions seems inevitable to achieve efficiency gains within the underfinanced system. In rural areas, however, this process implies the challenge to maintain geographical access to health care services in the future¹⁴⁰.

Worrying is also the decreasing popularity of the hospital sector due to low wages and possibly for qualified people to seek employment elsewhere in the EU. In this generally bleak context however it has to be noted that by 2006 the number of specialists with higher medical professional education has increased more than six times and nurses with higher education more than nine times since 1998.

Basic indicators of health care services at the end of the year					
	Physicians of all specialities	Residents and apprentices	Specialists with higher medical professional education	Nurses with higher education	Medical personnel with secondary medical education
1990	12 505	...	...	...	28 311
1991	12 203	...	...	...	27 427
1992	10 701	...	...	...	23 819

¹³⁷ <http://www.euro.who.int/document/e72467.pdf>

¹³⁸ <http://www.csis.org/media/isis/programs/IAC/diestudylatvia.pdf>

¹³⁹ <http://www.euro.who.int/document/Obs/LTVsum2003.pdf>

¹⁴⁰ <http://www.csis.org/media/isis/programs/IAC/diestudylatvia.pdf>

1993	9 349	...	...	...	22 042
1994	8 682	...	...	...	19 361
1995	8 399	...	...	...	18 270
1996	8 627	688	...	...	17 908
1997	8 395	631	...	103	16 663
1998	7 964	654	56	63	15 606
1999	8 041	893	82	77	15 344
2000	8 134	892	117	94	14 934
2001	7 744	498	141	102	14 663
2002	7 921	492	164	174	14 610
2003	7 883	491	211	231	14 741
2004	8 087	501	269	292	14 725
2005	8 207	502	299	410	14 927
2006	8 341	420	379	593	14 751

Source: Central Statistical Bureau of Latvia

Outline of system of industrial relations

No single and coherent national labour code has been developed in the time after independence. The industrial relations in the country are regulated through a series of special or amended acts covering trade unions; employer associations; assemblies demonstrations, and protest actions; strikes; and an industrial dispute law that was enacted in 2002. The process of social dialogue is organised in a consensual manner within the framework of the National Tripartite Cooperation Council on the basis of a tripartite agreement of 1998, supplemented in 2004.

National Tripartite Cooperation Council (NTCC) is a framework for national level tripartite social dialogue uniting in collaboration and discussions the appointed representatives of Government, LDDK and Free Trade Union Confederation of Latvia. The aim of the NTCC is to foster the cooperation of social partners at national level and to ensure an integrated way of dealing issues on socioeconomic development in compliance with the interests of whole society and state, that would guarantee social stability, increase of the level of well-being and economical growth in the country. At the NTCC social partners evaluate draft regulatory enactments and submit proposals concerning taxes, EU structural funds and other issues on economics, finance, employment rights, social security and social insurance. As of 2006 the meetings of the NTCC are called and steered by the President of Ministers, and a secretariat of the NTCC is working as a structure within the State Chancellery. Nevertheless, any of the three sides represented in the NTCC has the right to initiate a meeting of the Council.

The collective labour law permits, in addition to trade union representation, a works council elected by all employees, although clear competencies for each are not defined. Works councils can conclude collective agreements at company level and organise industrial action. The Latvian trade union confederation (LBAS) did not welcome this kind of competition. Opposition to a double structure of workplace representation probably contributes to the weak union density and low representation.

Company agreements that require a local trade union organisation are nonetheless fragmentary because of weak representative structures, particularly in SMEs. Another important aspect is that a system of sectoral agreements is just starting, hampered by lack of partners in some sectors of private industry. Also the development of social dialogue at the

level of municipalities remains a future challenge in Latvia. Therefore, in many cases only individual contracts based on minimum wage can be concluded¹⁴¹.

No major conflicts are reported recently except for some industrial actions by teachers, cultural workers, and the health and social care union. The law on strikes adopted in 1998 is somewhat restrictive. It contains a bureaucratic procedure for the approval of strike action – a long notice period – and a legal ban on solidarity action and political strikes. The decision to strike must be taken at a general company meeting, at which at least 75% must vote to strike. The employer must be given the minutes of this meeting as notice 10 days before a planned action. Permission for protest actions and demonstrations is issued by the local authority, which can impose restrictions on timing and prescribe or change the route. After the adoption of the strike law, the trade unions protested against the ban on solidarity action and the length of time before a strike could be initiated. The industrial dispute law (Conflict Resolution Law 2002) opened the way for conciliation, mediation, and arbitration procedures to precede industrial action and reduce labour conflicts. The right to lockout was enacted in 2003¹⁴²

Main actors participating in the social dialogue

Trade Unions

The Free Trade Union Confederation of Latvia (Latvijas Brīvo Arodbiedrību savienība – LBAS) is the biggest non-governmental organisation in Latvia. Established in 1990 it protects the interests and rights of professional trade union members and employees on the branch and inter-branch level, coordinates the cooperation between 24 independent Latvian trade unions, represents the interests of its members in national and international institutions, and implements a joint working programme.

Together with the government and Latvian Employers' Confederation (LDDK) LBAS works in the NTCC constituting a national-level platform for social dialogue in the country. LBAS participates in the elaboration of economic and social development programmes, in the evaluation of draft laws, in working groups on improvement of labour conditions, salaries, tariff policies, compulsory social insurance and social guarantees, healthcare as well as employment, vocational education and lifelong learning. LBAS also represents the interests of its members in the sub-councils of National Tripartite Cooperation Council, state and municipal institutions as well as courts. LBAS provides consultations to the trade union members on concluding the collective agreements, participates in revision of labour disputes, social and economic discords.

At present LBAS unites 165 000 trade union members in almost 2900 state, municipal and private enterprises¹⁴³ and is the only Trade Union Confederation in the country. Having just a single, politically independent union confederation is an advantage because it rules out rivalry. With a trade union density of about 19% in 2004 (2000, 23%) Latvia has the strongest union representation of the three Baltic States. The continuous decline in union density in the last years is affected by privatisation as well as by the large number of SMEs. Most Union members are from the public sector. Only about 25% of LBAS members are employed in the private sector. Unionisation is especially low in SMEs – currently unions are in about 25% of companies. Even in bigger companies, the opportunity to form works councils, available since 2002, is seldom used¹⁴⁴.

¹⁴¹ http://www.eurofound.europa.eu/eiro/country/latvia_2.html

¹⁴² http://www.eurofound.europa.eu/eiro/country/latvia_4.html

¹⁴³ http://www.lbas.lv/Eng/lbas_parlbas.php

¹⁴⁴ http://www.eurofound.europa.eu/eiro/country/latvia_3.html

Employers

In contrast to employee organisations, employer associations are divided into several organisations, often without clear boundaries between spheres of activity and areas of influence. The single partner for social dialogue with trade unions is the Latvian Employers' Confederation (Latvijas Darba Devēju konfederācija – LDDK). It is considered the strongest employer confederation and the biggest organization representing the interests of employers.

LDDK, as the single employer representative, strongly supports social dialogue but in most cases there is no mandate for collective agreements at sectoral level. A first attempt to conclude a multi-company agreement in the business sphere is a frame contract developed by construction industries in some regions and in the metal industry. To date no sectoral or multi-employer agreements (i.e. with detailed regulations and precise provisions for wages and working conditions) have been concluded in the private sector. However, there are such agreements in several of public companies and administration sectors and these are often extended¹⁴⁵.

LDDK acts as a partner in socioeconomic negotiations with Saeima, the Cabinet of Ministers of Republic of Latvia and Free Trade Union Confederation of Latvia. It unites 26 branch and regional associations and federations that take a significant place in Latvian economics, as well as enterprises that employ over 50 people. The members of LDDK employ at large 25% of employees in Latvia¹⁴⁶. LDDK as a social partner at national level has set a goal to join in social dialogue at EU level representing the interests of Latvian enterprises and ensuring the implementation of the agreements signed by EU level social partners in Latvia¹⁴⁷.

Collective bargaining

There are some sectoral agreements, particularly in the public sector, but company agreements prevail. LBAS registered 2,436 corporate contracts in 2001, 20 of them national and sectoral agreements in various civil service and public companies, for example, energy and water suppliers and forests. Because of LBAS's dominance, central negotiations are done in only a few parts of the public sector. Most bargaining is decentralised. Outside the public sector wage bargaining is not coordinated because of LBAS's many affiliates and the low union representation in the private sector.

The coverage rate of collective agreements is about 20% of employees (the percentage is higher in the public sector). About 65% of salaried earners negotiate wages individually. The Labour Code 2002 enables agreements to be extended generally if the contracting employers' representatives cover more than 60% of a sector's workers. In the public sector (civil service and public companies) the existing sectoral agreements are extended to all employers.

Because collective agreements have a low coverage rate individual contracts, based on the minimum wage, are the rule for most salaried Latvians. Only 27% have the workplace representation that is a precondition for a company collective agreement. This situation has not, so far, been significantly changed by the introduction of works councils.

Latvia has a long tradition of tripartite concentration initiated by the state and the social partners. Results of consensual concentration always depend on the political decision-making process. In addition to legislation the main items of discussion are taxes and tax-free incomes and the definition of the minimum wage¹⁴⁸.

¹⁴⁵ http://www.eurofound.europa.eu/eiro/country/latvia_3.html

¹⁴⁶ <http://www.iddk.lv/index.php?lang=2&c=141>

¹⁴⁷ <http://www.iddk.lv/index.php?lang=2&c=157>

¹⁴⁸ http://www.eurofound.europa.eu/eiro/country/latvia_4.html

Social partner organisations in the hospital sector

In 1997 the **Latvian Hospitals' Association**¹⁴⁹ (LHA) was established in order to promote organizational and managerial improvements in hospitals. LHA is a member of Employers' Confederation of Latvia (LDDK) and of the European Hospital Employers Association (HOSPEEM).

As of 2006 the interests of LHA are represented in NTCC though one of LDDK seven sub-councils - Health Care Sector Sub-council. As a rule, the interests of employers in NTCC are represented by seven appointed representatives. The same number of individuals represent the sides of the Government and Trade Unions in the NTCC. The Health Care Sector Sub-council meets once in two month on the sectoral level and one in a quarter on the national level. Provided that there is a pressing issue or problem it may meet on need.

The LHA comprises members from both hospital and health sector in general mostly in national level social partner negotiations, but also on the sectoral, local and separate enterprise scales. Since General Agreement negotiated in the end of 2006 and signed beginning of 2007, the LHA though the NTCC Health Care Sector Sub-council represents 52 hospitals in collective bargaining on the national level and an estimated 70% of the employees in the sector. On the level of enterprises the collective bargaining is usually done on the yearly basis and renewed, if all the parties have no objections. LHA strives to represent all the professional groups in the health and hospital sectors – medial personnel of different levels as well as all the support and administrative staff.

Trade Union of Health and Social Care Employees of Latvia¹⁵⁰ (LVSADA) was established in 1990. It represents and defends the social and economic interests and rights of 12.650 members in the health care sector and 5 146 members in other sectors - in total 17.796 invoiced members. The number of LVSADA members per professional category is listed in the Table below.

The number of LVSADA members	17 200
Doctors	2 484
Nurses with higher education	162
Health care personnel with the 1 st degree of higher education	6 841
Pharmacists	91
Social workers	285
Teachers and professors	322
Nurse assistants	2 469
Employees of other professions	4 587

Source: [LVSADA](#)

LVSADA represents and seeks to improve the economic situation and working conditions of the following groups of its members working in the health care sector – youth, women, doctors, nurses, social workers, pharmacists, education staff, representatives of member

¹⁴⁹ Latvian: Latvijas Slimnīcu biedrība (LSB)

¹⁵⁰ Latvian: Latvijas Veselības un sociālās aprūpes darbinieku arodbiedrība, LVSADA

organisations, trade unions and other workers in the health care sector. It seeks to improve their working conditions, arrange the socio-economic questions concerning these groups and assist students the fields of its competence. LVSADA has 138 sectoral organisations covering all the Latvian territory. Its members are working in hospitals, health centres, schools, laboratories, social care and rehabilitation centres.

LVSADA cooperates with the International Confederation of Free Trade Unions (ICFTU). It is an affiliate of the European Federation of Public Service Unions (EPSU). Though its membership in the Free Trade Union Confederation of Latvia (LBAS), LVSADA voices its position in the NTCC.

LVSADA has its own youth centre and newspaper "Arodbiedrības vārds" (Word of Trade Union) that come out four times a year on the current issues in health and social agenda.

Presently LVSADA is actively engaged in work with the questions related to the emergency aid brigades (neatliekamās palīdzības brigādēm – NMP), workers in the social care and medial nurses.

Another trade union that represents the interest of the workers of health and hospital sectors in Latvia is the **Nursing and Healthcare Personnel Trade Union** (Latvijas Ārstniecības un aprūpes darbinieku arodsavienība, LĀADA). It was created and registered in 1992. LAADA was admitted to LBAS in November 2002 and is also a member the European Confederation of Independent Trade Unions (CESI).

The members of LAADA are medial nurses, doctor assistants, laboratory workers, obstetricians, and nurse assistants – professional groups that often work under the worst conditions in the health care sector. LAADA represents the interests of these members in negotiations with the employers though control of individual work contracts and the application of labour law in the institutions, both in concluding General Agreements contracts with the employer associations and with Welfare as well as Health Ministries of the Republic of Latvia.

LAADA is also representing the interests of its members in the institutions of state administration by filing proposals to the Welfare and Health ministries and taking part in the employer and employee councils, representing the interests of its members in courts, providing them with free-of-charge judicial assistance, concluding collective agreements in their interests with employers as well as organising seminars and training for its members in judicial, economic and social questions.

Structure of collective bargaining and social dialogue in the hospital sector

For everyone who is included in the health care sector the salaries and working conditions as well as the tariffs state covered services are negotiated on the national level and included in the national labour laws. As sketched above, the negotiations take place in the National Tripartite Cooperation Council (NTCC) between Latvian Employers' Confederation (LDDK), Free Trade Union Confederation of Latvia (LBAS) and the representatives of the Government of the Republic of Latvia. Specific issues related to the hospital sector are discussed in the relevant Health Care Sector Sub-council. Specific NTCC working groups are focusing on improvement of labour conditions, salaries, tariff policies, compulsory social insurance and social guaranties, healthcare as well as employment, vocational education and lifelong learning.

The health care sector minimum salaries and working conditions on the national level are set on the quarterly bases in NTCC, negotiated seven times a year on the sectoral level (Health Care Sector Sub-council) and once a year (or more often - according to the need) on the level of individual enterprises. The salaries and working conditions of the staff and technical personnel in the hospital sector are not included in the nationally negotiated prices of

services; therefore these are negotiated on the individual hospital level, so as to retain skilled workers in their positions.

LHA, LVSADA and LAADA, the social partners of the hospital sector are participating in the national social dialogue in the form of NTCC through their umbrella organisations LDDK and LBAS respectively. They mainstream their position to the umbrella organisations, the Chairs of which further defend these in NTCC. The social dialogue on the national level is established and regulated by the decree of the Cabinet of Ministers, which established the partners that are eligible to take part in this dialogue and the frequency of meetings as well as the scope of the competences of the different structures within NTCC. The sectoral dialogue on the sectoral level is not regulated by law, but is encouraged in the above mentioned legislation.

Key issues for the hospital sector

As mentioned above the two issues of current concern in the Latvian healthcare system and hospital sector in particular are the provision of the adequate financing of the health care personnel and the lack of professionals in this branch of services mostly due to the declining status of these professions related to the low pay.

The social partners on the sectoral level have repeatedly demanded the government to raise the remuneration level of the various professional groups in the health care sector and to set the state compensated cost of the services to match the real prices and costs faced by the sector. However, making the state consider and to take in account the results of the social dialogue in the development of legislation and allocation of financing still remain the central challenges faced by the employer and employee representatives. These social partners are often able to achieve mutually satisfying solutions, but these must be taken in account by the government.

Until 1990 primary health care in cities and larger towns was provided in polyclinics. In rural areas, primary health care was provided by the local internist and nurse. The speciality of general practitioner (family doctor) was established in 1991, and was consecutively developed. There are 1230 general practitioners now, and they are managing primary health care associated with gate-keeping role on access to specialist services. This indicates that the first major reform in Latvian health care - the reform of primary health care - has been completed. However, some social anxiety has risen after introduction of this regulation because of experienced delay consulting a specialist. Patients are free to change their family doctor once or twice per year, to any other doctor within the administrative territory. In practice, only the inhabitants of cities have a real choice of practitioner, because there are few to choose from in many rural areas, particularly in Latgale, eastern part of Latvia.

The second major reform - the reform of hospital services - has been promoted as so-called "Masterplan" and is still ongoing. It is aimed to shorten the high number of hospital beds in the country (774 per 100 000 inhabitants), to concentrate modern medical facilities, and to reconstruct buildings of hospitals selected for leading role in the field.

All mentioned above was intended to improve the quality of health care services. However, this can not be reached without appropriate human resources. Reforming of health care in Latvia was started about 10 years ago and resulted in remarkable lack of skilled personnel now, mainly because of persistent ignoring of human needs of employees. The average monthly wage of physician was only 291 LVL (1 EUR = 0.7 LVL) in 2004, and this was 1.4 times the average wage in national economy. For nurses, the corresponding figures were 169 LVL and 0.8, respectively.

Thanks to the Trade Union of Health and Social Care Employees of Latvia (LVSADA) call for strike and continuous negotiation with the Ministry of Health, the situation was improved in two steps. The first one was the governmental regulation of minimum wages depending on

qualification in health care issued in 28.09.2004 (in fact, equivalent to general agreement) and upgraded in 2005. According to the last upgrade, the average wage of physician have to reach 440 LVL (630 EUR) at 01.07.2007, and this is 2.0 times the estimated average wage in national economy; for nurses, the corresponding figures are 264 LVL (377 EUR) and 1.2, respectively. As the second step, the governmental plan of action "On Development of Human Resources in Health Care" was adopted in 2005 and is going to be upgraded in 2006. The plan comprises following main tasks to be completed at year 2010:

- to meet the requirements for human resources in quantity, location and qualification necessary according to evidence-based forecast,
- to modify the national system of medical education according to demands of labour market,
- to develop an appropriate system of remuneration and social guarantees.
- If the plan will not be upgraded and followed successfully, there will be a deficit of 1000 physicians and 2000 nurses in Latvian health care services in 2010 (according to optimistic scenario)¹⁵¹.

The average monthly wage in the health care sector in LVL¹⁵²

Profession	2004.g.	2005.g.	2006.g.
Doctors	291	364	429
Middle med. Professional	169	211	248
Junior med. Professional	122	153	180

Source: [LVSADA](#)

The average monthly wage in the social care sector in LVL

Profession	2004.g.	2005.g.	2006g.
Social worker	133	167	200
Social assistant	112	158	167

Source: [LVSADA](#)

Women, junior level staff and social workers are the most vulnerable groups that must face the situation of poor financing in the health care sector. The LVSADA was addressing this problem by calling for salary improvements that would reflect women's vital role in social services. The trade union organised a picket in Riga on March 8, calling for increase of salaries and improvement of working conditions of social workers working in social care and assistance. The survey of the LVSADA revealed that 98% of employees in social care sector in Riga City are women and 49% of them are main bread-winners in their families. The LVSADA was calling on the Riga City Council to make appropriate changes in the budget and increase the salaries of social workers delivering very important public services¹⁵³.

Another particular problem faced by the whole health sector and Latvian economy in general is that of a non-declared income. In addition to a formal salary, which is often an equivalent to the minimum wage¹⁵⁴ many employees get an informal salary. The prevalence of so called

¹⁵¹ <http://www.epsu.org/a/2442>

¹⁵² ECB: 1 Euro = 0.6963 Latvian lats (LVL) (29 June 2007)

¹⁵³ <http://www.epsu.org/a/2858>

¹⁵⁴ On 01.01.2007 the minimum wage in Latvia was 120.00 LVL or around 172.00 EUR

'envelope-wages' has increased in recent years. That is, part of wages are paid in cash while only the minimum wage is officially declared¹⁵⁵. In order to reduce the under-reporting of earnings and its negative implications for social security and tax revenues the government decided on a mid-term programme in 2004¹⁵⁶.

¹⁵⁵ European Commission 2004, p. 158 and Antila/Ylöstalo 2003, p. 126

¹⁵⁶ http://www.eurofound.europa.eu/eiro/country/latvia_4.html

LITHUANIA

Economic and labour market context

Lithuania has experienced a period of remarkable economic growth over the last few years.¹⁵⁷ Since 2000, the annual GDP growth hovered around the 6% mark (10.5% in 2003), the latest figures from 2007 showing the annual GDP growth being 6.2%. This has to be considered against the background of deep economic crisis in the 1990s, when in some years the GDP was shrinking significantly (-9.8% in 1994, -1.7% in 1999).

The overall employment rate (15-64) was 62.6% in 2005 (the latest data available from Eurostat). This missed the intermediate Lisbon strategy target to have the overall employment rate at 67% by 2005. The employment rate has been rising only very slowly over the last few years. Indeed, the employment rate of 62.6% in 2005 is only marginally higher than the employment rate of 62.3% in 1998. Based on the past growth, it is unlikely that Lithuania will meet the Lisbon target of 70% employment rate in 2010.

Male employment rate (15-64) was 66.1% in 2005. It has been increasing steadily over the last few years. The female employment rate (15-64) was 59.4% in 2005 (the intermediate Lisbon strategy target was 57% by 2005). Thus, it is likely that Lithuania should be able to meet the Lisbon target of 60% female employment rate by 2010. However, the female employment rate has remained fairly stable over the last few years.

The latest unemployment data available show the unemployment rate (15+) at 8.3% in 2005, which is a significant reduction, compared to the unemployment rate of 13.2% in 1998. The male unemployment rate has also been reduced significantly, to 8.2% in 2005, from a high of 18.6% in 2000 and 2001. Similarly, the female unemployment rate dropped significantly, to 8.3% in 2005, from a high of 14.3% in 2001.

Employment trends in hospital sector

According to Eurostat data, the absolute number of workers in health *and social care* sector in Lithuania was 105,700 in 2006. It has been growing over the last few years (from 94,100 in 1998). However, the proportion of employees in health and social care sector in the total employment has remained stable, around 6-7% of the overall workforce.¹⁵⁸

The health and social care sector is dominated by women in Lithuania. Out of 105,700 workers in 2006, men constituted 15% of the workforce (16,600), whereas women made up 85% (89,100) of workers.¹⁵⁹

The national data suggests that the number of employees in the healthcare sector was 48,385 in 2006,¹⁶⁰ consisting of the following categories of workers:

- Doctors – 13,510, of which 1,087 were working in the private sector (as their main job),
- Dentists – 2,249, of which 1,070 were working in the private sector (as their main job),

¹⁵⁷ The data in this sub-section is taken from the Employment in Europe 2006 report.

¹⁵⁸ Eurostat, LFS, 'Employment by sex, age groups and economic activity'.

¹⁵⁹ Lithuanian Statistics Department, www.stat.gov.lt, Temines Lenteles, Uzimtumas ir darbo rinka, Uzimti gyventojai pagal ekonomines veiklos rusis ir lyti.

¹⁶⁰ Lietuvos gyventoju sveikata ir sveikatos prieziuros istaigu veikla 2006 m. (The health and activities of healthcare organisations in Lithuania in 2006), Lietuvos sveikatos informacijos centras (Lithuanian health information centre), www.lsic.lt

- Other personnel with higher or vocational higher education (such as nurses, laboratory specialists, dieticians) – 32,626, of which 2,486 were working in the private sector (as their main job).

Structure and organisation of hospital sector and key recent reforms

Funding and expenditure

Total expenditure on health care in Lithuania was 3.9% in 2003.¹⁶¹ This was low compared to the EU25 average of 7.6% in 2003. This proportion has been growing since. In 2005, the overall expenditure on health care reached 6.3% of GDP, of which public expenditure formed 4.6% of GDP.

The health care system provides comprehensive coverage to all residents in the country irrespective of their citizenship. The health care system is mainly financed through statutory health insurance (around 70%). Other sources of funding are monies from the voluntary health insurance and insurance against accidents at work and work-related illnesses, monies for services which require payment, and interest earned from monies deposited by health care institutions in the banks.

Compulsory Health Insurance Fund (CHIF) is the main source of health care financing. CHIF expenditure in 2005 constituted 2512.8 million Litass or 88% of all public sector expenditure on health. CHIF expenditures on personal health care reached 1666.4 million Litass or 66.3% of all CHIF expenditure, compensations for medicines reached 495 million Litass or 19.7%.¹⁶²

The private expenditure on health was calculated using data of household expenditure on health (in cash and in kind) per capita provided annually by the Statistics Lithuania on the basis of the national household budget survey and the average annual number of inhabitants. During the years 1998- 2005 the average household expenditure on health per capita increased by two times (from 177,6 Litass in 1998 to 357,6 Litass in 2005). The household expenditure in 2005 increased up to 1.2 billion Litass, which accounted for 30% of all expenditure on health.

Those covered by compulsory health insurance are citizens of Lithuania and citizens of other Member States and citizens of third countries whose permanent place of residence is Lithuania, as well as citizens of other Member States and citizens of third countries living temporarily in Lithuania, if they are working legally in Lithuania, and minors in their families.

People who do not have statutory health insurance only receive the emergency care for free. All non-emergency healthcare needs in such cases need to be paid by the individual.

The laws foresee also the possibility to have a voluntary health insurance in addition to the statutory health insurance. However, its take-up is not widespread amongst the population.

Enterprises, institutions and organisations pay statutory health insurance contributions amounting to 3 per cent of pay for persons who work under an employment contract or in management. Statutory health insurance is co-ordinated by the following institutions: Compulsory Health Insurance Council, the State Patients' Fund under the Ministry of Health, and regional patients' funds.

The State patient's fund is responsible for preparing, implementing and reporting on the annual budget of the statutory health insurance fund. It also oversees and audits the activities of the regional patients' funds. Regional patients' funds (there are currently 5) register and monitor people with the statutory health insurance. Regional patients' funds contract with

¹⁶¹ Eurostat Statistical Yearbook 2006/2007, p.108.

¹⁶² Lietuvos sveikatos informacijos centras (Lithuanian health information centre), www.lsic.lt

providers of personal health care to provide personal health care to patients and then reimburse expenses incurred by health care providers in providing health care services.

The health care providers are financed in practice in two ways:

- Through providing the types of personal and public health care which are then compensated from the statutory health insurance fund,¹⁶³ state or local municipalities' budgets or special budgetary programmes;
- Through providing the types of personal and public health care where the recipient (private person or company) is paying directly.

Both publicly owned and private entities in the healthcare sector can be paid from the statutory health insurance fund. This has enabled the development of private providers in the health care sector.

Organisational structure and management

The publicly owned health care institutions are run by local authorities, counties (apskritis) or the Ministry of Health.

All health care services are organised at three levels:

- Primary care, which is primarily the responsibility of local authorities. The patient accesses the primary care through the family doctor who decides on the level and type of health care required and whether further specialists need to be seen. Individuals have a legal right to choose the family doctor closest to his/her place of residence. Family doctors' services are paid for by the regional patients' funds. Recently, the number of private primary care providers has been increasing. Their services are compensated by the regional patients' funds, and hence the individual does not pay at the point of use.
- Secondary, where the responsibilities are divided between local authorities and counties.
- Tertiary, where the primary responsibility is divided between counties and the ministry of health.

The main responsibilities at the national government, regional (county) administration and local authority level are as follows:

- The national government provides the legal framework and determines the implementation mechanisms in the health care system.
- The Ministry of Health establishes, restructures and closes down those health care institutions for which it is directly responsible. It undertakes global and strategic analysis of the health and health care situation to determine the main directions of health care policy. It also prepares and implements special

¹⁶³ The following health care services are covered by the statutory health insurance:

- Preventative medical help,
- Medical help,
- Medical rehabilitation,
- Nursing,
- Diagnosing the state of personal health,
- Compensating for certain drugs.

state health programmes. In co-operation with local authorities, it develops the main directions for the development of primary health care. The Ministry is also responsible for the accreditation of health care providers and oversees the activities of health care providers.

- The regional (county, apskritis) administrations are responsible for implementing the strategic health care system documents in the region, can establish, restructure or close the secondary level health care providers and oversees their activities. They are also responsible for construction and maintenance of the buildings of the secondary health care providers.
- The local authorities are responsible for developing and implementing the programme to develop the primary health care level, agreeing, implementing and monitoring the implementation of the local authority budget for healthcare, establishing, restructuring and closing the primary health care providers and is responsible for construction and maintenance of the buildings of the primary health care providers.

Providers

In 2006, there were 2,931 health care providers in Lithuania.¹⁶⁴ 50% of these were publicly owned and managed (by the Ministry of Health, counties and local authorities) and 50% of the health care providers were private. However, 60% of private health care providers were dentists. So, it can be concluded that the private health sector is heavily concentrated in provision of dentistry services.

The public hospitals account for 90% of all hospitals. There are only 14 private hospitals and 158 hospitals are in the public sector. Out of all public hospitals, 65% are legally autonomous and manage their own budget. There are four types of hospitals in Lithuania:

- 67 general hospitals,
- 58 nursing hospitals,
- 29 specialised hospitals,
- 4 rehabilitation hospitals.

Key aspects of reform in the last five years

The main drivers of the reforms have been attempts to:

- increase the effectiveness and quality in health care,
- restructure the network of providers and structure of services provided to ensure they respond to demand and meet quality requirements, especially in rural communities,
- reduce the queues of patients at health care providers,
- encourage private activity in health care.

Statutory health insurance system was introduced in 1997.

The Strategy of Reorganization of Health Care Institutions was adopted in 2003. It stresses the further development of primary health care and optimising inpatient services by reducing the average length of stay, increasing bed occupancy rate and reducing admission rate. In 2003-2005, 22 hospitals have been reorganised, the number of beds reduced by 20%, and the patient is staying 2 days shorter in the hospitals overall. The out-patient care increased by

¹⁶⁴ Lietuvos sveikatos informacijos centras (Lithuanian health information centre), www.lsic.lt

6%, the in-patient care decreased by 8%, and nursing volumes increased by 15%. The cost savings amounted to 154 million litas which was redeployed in the health care system.

In the next stage, the main aims of the reform are to further increase the share of private health care providers, improve the structure of in-patient care and prepare models for differentiated hospitals, improve the quality and timeliness of services, increase the prices for services, increase the take-up of voluntary health insurance and improve the training and qualifications of medical personnel. The main targets until 2015 are to ensure that the private financing of health care system does not exceed 30%, the growth of public expenditure on health equals the GDP growth, the salaries for medical personnel grow by no less than 5 times and exceed the growth of average salaries.

Outline of system of industrial relations

A new system of social partner organisations and industrial relations has been forming in Lithuania since its independence in 1990. The development of the system has been marred by a perception of trade unions, collective labour relations and involvement of employees in business management as part of the former socialist system, and thus unsuitable for the newly independent country.¹⁶⁵ Some 'old' trade unions have survived and reformed to a large extent to adapt to a present situation of capitalist economy. The establishment of employers organisations was mainly driven by the need of employers to represent their business interests, with the government, rather than trade unions, seen as the key partner. To some extent, employer organisations tend not to regard the trade unions as equal partners. The situation is different in the public sector, including the healthcare sector, where strong trade unions have traditionally existed.

Trade union and employer organisation rate

Lithuania has a low density of trade union membership, with only 14% of the workforce belonging to a trade union (EU25 average is 25%).¹⁶⁶ The number of people belonging to a trade union is 200,000, which is 7% of adult population. Employer organisation density is also low, with 20% of employers belonging to an employer organisation (EU25 average is 58%). Only 23% of establishments have workforce representation, compared to 53% in the EU25. Collective bargaining processes cover 15% of the workforce, compared to 66% in the EU25.

It is also noteworthy that all trade unions report a decreasing membership trend since 2000.¹⁶⁷

Main actors

Industrial relations are characterised by a pluralistic system of competing associations. There are three competing trade union confederations:

- Lithuanian Trade Unions Confederation has about 60% of union members and 25 affiliate sectoral organisations,
- Solidarumas represents about 25% of union members,
- Lithuanian Labour Federation is the smallest confederation and represents around 10% of unionised workers.

The two employer confederations are:

¹⁶⁵ Blaziene, I. (2005) Social Dialogue capacity Building in Lithuania: Approach of trade unions and employers organisations, Workshop on social dialogue capacity building for the new EU member states.

¹⁶⁶ EIRO Industrial Relations Profile: Lithuania.

¹⁶⁷ Blaziene, I (2006). Social Dialogue Capacity Building at Sectoral and Company Level in Lithuania. EIRO.

- The Confederation of Lithuanian Industrialists, established in 1993 to represent the interests of companies and employers and is an umbrella organisation with 38 branch and 8 regional associations.
- The Lithuanian Business Employers Confederation was formed in 1999 from a merger of two employer organisations. It is the biggest confederation with more than 3,000 employees, of which 80% are small businesses.

Level of bargaining

Wage bargaining takes place only at company level (several large companies which have near monopoly in their sectors have collective agreements on wages). Because the company is the key level for collective agreements, workforce representation is very important. However, the workforce representation through local trade union organisations is very low (23%).

According to some estimates, there could be about 1,000-1,500 company level collective agreements currently valid in Lithuania.¹⁶⁸ However, the coverage of such agreements is not wide, at around 10-15% of the total number of employees in Lithuania. Social dialogue and collective agreements take place mostly in big Lithuanian companies. However, the lack of statistical information on the level and coverage of collective agreements makes such estimates preliminary, and allows only to identify the tendency that the bigger the enterprise, the higher a probability of it having a collective agreement.

The government determines the statutory minimum wage on the recommendation of the Tripartite Council. Because the level of unionisation is weak, the statutory minimum wage often plays a decisive role in setting individual salaries.

So far there has been only one sectoral agreement in the private sector – agriculture, concluded in 2005. This agreement only sets general principles for wage setting, and it does not determine actual wages. In some public sectors (including health, also education) wages were increased several times following the demands of trade unions. But such increases can hardly be attributed to the processes of collective bargaining.

Weak sectoral social dialogue is attributable to weakness or even absence of suitable partners for discussions and negotiations. This view is shared by unions and employer organisations alike.¹⁶⁹ Problems reported within the structures of trade unions and employer organisations are the lack of personnel resources, including the lack of skilled personnel to undertake collective bargaining, the lack of financial resources and moderate organisational capacity to conclude sectoral collective agreements. The lack of financial resources is mainly due to the low membership fees (stemming from low average wage and competing trade unions) and inefficient use of membership fees whereby up to 80-90% of accumulated funds stay with local level organisations.

Policy development

At the national level social dialogue takes place in the Tripartite Council, established formally in 1995. The five partners – three trade union confederations and two employer confederations – are represented in the Tripartite Council. It is required to operate by consensus. If no consensus is reached, the decisions are usually postponed.

¹⁶⁸ Blaziene, I (2006). Social Dialogue Capacity Building at Sectoral and Company Level in Lithuania. EIRO.

¹⁶⁹ Blaziene, I (2006). Social Dialogue Capacity Building at Sectoral and Company Level in Lithuania. EIRO.

Social partner organisations in the hospital sector

Trade unions

Trade unions in the health sector look after interests of different professional groups within the health profession and often focus on different issues key to their members. For example, the Lithuanian healthcare workers trade union is focussed on the issue of wages and pay, whereas another trade union, for the Lithuanian nursing specialists organisation a key priority is the issue of increasing the levels of qualifications of nurses.

The main trade unions in the healthcare sector in Lithuania are:

- Lithuanian healthcare workers trade union (LSADPS),¹⁷⁰ established in 1991, consisting of around 4,500 members (probably around 6% of the overall healthcare workforce), covering all types of workers in a healthcare institution. It has 41 primary organisations in the workplaces across Lithuania. It is a member of the Lithuanian trade unions confederation, Baltic association of public service unions, and EPSU.
- Lithuanian Trade Union Federation of Public Services (LVPF) has a total of 3350 members. LVPF is a member of EPSU.
- Lithuanian hospital managers union¹⁷¹ comprises 92 healthcare institutions and their managers, which is around 50% of all hospitals in the country. It also has 50 associated members, who can be members without managerial responsibilities for a healthcare institution. The Union has been established in 1991. It is a member of the European association of health managers (EAHM).
- Lithuanian doctors union¹⁷² has been established in 1989. It covers around 80% of doctors in Lithuania. It is a member of CPME (Standing Committee of European Doctors). Its main priorities are to protect social, economic and professional rights of its members, negotiate and manage collective agreements, increase the level of knowledge and qualifications of doctors through organising courses, seminars, conferences, publications and deal with the questions of professional ethics.

Other trade unions and professional organisations active in the healthcare field include:

- Lithuanian medical workers trade union,
- Lithuanian healthcare institutions administrators trade union,
- Lithuanian national healthcare institutions managers association,
- Lithuanian nursing managers union,
- Lithuanian nursing specialist union,
- Lithuanian odontologists' association,
- Lithuanian general care doctors association,
- Private healthcare providers association,
- Lithuanian Work Federation's Medical Workers Federation,

¹⁷⁰ <http://www.abc.lt/LSADPS/>

¹⁷¹ <http://www.lgvs.lt/>

¹⁷² <http://www.lgs.lt/>

- Lithuanian hospitals association,
- Lithuanian forensic psychiatrists' association,
- National medical workers association.

There is also a plethora of specific professional organisations in the healthcare sector, such as the union of cardiologists, neurosurgeons, eye doctors, dieticians, psychiatrists, and others.¹⁷³

A high number of organisations in the healthcare sector is partly due to the newness of industrial relations system since 1990, when new trade union organisations have been appearing on a constant basis, sometimes in response to issues arising in a specific workplace.

Employers

The absence of partner for collective bargaining in the public sector overall is a very important part of the industrial relations landscape in Lithuania. This is partly due to the fact that the legal system does not lay down clearly who is the employer in the healthcare sector.

None of two main employer organisations of the private sector (described in section 1.4.2) has a sectoral affiliate or member organisation in the health sector. In fact, it is the state which is considered to be the main employer in the health sector, setting the framework for wages and conditions for work. Although in theory the state as an employer should be a more favourable partner for industrial relations, in the majority of state-owned enterprises, including those in the health sector, the state could do more to become a full partner in bilateral negotiations and take on the role of employer in collective bargaining.¹⁷⁴

However, some of the organisations discussed above in section 1.5.1 could be considered to be healthcare 'employer' organisations. These are, for example:

- Lithuanian hospital managers union,
- Lithuanian healthcare institutions administrators trade union,
- Lithuanian national healthcare institutions managers association,
- Private healthcare providers association,
- Lithuanian hospitals association.

It is however more the case that these organisations work together with more traditional trade union type organisations to negotiate working conditions and wage framework with the state.

Structure of collective bargaining and social dialogue in the hospital sector

Background information

Collective agreements at the workplace level are not signed in all healthcare workplaces. It is estimated that around 50-60% of workplaces in the healthcare sector have collective agreements in place. The negotiations are usually extensive and difficult. This is perceived as a major area for improvement by trade unions and professional organisations, including negotiating collective agreements at a sectoral level.

¹⁷³ A full list can be accessed at http://www.sam.lt/lt/main/tarptautinis_bendrad/lietuvos_organizacij/visuomenines_organiz/mediku_organizacijos

¹⁷⁴ Blaziene, I. (2005) Social Dialogue capacity Building in Lithuania: Approach of trade unions and employers organisations, Workshop on social dialogue capacity building for the new EU member states.

In practice, wages of healthcare workers are determined in the state budget, which assigns healthcare funds. A healthcare provider operates with an annual budget, and together with the body responsible for establishing and overseeing the provider (which can be the Ministry of Health, country administration or local municipality) determines the budget proportion allocated to wages. This is usually around 50% of the overall annual budget.

Key sectoral agreement in 2005

As discussed above in section 1.5, the legal system does not determine and determine clearly the employer in the healthcare sector. Private activity is mainly concentrated in the dentistry profession. Hence, it is perceived that the state should be recognised as the main employer in the healthcare sector, and thus assume the responsibilities of employer.

A body to co-ordinate the activities professional and trade union organisations in the healthcare sector was established in 1992. In 1994 there was a co-operation agreement signed with the Ministry of Health which foreseen activities to co-operate and exchange information.

A major development in the social dialogue in the healthcare sector took place in 2004 when the main trade unions decided to limit their requirements and concentrate on the issue of wages. This was done in the context of cuts in the healthcare budget, which occurred against the rising GDP. The trade unions presented a four-year wage increase framework and there were threats of strike. A working group was formed by the Prime Minister, including all the main trade unions, Parliament, minister of health and other ministry representatives, to negotiate wages and workloads. It was not possible to reach an agreement on workloads, but in 2005 an agreement was reached on wages. It was agreed to increase wages over a four year period, and in the Lithuanian context the increases were significant. For example, in the first year wages were increased across the board by around 30%. This year, 2007, the wages are again expected to increase by around 20-30%. It is planned that by 2008 the wages in the healthcare sector should exceed the average wage by 5 times.

The wage increases were tied with increased payments from the state budget for healthcare services provided by healthcare providers. However, if providers were not providing a certain level of services, such wage increases did not necessarily take place. Hence, the trade unions report that wage increases took place in a very differentiated way between different providers, resulting sometimes in wage differences of 2-3 times between different providers.

Key issues for the hospital sector and the sectoral labour market in particular

Key issues facing the healthcare sector are identified as following:

- Lack of collective agreements in all healthcare providers which would ensure a higher level of collective bargaining and social dialogue at the provider level, which would strengthen the basis for agreeing a collective agreement at a sectoral level in the future.
- Shortage of staff across all the professions in the healthcare sector, including lower-qualified workers, arising from low wages and high level of external migration from the country.
- Continuing lack of funding and prioritisation of healthcare reform and expenditure in the state budget which means the lack of funds to ensure decent wages for healthcare professionals and good quality of health services provided to the patients. A contributing factor is a complicated system of funding the healthcare sector from the state budget, consisting of several streams and funding sources. There is also a perception amongst the trade unions that the healthcare system is not really a public policy priority for the government.

- Ensuring open and honest competition between private and public healthcare providers is an issue in the sense at the moment the competition is somewhat distorted. Public providers have some privileges which are not available to private providers, and vice versa. For example, private healthcare providers can charge an additional amount for services they provide, which is not an option available to public healthcare providers.

LUXEMBOURG

Economic and labour market context

Luxembourg GDP is more than double the European average. In 2007 GDP growth was 4.5%.¹⁷⁵ Growth in the economy over the past 15 years is reflected in the growth of employment. Overall employment rate was 5% in 2005 (73.3 for men and 53.7 for women).

Almost 40% of the working population of Luxembourg nationality works in the public or semi-public sector (e.g. education).

Unemployment rate has for a long time been marginal. Unemployment has recently increased slightly, to 4.5% in 2005. It goes down to 3.5 for men and reaches 5.9 for women.¹⁷⁶

Employment trends in hospital sector

According to Eurostat data (2005), employees in the health and social sector represent 10% of total workforce (all NACE branches).¹⁷⁷ This percentage increased over time: it was only 4% in 1992 and 8% in 2000.

The number of physicians, specialists and dentists per 1000 population increased during the 1980s and 1990s but remained below the numbers in other EU countries. In 2002 there were 2.6 physicians and 7.8 nurses per 1000 population. The number of doctors practising in Luxembourg will probably continue to increase for the foreseeable future, because the country has an attractive remuneration and licensing system and, since European Union legislation introduced the mutual recognition of medical qualifications, there has been no legal means to restrict the influx of medical personnel.¹⁷⁸

The vast majority of employees in the health and social sector are women (76%), and in the age group 25-49 (74%). Employees above 50 years old represent 16% of the total.¹⁷⁹

¹⁷⁵ Key employment indicators

http://ec.europa.eu/employment_social/employment_analysis/eie/eie2006_annex_en.pdf

¹⁷⁶ OECD Statistical Profile of Luxembourg

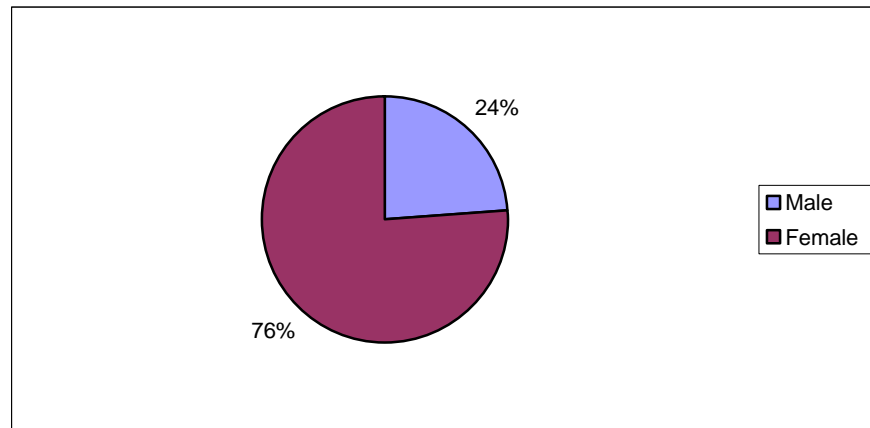
<http://stats.oecd.org/wbos/viewhtml.aspx?queryname=323&querytype=view&lang=en>

¹⁷⁷ Classification of economic activities - NACE

¹⁷⁸ Snapshots of health systems, World Health Organization 2005, on behalf of the European Observatory on Health Systems and Policies, <http://www.euro.who.int/document/e87303.pdf>

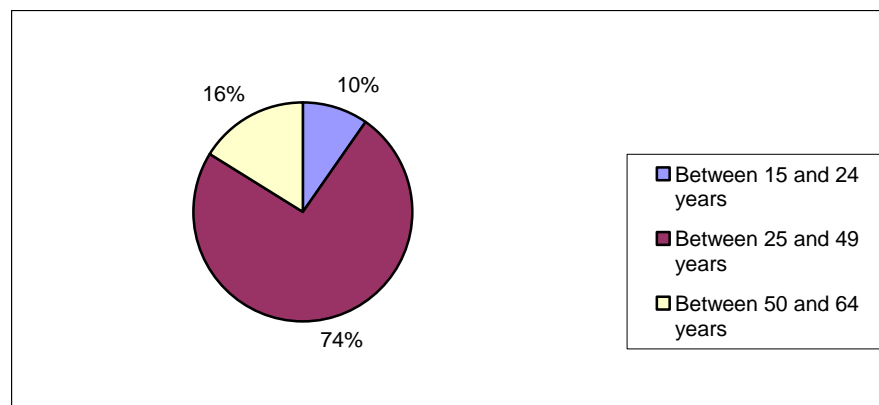
¹⁷⁹ Eurostat: Labour Force Survey 2005 (Employees by sex, age groups and economic activity)

Figure 4 Employees in health and social sector broken down by sex – Luxembourg 2005



Source: Eurostat

Figure 5 Employees by age groups in Health and social sector in Luxembourg–2005



Source: Eurostat

Structure and organisation of hospital sector and key recent reforms

Luxembourg’s health care system is based on three fundamental principles: compulsory health insurance, patients’ free choice of provider and compulsory provider compliance with the fixed set of fees for services.¹⁸⁰

Funding and expenditure

Similar to its neighbouring countries (Belgium, France and Germany) Luxembourg’s health care system is mainly publicly financed through social health insurance. In 2000 total health expenditure was funded by statutory insurance (72.7%), taxes (15.1%), out-of-pocket payments (7.7%) and voluntary health insurance (1.6%).

Total health expenditure was estimated to be 6.2% of gross domestic product (GDP) in 2002, the lowest share in the EU-15. Public sources were estimated to account for 86%. In the

¹⁸⁰ European Observatory on Health Systems and Policies: *Health Care Systems in Transition: Luxembourg*, 1999 <http://www.euro.who.int/document/e67498.pdf>

same year, health care expenditure per capita calculated in US\$ PPP (purchasing power parity in US dollars) was US\$ 3065, the highest figure in the EU-15. This apparent contradiction can be explained by two factors:

- per capita expenditure calculations are based on the resident population which can be misleading since 25% of Luxembourg's insured workers are commuters from neighbouring countries; and
- Luxembourg's per capita GDP is the highest in the EU.

Luxembourg is very small so few resource allocation decisions are delegated to local authorities. The exceptions are hospital budgets that are negotiated between individual hospital administrative boards and the Union of Sickness Funds.

The standard contribution level is set by the Union of Sickness Funds that manages and provides statutory health insurance for 99% of the population. Civil servants and employees of European and international institutions have their own health insurance funds.¹⁸¹

Statutory and voluntary health insurance

Health care services are financed by the statutory health insurance system which covers 99% of the population. The health insurance has three sources of finance: contributions from the state (a maximum of 40% of the total), from employers (about 30% of the total) and from insured individuals (about 30%).

Voluntary health insurance has always played a limited role in Luxembourg. Nevertheless, approximately 75% of the population purchases complementary health insurance coverage, mostly to pay for services that are categorized as non-essential under the compulsory schemes. The main Luxembourg-based voluntary health insurance scheme is the Caisse Médico-Chirurgicale Mutualiste or "CMCM".¹⁸²

Hospitals financing

The 1992 Act introduced a new financing system for hospitals: instead of the previous uniform per diem payment system, which encouraged spiralling hospital costs, each hospital was to negotiate its own individual budget directly with the Union of Sickness Funds.

The financing of hospitals is drawn from two sources:

1. Each hospital negotiates its operating budget with the Union of Sickness Funds, without the direct interference of the state.
2. Major investment costs for construction and equipment are financed by the state at a rate of 80%. Significant new equipment has to be authorized by the Minister of Health.

Hospitals receive three categories of payments:

- Non-activity-related (hospital maintenance) payments, paid each month: this pays for the cost of keeping the hospital ready to treat patients;
- Activity-related payments, paid according to units of activity accomplished and documented in invoices presented by the hospital to the sickness funds. To be reimbursed, a hospital has to establish an individual bill for each patient;

¹⁸¹ Snapshots of health systems, World Health Organization 2005, on behalf of the European Observatory on Health Systems and Policies <http://www.euro.who.int/document/e87303.pdf>

¹⁸² European Observatory on Health Systems and Policies: *Health Care Systems in Transition: Luxembourg*, 1999 <http://www.euro.who.int/document/e67498.pdf>

- Bonuses of up to 2% of the total hospital budget, which are payable if the hospital follows a quality programme determined by the Union of Sickness Funds.

All requests for investments and authorizations, and all draft legislation related to the hospital sector, must be submitted to the 'Permanent Hospitals Committee'. This Committee is composed of representatives of the government, the Union of Sickness Funds, the Federation of Hospitals, the medical profession, and other health professions, and is chaired by the Director General of Health. The services of the Directorate of Health generally give technical advice to the Committee.¹⁸³

Organisational structure and management

For the most part, preventive services are the responsibility of the Ministry of Health; Curative treatment is a shared responsibility of the Ministry of Health and the Ministry of Social Security. Two sections of the Ministry of Social Security are responsible for the sickness insurance system.

The Minister of Health defines and implements health policy, prepares legislation, ensures the implementation of laws and regulations on health and health services and authorizes, supervises and funds public and private health institutions and services.

Hospitals are administered by boards of administrators, who are responsible for the general policy of the hospital. Hospitals are independent of the state although there may be representatives of the state on some boards.

Providers¹⁸⁴

Primary care

The supply of primary care in Luxembourg is dictated by demand, since patients have free choice of primary care provider and there is no legal means to limit the volume of medical activity. Primary health care in Luxembourg is provided mainly by general practitioners (GPs) who are self-employed and mostly work in single practices.

There is no distinction between doctors on the basis of whether they work from within hospitals or not. Doctors are paid on a fee-for-service basis.

Secondary and tertiary inpatient care

During the twentieth century, the total number of health care facilities has fallen due to ongoing rationalization and to the decline of certain facilities such as independent midwifery practices. Thus from 33 general and maternity hospitals/facilities and 2 psychiatric establishments in 1953, numbers have dropped to a total of 14 acute care hospitals.

On 1 January 2004 there were 14 acute care hospitals. One of these, specialized in maternity services, is run for profit. The remaining 13 are run by local authorities as well as not-for-profit and mainly religious organizations.

The hospital sector in Luxembourg is regulated by the law on hospitals of 28 August 1998. Numbers of hospitals and minimum standards for hospital services are planned via regulations (the so-called National Hospital Plans) enacted under this law.

¹⁸³ European Observatory on Health Systems and Policies: *Health Care Systems in Transition: Luxembourg*, 1999 <http://www.euro.who.int/document/e67498.pdf>

¹⁸⁴ *Health Care Systems in Transition: Luxembourg*, European Observatory on Health Care Systems 1999

Management structures differ almost between every hospital. All hospitals are run by Administrative Boards, which negotiate separately with the Union of Sickness Funds for their hospitals' annual budgets.

Reforms

Health care expenditure as a percentage of GDP has remained low over the past decades compared to other EU-15 states. The reforms of the 1980s and 1990s mostly focused on attaining financial stability for the sickness funds.

In 1995 a change in the payment system was introduced in response to spiralling hospital costs: a tariff scheme with annually negotiated global prospective budgets between the individual hospitals and the Union of Sickness Funds.

Recent reforms have tried to develop the sense that even in a rich country, the insured citizen and potential patient has a right to expect money to be spent in the most effective way.¹⁸⁵ Legislation clearly expresses the view that services charged to the health insurer should be what is most appropriate for patients' health conditions, and should be restricted to what is 'useful and necessary'. The objective is to prompt a change in attitudes and encourage a greater sense of personal responsibility for the health insurance system on the part of all involved both actively and passively, including prescribers and service providers, beneficiaries and underwriters.

The goal of transforming the principle of the 'useful and necessary' into tangible reality has led the quadripartite committee to propose the establishment of a board of scientific oversight. The concerted work of service providers, social partners and ministerial departments concerned within the four-party committee played an important role in implementing the medium and long-term strategy in the field of healthcare and health insurance.¹⁸⁶

Developments in the hospital sector¹⁸⁷

Given that there is currently little relevant information on medical activities in hospitals, additional analysis resources are being set up. Research needs to be carried out in a general context where the vast majority of doctors carry out their profession in a liberal manner within the hospital sector. Given the importance of hospital sector costs, the following measures are planned:

- In order to control increasing variable hospital expenses, the **Luxembourg Hospital Association** has been given the responsibility of setting up a purchasing unit so as to have the possibility of negotiating better prices and to bring a level of standardisation to the products used (medication, prosthesis, other consumables...).
- In order to analyse the real needs in terms of recruiting medical specialists and to regulate medical services in hospitals, statistical monitoring will be set up.
- In the absence of a hierarchy stemming from the liberal nature of medical practice and with the aim of bringing together the medical body and hospital management, the definition of the profile of a service coordinator doctor shall be set out.

¹⁸⁵ *Health Care Systems in Transition: Luxembourg*, European Observatory on Health Care Systems 1999

¹⁸⁶ MISSOC-INFO 02/2005 - Health care: User charges
http://ec.europa.eu/employment_social/missoc/2005/02/2005_02_lu_en.pdf

¹⁸⁷ MISSOC-INFO 01/2006 - Evolution of Social protection in 2005
http://ec.europa.eu/employment_social/missoc/2006/01/2006_01_lu_en.pdf

The conclusion to be drawn is that the factors contributing to maintaining the balance for 2006 come from, alongside the increase in contributions towards medical costs, legal and statutory measures concerning cash benefits introduced in 2005. Furthermore, certain other measures will encourage moderation in spending, notably measures taken for promoting a responsible prescription policy among doctors, a policy encouraging the use of generics as well as reduced costs for consumables expected as part of negotiating hospital budgets.

Outline of system of industrial relations¹⁸⁸

The 2004 law on collective labour relations, the regulation of collective labour disputes, and the National Conciliation Office (Office National de Conciliation, ONC) created a formalised system of collective bargaining. It requires any employer to enter into negotiations with a view to concluding a collective agreement when asked to do so by the relevant employee representatives. If an employer refuses or if, in the course of negotiations, the parties are unable to reach an agreement, the National Conciliation Service procedure must be initiated.

Main actors

Trade union

Trade union density is stable or has even increased. It was 45% in 1990 and 46% in 2004. Two trade union confederations are recognised as national representative unions and are mainly active in the private sector:

- The **Confederation of Independent Trade Unions** (OGB-L) is a group of 15 trade unions with a total of 50,000 members. While socialist in nature and orientation, the OGB-L is not organisationally attached to the Luxembourg Socialist Party.
- The **Confederation of Christian Unions in Luxembourg** (LCGB) represents 40,000 members. It groups 16 federations made up of 10 sector federations and six that organise specific target groups (for example, migrant workers and women).

In the public sector the CGFP (Confédération Générale de la Fonction Publique) is the most representative trade union.

According to the European Social Survey, workplace representation is high, with 58%. The central tool is the personnel delegation (délégation du personnel), which is directly elected by all employees. Companies with more than 150 workers have another type of works council, the joint company committee (comité mixte d'entreprise).

Employers

Organisational density is high on the employers' side, with an estimated 80% of companies being members of an employer organisation.¹⁸⁹

The principal confederation is the Union of Luxembourg Enterprises (UEL), representing all the private sector companies except those related to the primary sector. The Federation of Luxembourg Industrialists (FEDIL) represents companies from construction, manufacturing, and services.

Professional chambers

Chambers have the statutory right to be consulted by the public authorities on all social and economic issues affecting their members' interests. Six chambers were created in 1924:

¹⁸⁸ Luxembourg industrial relations profile, EIRO
<http://www.eurofound.europa.eu/eiro/country/Luxembourg.pdf>

¹⁸⁹ Year: 2003; Source: Visser, Industrial relations in Europe 2004

three for employers (Chamber of Commerce, Chamber of Artisans, and Chamber of Agriculture) and three for employees (Chamber of Labour, Chamber of White Collar Workers, and Chamber of Civil Servants).

Collective bargaining

There is no inter-sector level of collective bargaining. The two main bargaining levels are the **sector** and the **company** level. However, the Industrial Relations Act of 2004 makes cross-sector agreements possible. A first example has been an agreement on individual access to vocational training. Observers predict that other agreements will follow, not so much on wages, but on other topics. The incentive to bargain wages at a national central level is not high because there is still automatic indexation and a high minimum wage that was established by law after consultation by the social partners.

About **250–300 collective agreements** are currently in force, mainly at company level. Some 100 agreements are renewed each year. Collective agreements are, by law, supposed to contain provisions relating to company training policy and continuing training packages, but they rarely do.

Although collective agreements have, since 1999, been legally obliged to deal with the principle of equal treatment of men and women, none of these matters has been addressed in practice. By and large, the social partners have simply relied on legal provisions and formulated clauses setting out principles.

Wages, salaries, and certain social benefits are automatically adjusted to the cost of living.

Coverage rate

About 60% of employees have their terms and conditions of employment regulated by collective bargaining, which is rather low compared to other Western European countries.

Collective agreements have an erga omnes or 'towards all' effect. That is, if an employer is bound by an agreement, its provisions regulate the terms and conditions of the employment relationships of all the employees. There is also a process of extension of collective agreements on sectoral level. Such an agreement is generally binding on all employers and employees in the occupation or branch concerned. But because sectoral agreements are rare, a lot of employees, mainly in small firms, are excluded from collective bargaining.

Policy concertation

There is no cross-sector collective bargaining. Nevertheless, tripartite consultation is important in the consensus-seeking 'Luxembourg model' and depends on a large network of institutions. The two most important are:

- The **Economic and Social Council (ESC)** is the government's permanent consultative body for socioeconomic matters.
- The **Tripartite Coordination Committee** brings together representatives of employers, labour, and the public authorities. It is a consultation mechanism that systematically seeks consensual solutions for economic and social problems. The government participates directly in this committee.

Strike activity is very low partly because of the high wages. A complementary explanation can be found in the collective bargaining framework. Before industrial action can be taken, both employers and employees must have tried to negotiate a settlement. Employers must begin negotiations if asked to do so. Mediation by a **National Conciliation Office (ONC)** is mandatory in case of a breakdown in bargaining and must precede any industrial action.

Nevertheless, industrial action takes place from time to time. Pay was the cause of a number of disputes in 2004. For example, in the hospital sector, 2,000 employees of the Association of Luxembourg Hospitals (Entente des Hôpitaux Luxembourgeois, EHL) demonstrated to

underline a threat to go on strike over pay. One week later, the employers accepted a proposal from the ONC.

Social partners organisation in the hospital sector

Trade Unions

Confederation of Independent Trade Unions OGB-L (Confédération Syndicale indépendante du Luxembourg)

The Health and Social Sector trade union (Syndicat Santé, Services sociaux et éducatifs) is one of the 15 trade unions grouped in the Confederation OGB-L. It was founded in 1980.¹⁹⁰ At the European level OGB-L is a member of EPSU.

OGB-L Health and social sector is the main trade unions in the health and social sector, with more than 5,600 employees and public agents in this sector being members. It represents 75% of undertakings. Since November 2003 there has been a 12% increase in the number of members.

Employees in the health sector in Luxembourg do not belong to the civil service anymore; they have the status of employees.

OGB-L is the main interlocutor in the negotiation of collective agreements in the health and social sector. It is involved in collective bargaining with employers at the national level. Collective agreements include:

- Convention Collective de Travail des employés privés des établissements hospitaliers luxembourgeois (EHL)
- Convention Collective de Travail des employés privés du secteur d'aide et de soins et du secteur social (SAS)
- Convention Collective de Travail des salariés du Centre Thermal et de Santé de Mondorf
- Convention Collective de Travail des salariés de la Transfusion Sanguine de la Croix-Rouge Luxembourgeoise

The first one, the collective agreement for employees in the hospital sector, is the most important.

Confederation Generale du Travail du Luxembourg, Secteur Public (CGT-L) has a total of 5888 members and is a member of EPSU.

Confederation of Christian Unions in Luxembourg (LCGB)

The «Confédération Luxembourgeoise des Syndicats Chrétiens» or «LCGB» is a trade union open to all employees. In the hospital sector they have around 1000 members. They are members of EPSU.

Employers

Entente des Hôpitaux Luxembourgeois:

The EHL represents the institutions of the health sector (hospitals and clinics) at management level. The aim of the EHL is to bring together hospital managers and to defend the interests of the hospital sector. It also provides a number of services such as industrial medicine. It

¹⁹⁰ http://www.ogb-l.lu/html_fr/qui/sante.html#Contact

represents a dozen of hospitals as well other institutions such as retirement homes. It is the only employer organisation for Luxembourg hospital and therefore covers 100% of hospitals. It is involved in collective bargaining with the trade unions to negotiate the 'Conventions Collective'.

At the international level, EHL is a member of HOPE (European Hospital and Healthcare Federation), AEDH (Association Européenne des Directeurs d'Hôpitaux), FIH (Fédération Internationale des Hôpitaux), ALASS (Association Latine d'Analyse des Systèmes de Santé) and GISEH (Gestion et Ingénierie des Systèmes Hospitaliers).

Structure of collective bargaining and social dialogue in the hospital sector

Collective bargaining

Terms and conditions for the hospital sector are set by the main collective agreements that are negotiated between trade unions and employers (bipartite negotiations) on a regular basis. Collective bargaining is thus characterised by the autonomy from the government. Collective bargaining takes place in the *Commission Paritaire*, with equal representation on both sides (trade unions and employers).

Collective agreements have a minimal duration of six months, and maximum three years. This means that collective bargaining takes place at least every three years. Collective conventions are regulated by the law on Collective Bargaining.

The key issues negotiated in collective bargaining are:

- wages and other salary issues (13th month);
- Working time organisation: i.e. reduction to 38 hours;
- Work/life balance: given that almost 80% of employees in the sector are women, these issues are increasingly important. The recent convention improved the rights of employees in the area of unpaid leave (for child care or other family members) and part-time work;
- Lifelong learning (formation professionnelle) and its financing system (co-gestion).

Collective bargaining between social partners is constrained by two factors:

- The collective agreements negotiated at the public sector level, in particular agreements on wages (hospital employees are not civil servants but the health sector is still a public sector financed entirely by the Sickness Fund). Wages are also determined by the 'point indiciaire' or automatic adjustment to inflation. The agreement negotiated for the civil service is then integrated and adapted to the hospital sector.
- The budget that has been allocated by the Sickness Fund prior to the collective bargaining process and that has to be taken into account when negotiating wage increases and other work conditions. Social partners have the obligation to inform the Sickness Fund about their plans before starting the negotiation process.

The last main Collective agreements in the hospital sector (EHL) or the Convention Collective de Travail des employés privés des établissements hospitaliers luxembourgeois was signed in January 2006 and will end in December 2007.

In 2006 the EHL, OGB-L and LCGB renewed the Convention Collective de Travail applying to employees in organisations members of the EHL. They discussed in particular the salary rise,

but also a better work organisation (time plan) to have a more effective planning of staff while ensuring a good work/life balance. Another key issue was to limit and better manage over-time which is very costly to hospitals and detrimental to employees.

Social dialogue

In addition to the Collective bargaining process described above, a more informal 'social dialogue' is taking place on a more regular basis. Collaborative work platforms are set up to reflect upon specific issues such as career development or on call shifts. These platforms have specific missions. They create a more favourable environment for industrial relations in preparing evolutions for the next round of collective bargaining.

Consultation on issues related to the hospital sector also takes place as an informal consultation process between social partners and government representatives. Trade unions meet the Minister of health at least two or three times a year.

In the employment sector in general, social dialogue also takes place in the consultation bodies set up between social partners and the government. Tripartite consultation is important in the consensus-seeking 'Luxembourg model' and depends on a large network of institutions. The two most important ones are the Economic and Social Council (ESC) – government's permanent consultative body for socioeconomic matters – and the Tripartite Coordination Committee.

Key issues for the hospital sector and the sectoral labour market

Pay was the cause of a number of disputes in 2004. For example, in the hospital sector, 2,000 employees of the Association of Luxembourg Hospitals (Entente des Hôpitaux Luxembourgeois, EHL) demonstrated to underline a threat to go on strike over pay. One week later, the employers accepted a proposal from the ONC.

According to a member of the OGB-L executive board, the main problems affecting the hospital sector in Luxembourg have been resolved thanks to the process of collective bargaining over the last 15 years. Progress has been made in a number of areas.

At the end of 80s one of the main problems was staff retention and there was a risk of staff shortage because of the high turnover: the average length of stay in the sector for an employee was seven years. The issue of staff retention was addressed through various collective agreements that resulted in a substantial improvement of work conditions in the sector. Between 1995 and 2005:

- Wages substantially increased (between 32 and 56%) thanks to the careers being re-valued (recognition of qualifications), the introduction of a 13th month and of a holidays 'bonus' (*pécule de vacances*).
- Working time was reduced of 5% (38 hours per week) while preserving salaries, working time was reorganised (e.g. 35 days annual leave and maximum working days per year).
- A system of part-time work and early retirement was created.
- Provisions were put in place to facilitate work/life balance such as the introduction of 'social' leave (*congé social*) and other forms of unpaid leave.
- Setting up of the co-financing for lifelong learning.

As a result, the turnover significantly decreased in the sector and the number of employees in the sector also increased substantially. Today, new issues are arising such as the ageing workforce and a better work/life balance.

According to the EHL, recruitment is still an issue. The situation in Luxembourg is particular due to the number of cross-border workers coming from France, Germany and Belgium, with an impact on the work condition and organisation. Medical staff coming from bordering countries benefit from a more practical training due to their higher level of qualifications (often 2 years of higher education). Discussions are under way with the Ministry of Education to modify the training of nurses and medical staff in Luxembourg (more practical oriented training and higher level of qualifications).

From January 2006 it was decided to introduce a system of reduced working time for employees over 50 years old. The operational details will be determined by the *Commission Paritaire*. The issue of senior workers is becoming increasingly important in the hospital sector in Luxembourg.

Budget issues are also increasingly important in the hospital sector, although so far core budgets (wages etc) have not been affected. But solutions to limit spending are being experimented. In order to control increasing variable hospital expenses, the EHL has been given the responsibility of setting up a purchasing unit so as to have the possibility of negotiating better prices and to bring a level of standardisation to the products used.

MALTA

Economic and labour market context

Possessing few indigenous raw materials and a very small domestic market, Malta has based its economic development on the promotion of tourism, accounting for roughly 30 per cent of GDP, and exports of manufactured goods, mainly semi-conductors, which account for some 75 per cent of total Maltese exports. Since the beginning of the 1990s, expansion in these activities has been the principal engine for strong growth in the Maltese economy.

The employment rate, especially female employment, remains significantly below the EU average. The unemployment rate on the other hand is still below the average for the EU. Following the September 11 attacks, the tourist industry has suffered some setbacks with tourist arrivals falling by 8 per cent since 2000. At the same time, the bursting of the high tech bubble dampened exports and private investments. These are the main reasons for the fall in employment on one hand and for the growth of unemployment on the other.

Figure 1 - Employment and unemployment rates in Malta and in the EU-25, 2000/2005

	Malta in 2000	Malta in 2005	EU-25 in 2005
Employment rate – total	54.2%	53.9%	63.8%
Employment rate – male	75.0%	73.8%	71.3%
Employment rate – female	33.1%	33.7%	56.3%
Unemployment rate – total	6.7%	7.3%	8.7%
Unemployment rate – male	6.4%	6.6%	7.9%
Unemployment rate – female	7.4%	8.8%	9.8%

Source: European Commission (2007) *Employment in Europe 2005*.

Employment trends in hospital sector

The health sector is one of the largest employers in Malta; the public sector alone employs over 6,000 workers. The Government health sector employees are part of the civil service.

The number of healthcare professionals has steadily increased. For example the number of doctors employed by public hospitals and clinics increased from 1,028 in 1995 to 1,114 in 2001. Statistics from Eurostat indicate that the health and social sector employment grew from 10,400 in 2000 to 11,500 in 2006.

Structure and organisation of hospital sector and key recent reforms

The Maltese health care system consists of a public health care system that covers all the population, supplemented by a private health care system that operates independently. The public health care system is publicly financed and is free at the point of use. It is currently in the process of being transformed from an integrated health care system to a contractual health care system.

*Organisational structure and management*¹⁹¹

The Ministry of Health acts both as a regulator and as a service provider for primary and secondary / tertiary care. The public health care system falls under the portfolio of the Minister of Health. The annual budget for public health care is determined through consultation between the Minister of Health and the Minister of Finance. It is then endorsed by the Parliament. The Minister also takes direction from the Cabinet on any major proposals for change.

¹⁹¹ Abela, A. et al (2003) Study on the Social Protection Systems in the 13 Applicant Countries; Malta.

The health care system has traditionally been highly centralised with nearly all decisions being taken at the level of the Ministry of Health. Since the early 1990s a planned process of decentralisation has gradually been taking place in order to reduce bureaucracy. It is also in line with a wider decentralisation process that has taken place in the Maltese public sector over the past decade. The decentralisation process has enabled a number of management decisions to be taken within the hospitals and health centres. However, the management system is still somewhat bureaucratic due to complex civil service procedures notably involving financial regulations and human resource management. Recently the Foundation for Medical Services, responsible for the construction and commissioning of the new Mater Dei Hospital, has also been given the mandate to eventually oversee the running of Malta's public hospitals through a system of autonomous agencies.

Health care delivery

The public health service provides primary care services through a number (8) of health centres situated in towns across the country. It has been estimated that around two-thirds of primary care is in the hands of private 'family doctors'.

The interface between primary and secondary care remains underdeveloped. Whilst specialists provide outreach clinics in the health centres, the communication and dialogue between general practitioners and specialists remains poor.

Secondary / tertiary health care within the public health care sector is provided in a number of public hospitals that together cater for the different health care needs. There are 6 state funded hospitals in Malta and 3 private hospitals. The private hospitals are considerably smaller than the public ones; less than 7 per cent of hospitals beds are in private hospitals.

There are no formal links between the public and private health care providers, neither at primary nor at secondary/tertiary level. However, a number of medical doctors and paramedical professionals working within the public health care system also work as private practitioners.

Health care expenditure

According to the Eurostat statistics the health care expenditure in Malta remains considerably below the EU average, though it is on the increase. In 1995 the health care expenditure stood at 4.2 per cent of GDP but rose by over a half percentage point in eight years reaching 4.8 per cent in 2003. Other statistics from Malta contradict the statistics of Eurostat and rate the expenditure at 9 per cent of GDP. The Ministry of Health also stated: *"total public health expenditure in PPP per capita went up by 42 per cent between 2000 and 2004. The expenditure on the health sector is rising at a faster rate than GDP."*

Reforms

In the past the health policy has been directed towards improving management systems and decentralising power. The focus of the National Strategy for Health and Long-term care adopted during 2006 lies in the effective management of the public health-care system in order to ensure health care provision in the future. The government has announced that it will manage the performance of the health sector more rigorously and create a dedicated funding stream for health and long-term care.

Outline of system of industrial relations

The framework for collective bargaining (Industrial Relations Act) has been in place since 1976, and the power of industrial relations was strengthened with implementation of the Employment and Industrial Relations Act in 2002.

Main actors

The General Workers' Union (GWU) is the largest trade union in Malta organising more than 54 per cent of all unionised workers in Malta, and 35 per cent of all employed people. It represents employees in various sectors of the Maltese public service namely: health employees in different grades, social welfare, public health employees, water services, customs, postal services, instructors, general service grades including administrators in the civil service, agricultural staff within the service, public works employees and the technical and industrial side of the public services.

The Confederation of Malta Trade Unions (CMTU) consolidates 10 independent unions representing 41.4 per cent of all union members.

There are five employer confederations in Malta: Federation of Industry (FOI), Malta Chamber of Commerce and Enterprise, Malta Employers' Association (MEA), Malta Hotels and Restaurants Association (MHRA), and Malta Chamber of Small and Medium Enterprises (GRTU)

Level of bargaining

Industrial relations at national level operate within a tripartite framework; there is no established mechanism for bipartite social dialogue at cross-sectoral or sectoral levels. Bipartite social dialogue takes place at company level and bargaining in large companies often substitutes for sectoral bargaining due to the size of the country. Collective agreements in the private sector are typically based upon the basic requirements set by the national legislation. Collective agreements for public sector workers have been concluded since 1998.

A tripartite Employment Relations Board (ERB) has a consultative function to government on a wide range of issues concerning labour legislation. After consultations with the ERB, the minimum conditions of employment including payment of wages and overtime rates, hours of work and holidays are established by the government at both the national and sectoral levels.

National level bargaining is on the increase with the establishment of the tripartite Malta Council for Economic and Social Development (MCESD). While the role of the council is generally an advisory and consultative one, discussions have sometimes led to agreements.

Coverage rate

About 63 per cent of all Maltese workers were trade union members in 2003. In the public sector, the unionisation rate stands at around 90 per cent.

About 45 per cent of employees in the manufacturing industry are covered by collective agreements, 23 per cent of service sector employees and 87 per cent of public sector employees. The coverage is estimated to be somewhere between 51 per cent and 60 per cent. The length of agreements is relatively long in Malta, with a general duration of 3 years, and the conditions negotiated cover all workers in the enterprise.

Policy concertation

National level tripartite bargaining has developed with the introduction of the Malta Council for Economic and Social Development (MCESD). There are also a number of other tripartite councils and committees across different policy fields.

Social partner organisations in the hospital sector

The Medical Association Malta (MAM) represents doctors working public and private hospitals and health clinics. The Association is a member of the Federation of Professional Associations and the Confederation of Malta Trade Unions (CMTU). It is also affiliated to World Medical Association (WMA), European Forum of Medical Associations & WHO (EFMA), Permanent Working Group of European Junior Doctors (PWG), European union of family doctors (UEMO) and Commonwealth Medical Association (CMA).

The General Workers Union (GWU) is the largest trade union in Malta with over 46,000 members, of which 5,047 work in the public sector. In the health sector it represents health assistants, care workers, assistant care workers, health assistants, care workers and assistant care workers. It is an important union in the health sector. It for example represents 447 nursing aides from a total of 600 nursing aides in the country. GWO is a member of EPSU.

The Union Haddiema Maghqudin (UHM) represents over 26,000 members. The share of health sector workers from all members is unknown, but it represents nurses, paramedical staff and care workers in state-run hospitals and health centres, care homes and private hospitals. UHM has been a full member of the International Federation of Employees in the Public Service (INFEDOP) since 1971. The Union is also affiliated to the European Organisation of Public Service Employees (EUROFEDOP).

The Malta Union of Midwives and Nurses (MUMN) has 1,255 members (nurses and midwives) from a total of 1,600 nurses and midwives registered in Malta. It therefore represents 78 per cent of the Maltese nursing and midwifery personnel.

The Malta Union of Professional Psychologists represents 60 psychologists in Malta.

There is no active employers' organisation in the Maltese health sector. The trade unions negotiate directly with the state - through the Ministry of Health and/or Management & Personnel Office – or with hospital managers.

Structure of collective bargaining and social dialogue in the hospital sector

Three different types of collective agreements affect workers in the Maltese hospital sector: collective agreements for public sector workers, health sector agreements and local (hospital specific) agreements. Agreements usually last several years, for example the latest public sector agreement is valid for 6 years. Other characteristics are relatively lengthy negotiation periods (up to 7-8 months) and a wide range of topics addressed by the negotiations (from wages, education and training to all the main terms and conditions of employment).

Collective agreements for public sector workers (civil service) cover a total of 30,000 state employees, including the healthcare personnel from public hospitals and health clinics. The first collective agreement for public service employees was signed in 1998. The latest agreement was signed in 2005 and it will be valid until 2010, with the option that after three years new clauses can be negotiated as long as new conditions do not have any financial impact. The latest agreement was signed by the government and four active trade unions in the health sector (Union Haddiema Maghqudin, the Malta Union of Professional Psychologists, the Malta Union of Midwives and Nurses and the General Workers' Union) and the Malta Union of Teachers. The agreement addressed both quantitative and qualitative elements of terms and conditions, in particular a range of provisions to ease employment in the public sector for working parents.

Collective agreements are also concluded for the health sector and/or for individual occupational groups within the health sector. Two agreements were signed in October / November 2007, which are expected to have a significant impact on the attractiveness of public hospitals and clinics as employers:

- On 25 October 2007, the government signed a memorandum of understanding with the Union Haddiema Maghqudin and an agreement with the Malta Union of Midwives and Nurses that will improve the working conditions, salaries and job status of various health professionals employed in the public sector. The Memorandum of understanding affects around 1,000 workers including health inspectors, pharmacists, ECG technicians, paramedics and scientific professionals. The agreement covers about 2,500 nurses and 100 midwives. The indirect aim of these agreements was to create incentives for public sector

healthcare professionals to stay employed in the public sector and to encourage health workers, who have been out of the labour market for a while, to return.

- On 1 November 2007, the government and the Medical Association of Malta signed an agreement that will bring a marked improvement to the working conditions of doctors in public hospitals and health clinics. This includes sharp pay rises as well as incentives for specialists and consultants to leave their private practices and to work solely for the state health service. This agreement is also expected to reduce labour migration and improve career progression prospects for specialists. Around 600 doctors and consultants will benefit from this agreement.

Local (hospital specific) agreements are also concluded in non-state hospitals. For example, the Union Haddiema Maghqudin (UHM) and the management of Zammit Clapp Hospital signed a new collective agreement for the staff at the hospital. The hospital is state-funded but managed autonomously. With the new agreement the employees will benefit from salary scales similar to those in the public service.

In addition to collective bargaining, the dialogue between the state and the trade unions is ongoing and intensive and it covers most areas of the health and personnel policy in the health sector. As an example, the Directorate Nursing Services at the Ministry of Health recently drafted a Strategy for Nurse and Midwifery Specialisation. The nursing union MUMN was consulted and it agreed with the strategy, and the strategy later also featured in collective negotiations.

Key issues for the hospital sector and the sectoral labour market

The Maltese health sector is undergoing an unprecedented wave of expansion and service development. The demand for health care is outpacing the supply of financial and human resources for a number of reasons. The aging population requires investment in health and long-term care services and the development of new medicines and technology fuels demand for new modalities with the health service. The opening of the market for human resources and services in the European Union has rendered further challenges, for example, as a consequence of labour migration.

These are some of the greatest challenges faced by the health sector in Malta. In the following sections we look at some more specific problems that the sector is facing in relation to human resources. We also seek to highlight the ways in which social dialogue in the sector is aiming to address these challenges.

Addressing labour migration of doctors

In comparison to opportunities abroad and wages in the private sector, employment in public hospitals has not been an attractive option for Maltese doctors. As wages have been significantly lower than in the private sector, many young doctors have opted to move abroad to work or work part / full time in private clinics and hospitals.

An agreement was signed between the state and the Medical Association of Malta on 1 November 2007 to improve wages, working conditions and attractiveness of the public healthcare sector to doctors (see below). The agreement affects 600 doctors in the country.

Example – addressing labour migration through collective bargaining

The Medical Association of Malta (MAM) and the government signed in early November 'a historic agreement' that brings a marked improvement in working conditions of doctors working in public hospitals and health centres. The aim of the agreement is to reduce labour migration, provide incentives for specialists to leave their private practice and work in the public sector full time, and improve career progression

prospects for specialists.

The president of the Medical Association of Malta stated that he is “*convinced that the medical brain drain afflicting the country will somewhat be quelled through the advantageous conditions proposed.*”

In practice the agreement guarantees following:

- Specialists and consultants will be able to choose to forfeit their private practice against a Lm 15,000 (EUR 34,940) pay rise by 2010 to Lm 28,000 (EUR 65,222). Those who choose to keep their private practice will be able to earn up to a maximum of Lm 24,173 (EUR 56,308) in 2011. This scheme will be offered on a voluntary basis but the unions and the government are confident that this will encourage more doctors to stay or work more hours in the public sector, and potentially even attract some Maltese doctors from abroad or from the private sector to work in public hospitals.
- In order to improve career progression for doctors, the state has agreed to offer specialisation courses – that are presently only available abroad – in Malta. ESF funding has been used to pilot some of these courses.

Shortage of nurses

According to information from the Malta Union of Midwives and Nurses there is a shortage of around 300 nurses in Malta. In recent years hospitals have had to recruit some nurses from abroad while the university has not accepted all eligible candidates on nursing courses due to budget restrictions. Trade unions have been opposed to this situation, subsequently some of these concerns were addressed during the latest bargaining round.

Example – collective agreement for nurses and other healthcare professionals

On 25 October 2007, the government signed a memorandum of understanding with the Union Haddiema Maghqudin and an agreement with the Malta Union of Midwives and Nurses that improves the working conditions, salaries and job status of various health professionals employed in the public sector. The agreement covers the following:

- A special maintenance grant is awarded for students enrolling on nursing courses. As a result the Institute of Health Care has already doubled its intake.
- Pay increases.
- The Ministry of Health agreed to improve the status of paramedics and at the end grant them a ‘warrant’.
- Nurses will also be granted a ‘warrant’, and a permission to work without supervision.

The President of the Malta Union of Midwives and Nurses announced that a substantial number of nurses (in the region of 30) have shown an interest in returning to work.

Addressing attractiveness of the sector and improving working conditions

The negotiations on the latest collective agreement for public sector workers included significant improvement on working conditions, particularly for working parents.

'Family measures' – collective agreement for public sector workers

The latest agreement includes, in addition to pay increases, significant improvements on working conditions:

- Working mothers can keep working on reduced hours until their children are 12 years old.
- More flexibility to the use of parental leave.
- Additional “career break” leave has been raised from three to five years.
- New avenues for flexitime work, job sharing and teleworking.
- Establishment of a Conciliation Board within the Civil Service.
- Public service employees are given a day of pre-retirement leave for every four days of unutilised sick leave – up to a maximum of seven days per year.

Managing generation change

In order to capitalise on the knowledge of experienced doctors, the latest collective agreement for doctors makes training allowances available to experienced consultants to give training to new doctors. In addition, a consultant will be appointed to a post five years before the previous consultant retires.

THE NETHERLANDS

Economic and labour market context

The Dutch economy has been growing by around 3-4% annually during the nineties and slowed down over the last few years. Since 1998, unemployment has been less than 5.0% of the labour force; in the late 1990s, inflation was around 2.0% and rose over the last few years. The Dutch joined the first wave of 11 EU countries, launching the Euro monetary system on 1 January 1999.

The general expectation is that the economy will continue to grow, and employment will rise while unemployment will decline¹⁹². The Public Employment Service foresees a shortage of high skilled employees by 2010 and an excess supply of low skilled employees.

Employment trends in hospital sector

In recent years, employment in the Dutch healthcare sector has increased. In 2002, the employment growth in the sector was 1.7%, whereas that in the total healthcare sector was 2.8%. The number of hospital employees has increased from 233,430 in 2002, to 239.400 in 2003 and 241.280 in 2004. It is expected that employment in the hospital sector will continue to rise in the following years.

	2000	2001	2002	2003	2004
Hospitals					
General hospitals	150.990	153.490	166.860	167.730	169.390
Specialist hospitals	5.780	5.270	5.530	6.050	6.110
University hospitals	50.720	54.920	54.830	58.590	58.720
Rehabilitation centres	6.610	6.300	6.210	7.030	7.060
Subtotal	214.100	219.980	233.430	239.400	241.280

Source: Arbeidsmarktinformatie Zorg en Welzijn – Database ‘Employment per branch’ (<http://www.azwinfo.nl/databank/dataframe3.php?tabel=0>)

In terms of the profiles of the hospital employees, the majority are part-time workers (77.3% in 2001) and women (77.2% in 2002)¹⁹³. A slight decrease of the number of full-time staff has been observed in recent years. “This agrees with the general development in the Netherlands: men and women are working fewer hours.” The fact that a large proportion of employees in the hospital sector are women who often wish to combine their work with childcare further explains the high level of part-time work in this sector. As an increasing number of future medical specialists are women, it is expected that this trend will be confirmed or strengthened in the next years.

¹⁹² Van der Windt, W. and Talma, H. (2006) *RegioMarge 2006: De arbeidsmarkt van verpleegkundigen, verzorgenden en sociaalagogen 2006-2010*, Utrecht: Prismant, pp. 1.

¹⁹³ Feijen, V. (2004) *Labour Market Developments in the Dutch Hospital Sector*, Utrecht: Sectorfondsen Zorg en Welzijn, pp. 5-6.

At the same time, it is expected that the labour market in the sector will remain tight. A recent report, *Labour Market Developments in the Dutch Hospital Sector* (Feijen 2004:5-6)¹⁹⁴, indicates that the Dutch healthcare sector is faced with a shortage of qualified personnel at certain levels and in certain regions. In the Netherlands, nurses and professional attendants (N&PA) are subdivided into five levels. Shortages are particularly noticeable at nursing level four. There is a tendency to work with people below the appropriate level.

For nurses at level five, on the other hand, there is a potential surplus. Expectations are that this surplus will soon move on (via training) to more medical positions in order to tackle the shortage of doctors. Level-five nurses could replace level-four nurses if the latter are in short supply.

In total, there were 62,000 nurses and personal attendants working in hospitals in 2002. Though the recent slackening of the labour market has solved the most pressing problems, it is expected that shortages will rise again when the economy recovers. Increase of health care demand, partly as a result of ageing of the Dutch population, combined with the ageing of the present workforce, will lead to additional demand for new personnel. The structural training capacity has to be adapted to meet the future demands.

Structure and organisation of hospital sector and key recent reforms

Until 2006, medical care in the Netherlands is largely funded by a system of public and private insurance schemes. This fragmentation ended on 1 January 2006 with the introduction of a single statutory health insurance regime which governs all residents of the Netherlands. The insurance system is divided into three compartments.

The first compartment is the statutory insurance which covers the entire population against the cost of prolonged nursing and care. This entitlement is covered under the Exceptional Medical Expenses Act (AWBZ).

The second compartment covers normal, necessary medical care with a view to cure. Under the Health Insurance Act everyone is required to take out insurance to cover this kind of care. Under the *third compartment*, everyone has the option to take out supplementary cover for types of care not covered by the Exceptional Medical Expenses Act or the Health Insurance Act.

The Health Insurance Act made it mandatory for everyone who resides in the Netherlands and/or pays payroll tax to take out health insurance. An insured person pays a nominal premium directly to the insurer, as well as an income related contribution. The latter is levied by the Inland Revenue. Employers are required to reimburse their employees in full for these contributions. Individuals drawing social benefits usually have their contributions reimbursed by the body which pays their benefits.

Care can be provided in kind or on the basis of reimbursement of fees paid.

Health expenditure

Health care expenditure, in US \$ purchasing power parity, has tripled since 1980. In 2002, it represented 9.1% of GDP, close to the average of the EU Member States before 1 May 2004. The public share of total expenditure has dropped to about 63% in recent years, from around 70% in the 1980s and early 1990s, a relatively low value in Europe.¹⁹⁵

¹⁹⁴ Feijen, V. (2004) *Labour Market Developments in the Dutch Hospital Sector*, Utrecht: Sectorfondsen Zorg en Welzijn.

¹⁹⁵ HIT Summary - Health Care Systems in Transition (2005), European Observatory on Health Systems and Policies.

Trends in health care expenditure in the Netherlands, 2001-2004				
	2001	2002	2003	2004
Total expenditure as share of GDP (%)	8.3	8.9	8.9	8.9
Public share of total expenditure on health care (%)	5.5	5.8	6.1	6.0
Private share of total expenditure on health care (%)	3.2	3.5	3.7	3.8

Source: WHO Regional Office for Europe health for all database (<http://data.euro.who.int/hfad/b/>)

Healthcare has five funding sources (2003 estimate, in thousands of millions of euros and in percentages):¹⁹⁶

- National Health Services: 15.6 billion euros (35%)
- AWBZ: 17.3 billion euros (40%)
- Private Health Insurance: 6.3 billion euros (14%)
- Government subsidies: 2.3 billion euros (5%)
- Other payments / own contributions: 2.7 billion euros (6%)¹⁹⁷

In the breakdown of the country's national health expenditure since 1998, hospitals accounted for a quarter of total expenditure, and expenditure on nursing homes, home care for the elderly and home care institutions is about 30% as well. In 2001, the hospital sector claimed 24.3% of health care expenditure (11.4 billion €). In 2002, this rose to 12.8 billion € or 24.4% of the total health care expenditure.

¹⁹⁶ Feijen, V. (2004) *Labour Market Developments in the Dutch Hospital Sector*, Utrecht: Sectorfondsen Zorg en Welzijn, pp.14.

¹⁹⁷ den Exter, A., Hermans, H., Dosljak, M. and Busse, R. (2004) *Health Care Systems in Transition*, The European Observatory on Health Systems and Policies, pp. 60-62.

Funding hospital care

Four parties play central roles in funding hospital care: the Ministry of Health and Welfare (VWS), the Board of Healthcare Rates (CTG), the insurers and the hospitals. The Ministry of VWS established an annual budget for hospital care. The CTG, an independent, self-supporting administrative body, distributes this budget among the hospitals. The insurers enter into understandings with the hospitals concerning the amount of care that specific hospitals will deliver during the coming year. These agreements establish the number of care treatments and quality characteristics of the care to be supplied.

Governance – A Gradual Shift towards Decentralisation

In the Netherlands, policy traditionally has been prepared and implemented by a massive neocorporate bureaucracy, bringing together government agencies, quasi-governmental organizations (the advisory and executive agencies), the private national organizations of suppliers and providers, and the insurers. This national bureaucracy has developed a grip on the number and distribution of hospital beds and specialist places, and on investment decisions and management costs in health care.

Departing from this model of centralized steering, the 1986 coalition government started major reforms – mainly in the field of social health insurance. [...] Here a crucial element was the shift of the insurance risk from the public funding system towards the individual insurance plan. The credo of this shift was “less government, and more market”. More precisely, the shift of insurance risk involves a policy of transferring steering competencies from the collective sector to the private sector, such as the providers and insurance agencies. In the Netherlands, this policy of *delegation* is called “functional decentralization”; it has mainly occurred in the *cure*-sector – that is, acute care and both specialist and general medicine. Through negotiations and contracts, an increasing number of health insurers and providers have become more important participants in defining and interpreting health care, instead of the government and administrative agencies assuming these roles.

Apart from the shift from government to private enterprise, the Dutch health care system faces *devolution* or “territorial decentralization” – that is, a transfer of competencies from the central government to provincial and local governments. In health care, territorial decentralization has occurred in *care facilities*. Territorial decentralization in steering care facilities includes shifts in financing (such as involvement in project subsidies and reimbursement from general revenues) and planning of care. In the field of planning, an important example is the increased influence of local and provincial governments at the expense of other actors. Among other things, this shift in powers has manifested itself in the use of municipal committees for needs assessment (*gemeentelijke indicatiecommissies*, GIC). Due to a scarcity of facilities, care must be rationed, which has resulted in establishing and using independent integral needs assessment committees for an increasing number of facilities and disorders. Here, local governments play a major role, given the increasing number of regional assessment bodies – established by (collaborative) local governments.

Providers

Regular Dutch hospitals are not-for-profit institutions financed by VWS and income from agreements with care insurers. They hold permits based on the Hospital Provision Act. They work with rates based on the Healthcare Rates Act. For several years, however, the number of private clinics in the Netherlands has continued to grow. These clinics, which are polyclinic day-treatment centres, are partially funded by private resources. They can perform insured and non-insured treatment. Only in non-insured treatment or treatment in the context of ‘third component care’ are their prices not subject to government supervision and they therefore operate in the free market. Various conditions pertain to all other medical treatment, including the prohibition on working for profit. In 2002, there were approximately 100 private clinics in the Netherlands.

With the aim of increased marketing in the care sector and the transition to a supply-driven system, the Dutch government has provided several bills that will simplify the operation of private clinics. It should be possible, for instance, for private parties to make risk-bearing investments in care providers, to scrap rules per market segment, to free prices and to do away with the contract obligations of health insurers. Additionally, the government would like to remove barriers to care providers with offices in other EU or EER countries for providing care to people insured in the Netherlands.

Social partner organisations in the hospital sector

Employers' Organisations:

NVZ: Association of Hospitals organises 160 undertakings employing around 180000 workers.

VAZ: Association of Academic Hospitals

Trade unions:

ABVAKABO FNV: This is the largest employees' organisation in the healthcare sector, with 360,000 members in total and 20,400 members working in the hospital sector (figures date from April 2007). ABVAKABO FNV is a member of FNV, which represents employees in all healthcare and welfare sectors, such as hospitals, day nurseries, home care, nursing homes and homes for the elderly.

CNV Public Affairs: This is an employees' organisation with Christian affiliations. It has some 5,600 member and represents employees in the public sector. CNV Public Affairs is a member of CNV, which has a total of around 82,500 members.

Nieuwe Unie '91: This trade union particularly represents nurses and professional attendants. It is a relatively new trade union. It has 22,000 members.

Federation of Associations of Executive Personnel in healthcare and care for the elderly (FHZ)

Healthcare and Welfare Union: This trade union represents professionals as well as management and executive staff.

Other partners in the social dialogue include:

Government:

Ministry of Health, Welfare and Sports (VWS)

Ministry of Social Affairs and Employment (SZW)

Healthcare insurers: These implement most of the various legal regulations with respect to funding of healthcare. They collect insurance premiums and enter agreements with the institutions concerning the nature and scale of the healthcare to be provided.

The labour Foundation (STAR): In this organisation, employers, employees and the government consult with each other at national level on labour market policies and related subjects.

Structure of collective bargaining and social dialogue in the hospital sector

The wages and conditions for the staff of the hospital sector are determined at national level through bipartite and tripartite negotiations. Feijen (2004:8) explains that "Employers' and employees' organisations in the hospital sector negotiate with each other periodically and reach central understandings that apply to all hospital employees in the Netherlands. These understandings result in a Collective Labour Agreement. The understandings must of course comply with legal frameworks, within which both parties have considerable negotiating

leeway. An employer may only formally deviate from these understandings if explicitly permitted to do so by the Collective Labour Agreement.”

In the Netherlands, Collective Labour Agreements are negotiated for one to two years. The current Collective Labour Agreement runs from 2006 until 2008. The next one is to start from 1 February 2008. However, the preparations for this already commence before. In fact, already three quarters of key issues will have been decided upon before the parties sit together at the table to agree the next Collective Labour Agreement.

In terms of the content of the Collective Labour Agreements, the once concluded in 2004 contains arrangements regarding

- salaries
- holidays and leaves
- schemes for older employees
- pensions
- student nurses and apprentices
- multiple-choice terms of employment system
- Works Council elections
- day nurseries
- medical expenses

It has to be noted that in order to determine the wages of the staff in the hospital sector, the following process of collective bargaining takes place:

First stage: The government, upon consultation and discussion with the employers' organisations, decides upon the 'bandbreedte van de loonstijging', i.e. the percentage with which the labour costs are allowed to increase. By putting a cap on the rise in labour costs, the government hereby aims to reduce/ limit the costs of health care. The employers are allowed to increase the labour costs with a higher percentage than that set by the government, but then that increase will not be covered by the government.

Second stage: The three parties, i.e. employers' organisations, trade unions and government, negotiate (= collective bargaining) how this increase in labour costs will be distributed over:

- wages;
- pensions, holidays, etc.;
- working conditions;
- other issues.

Apart from regulating terms and conditions for employees, "social dialogue" between employer and trade union organisation in the sector also occurs in relation to other key issues affecting hospitals and the health care sector. In terms of the issues discussed, the ABVAKABO stated that the primary and secondary working conditions are the subject of social dialogue. "But in principle anything can be discussed and negotiated", such as the salaries of hospital directors. Recruitment abroad was mentioned as a recent topic for discussion. The trade union Nieuwe Unie' 91 referred to social dialogue on issues regarding human resources, such as training, staff retention, participation / consultation – ensuring that employees have a say in relation to the management of the company / firm, in relation to job content, etc. The employers' organisation NVZ Ziekenhuizen referred to issues relating

demand and supply on the labour market: recruitment; working conditions, safety, migration, etc.

There is a legal basis for negotiating Collective Labour Agreements, i.e. “de wet op de collectieve arbeidsovereenkomst (Wet CAO)”¹⁹⁸. This piece of legislation stipulates how a Collective Labour Agreement is to be negotiated. For example, it declares that social dialogue is to occur between trade unions and employers’ organisations. As not all employers are member of an employers’ organisation, the government is to decide whether the Collective Labour Agreement is binding to all employers or only to those who are member of an employers’ organisation (mentioned by ABVAKABO). The spokesperson of the employers’ organisation NVZ Ziekenhuizen emphasised that this law does not however make such Collective Labour Agreements obligatory.

Key issues for the hospital sector and the sectoral labour market in particular

The interviews unveiled a number of issues representing the key challenges for this sector.

Ageing

Several reports, such as Feijen (2004:14), make the argument that demographic developments have a major impact on the continuity of the care system. “In the Netherlands, population projects show an increase from 16.2 million in 2003 to 17.7 million by the year 2040. It is expected that, after this, there will be no further growth in population. Ageing is also increasing, from 14 % (people aged 65 or older as a percent of the total population) in 2003 to 23 % in 2040. This will have a significant effect on the affordability of social services. Currently, there are 22 people aged 65 or older for each 100 potential workers. In other words, ‘the greying factor’ is 22 %. In 2040, this factor will be 43%. Moreover, technological advances will enable people to live increasingly longer.

The consequences of these developments for the care sector are that an increasing number of older people will need care facilities; and that an increasingly smaller group of the population will have to bear the costs of this.” Seeking new measures that would enable the care system to remain affordable and to generate a sufficient workforce to meet the qualitative and quantitative demand for care is therefore a priority for the Dutch government and care sector.

All three interviewees identified the problem of the greying of society as a key challenge for the hospital sector and the sectoral labour market in particular.

The interviewee from NVZ Ziekenhuizen (employers’ organisation) claimed that the issue of ageing has been an important subject of the social dialogue between employers’ organisations and the trade unions in the hospital sector. Together they are seeking solutions to successfully bring the sector up-to-date or responsive to this changing situation. The fact that individuals are expected to work longer and retire at an older age is a sensitive and difficult topic to discuss. “You are touching people’s rights, rights which employees are often reluctant to let go.”

Both trade unions reiterated this issue. The interviewee from ABVAKABO argued that one of the biggest challenges for the three parties in the health sector is to render the sector attractive, in terms of working conditions and circumstances, to ensure sufficient personnel in the future within a tight labour market. The representative from Nieuwe Unie ’91 continued that the social dialogue on this issue is affected by ‘koud water vrees’ – fear of cold water. The representative explained that all parties involved – the employers’ organisations, the trade unions and the government – know what the problems consist of (e.g. demographic changes, aging population, labour shortages, the need to retain older workers), but avoid/ fear

¹⁹⁸ http://www.st-ab.nl/wetten/0647_Wet_op_de_collectieve_arbeidsovereenkomst_Wet_CAO.htm

the (drastic) measures that need to be taken to address the problems. However, the positive thing is that “we are sitting at the same table” and we are prepared to discuss these issues with the employers’ organisations”. Both parties are considering a range of measures to tackle the problems that the sector faces in terms of stimulating older employees to work longer, while ensuring better working conditions for them (e.g. additional training, more innovation).

Centralisation versus decentralisation

The three interviewees indicated that another key challenge for the hospital sector is the shift from centralisation to decentralisation, as described above.

While wages and working conditions are currently determined centrally through tripartite and bipartite negotiations, employers wish to move to a more decentralised system. The representative of the employers’ organisation argued that as hospitals expand in size, they want to have the space and legitimacy to decide upon courses of action locally or regionally rather than (necessarily) having to come to an agreement at the national level. As such, the employers’ organisations are in favour of reducing the frequency and the range of subjects of collective bargaining and social dialogue.

The trade unions, however, want to maintain the current level of collective bargaining - and the wages and working conditions that this bargaining has secured so far. The spokesperson of the trade union Nieuwe Unie '91 also expressed concern that such decentralisation would result in a division between top clinical hospitals and the others, with different employers’ organisations pursuing different working conditions with the trade unions.

In addition, the interviewee from ABVAKABO commented that with the new member states joining the EU and the lack or limited tradition of collective bargaining and social dialogue in these countries that this situation might be drawn upon by employers to argue for a decline in the level of collective bargaining and social dialogue.

Safety

The 2004 report states that the “healthcare sector is one in which there are high occupational health and safety risks and relatively high absenteeism.”¹⁹⁹ It refers to the Dutch Occupational Health Safety Act which went into force in 1998. This law creates a framework in which the social partners, the government and works councils can reach further understandings. As such, the Dutch government enters into occupational health and safety covenants with the social partners in certain sectors. The ultimate aim of such covenants is to reduce the number of employees exposed to certain work-related risks. This often takes the form of targeting a certain percentage.

“The emphasis in the occupational health and safety covenant for the hospital sector is on specific risks such as the pressures of work, physical stress, aggression and a feeling of insecurity, along with hazardous and allergen substances. [...] It includes an agreement to reduce the difference between the national absenteeism percentage and that in hospitals by 50%. [...] Complaints arising from aggression and a feeling of insecurity must decline by a minimum of 15%.”²⁰⁰

Securing the safety of those working in the hospital sector in particular and in the health sector in general is also a key topic of social dialogue, as was mentioned by the employers’ organisation NVZ Ziekenhuizen and the trade union Nieuwe Unie '91. The representative of

¹⁹⁹ Feijen, V. (2004) *Labour Market Developments in the Dutch Hospital Sector*, Utrecht: Sectorfondsen Zorg en Welzijn, pp. 11.

²⁰⁰ Feijen, V. (2004) *Labour Market Developments in the Dutch Hospital Sector*, Utrecht: Sectorfondsen Zorg en Welzijn, pp. 11.

the employers' organisation referred to a particularly successful project 'Veilige zorg' or 'Safe Healthcare Project'.

In the report 'Labour Market Developments in the Dutch Hospital Sector' (Feijen 2004: 12) this project is described as follows. The 'Safe Healthcare' plan, which aims to reduce aggression in hospitals, was originally set up by the West-Fries Hospital in Hoorn. Later, another 13 hospitals joined. "These hospitals conduct rigid policies against aggressive patients and visitors." Examples in relation to the measures that have been put in place are given, such as the staff using yellow and red cards to punish violent guests and refuse them admittance to the hospital for a period of three to six months. In addition, the participating hospitals seek to stimulate staff to report incidents by allowing them to mention the address of the hospital in the police report, so that perpetrators cannot discover the address of the person filing the report.

POLAND

Economic and labour market context

After weak results in the beginning of 2005 the Polish economy accelerated in the second half of the year, especially in the final quarter of the year, supported by the strong recovery in domestic demand. As a result, in 2005 as a whole GDP was 3.2% higher than a year earlier. The start of 2006 brought further intensification in the previous quarter's trends. As a result, the GDP reached 4.5% in 2006.

In 2005 the situation on the labour market improved significantly. Throughout the year employment rose and the unemployment rate fell in the final quarter of the year to 16.7%, its lowest level for five years. At the end of the year a strong acceleration in the rate of growth in wages was noted, and continued in the first months of 2006. An effect of low inflation is that growth rate in real wages will remain relatively high, however, wage pressures will be restricted by continuing high unemployment.

The employment rate (as % population aged 15-64) in 2005 was 52.8%. The total male employment amounted to 7,809,000 persons while the male employment rate (% population aged 15-64) was 58.9%. On the other side, the total female employment reached 6,306,000 persons and the female employment rate (% population aged 15-64) was 46.8% in 2005.

Since 1998, unemployment has been climbing and it has reached 17.8 % in November 2002. A strong factor behind the employment reduction was the restructuring of the state owned enterprises. This together with privatisation led to substantial shift in the employment structure – the private sector now accounts for over 73 % of total number of working people (including self-employed, on average in 2001) from 61 % in 1995.

The male unemployment rate (% labour force 15+) was 16.6% in 2004 while the female unemployment rate (% labour force 15+) reached 19.1%.

Employment trends in the hospital sector

The number of employed persons in the health and social work sector has decreased from 851,700 employees in 2002 to 706,800 2005. Among the 706,800 employed in 2005, 569217 were women.

Health personnel per 10 000 population, by type, 1990-2000

type	1990	1995	1999	2000
Physicians	21,4	23,2	22,6	22,0
Dentists	4,8	4,6	3,4	3,0
Pharmacists	4,0	5,0	5,7	5,7
Felzers	0,7	0,3	0,1	0,1
Nurses	54,4	54,8	51,0	49,1
Midwives	6,3	6,3	5,9	5,7

Source: GUS, Statistical Yearbook 2001, p. 262

Health personnel by type in absolute numbers, 1990-2000

Type	1990	1995	1999	2000
Physicians	81 641	89 421	87524	85 031
Dentists	18 205	17 805	13260	11 758
Pharmacists	15 110	19 447	21587	22 161
Felzers	2 710	1 315	501	374
Nurses	207 767	211 603	197153	189 632
Midwives	24 016	24 440	22683	21 997

Source: GUS, Statistical Yearbook 2001, p. 262

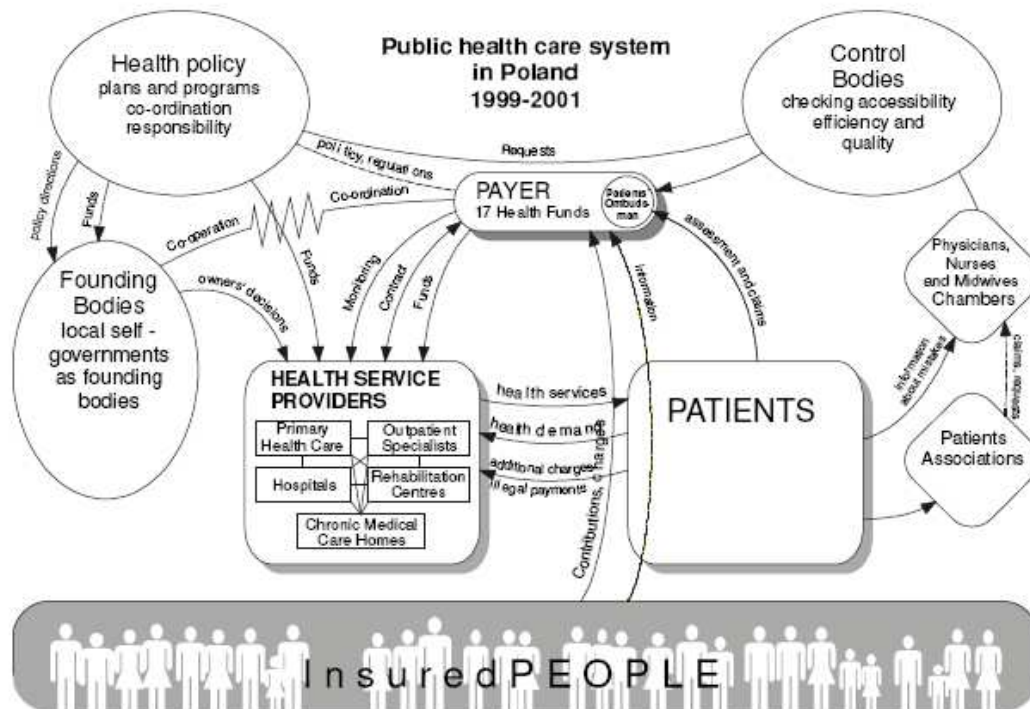
Structure and organisation of hospital sector and recent reforms

The stewardship, management and financing functions in the Polish health care system are divided between the Ministry of Health, the National Health Fund (NHF) and territorial self-government administrations.

The central government, represented by the Ministry of Health, is responsible for national health policy, major capital investments and medical science and education, with administrative responsibility only for those health care institutions that it directly finances. Medical academies, university hospitals and research institutes are semi-autonomous but are ultimately accountable to the Ministry of Health. The NHF, governed by 9 members of the fund council, finances the health services provided to insured persons from social contributions through its regional branches. The NHF contracts with service providers for the supply of health services.

Territorial self-governments are responsible for three domains: general strategy and planning based on the identified health needs in a given region, health promotion, and the management of public health care institutions. The local centres of Public Health fall under the voivodship self-government, county hospitals fall under the county level and the local authorities (gminas) are responsible for primary care services.

Organisation of Health Care System in Poland²⁰¹



The mainstays of the system of financing health care are universal health insurance institutions - sixteen regional and one branch sickness fund gathering first of all but not only professional soldiers, policemen and their families. 15 Sickness funds are independent of central authority quasi-fiscal institutions that operate on the principles of self-government and self financing. They are not profit-oriented, but they have to implement the standards of economy and goal-oriented activity. Their most important mission is to finance health services for patients insured in them. Sickness funds cannot, by law, manage their own health care institutions.

Health care expenditure

Until 1998, the public health care sector in Poland was financed from the state budget (mainly via the Ministry of Health and collective budgets of voivodas – the state administration bodies), and budgets of territorial self-governments (gminas). The financing system, including both its structure and sources, largely changed in 1999 when health and administration reforms were simultaneously initiated. In consequence, mandatory universal health insurance was introduced; the rate of insurance contributions and contribution payers were fixed, and 17 sickness funds were established. Sickness funds received financial resources mainly from health insurance contributions. These resources have become the major public source of health services financing. The state budget financing was limited only to targets of particular significance to the health care system. It should be noted that the range of these targets has been constantly modified since 1999.

The administrative reforms resulted in a new three-tier territorial division of the country based on gminas, counties and voivodships with territorial self government administration equipped with competencies and financial resources for health services. The first step away from a

²⁰¹ http://ec.europa.eu/employment_social/social_protection/docs/poland_final.pdf

centralized model was to increase the power of regional and local authorities by switching to local administration for most health care institutions. In consequence, in the period from 1999 to the first quarter of 2003, health services were financed from three main sources:

- sickness funds
- state budget
- self-government budgets.

Since 2003, the National Health Fund has taken over the sickness fund functions. Financial coverage of the costs of health services by sickness funds accounted for over 80% while the contribution of the state budget was limited to around 10%. Funds for health services were transferred from the state budget to local budgets, and there were also transfers between individual self government institutions at different levels. This mechanism has not changed since the introduction of the National Health Fund.

Departure from predominance of the state budget source of financing health care towards financial resources of sickness funds based on the universal health insurance contributions has not contributed to a considerable increase in public finances for health services.

In 1999–2000, public expenditure on health as a percentage of the gross national product (GNP) ranged slightly between less than 4.2% in 1998 to almost 4.5% in 1999. However, a slight decrease to 4.2% was again observed in 2002. In the years of high economic growth (1995–2000), a similar or even higher percentage was allocated from the state budget. In 2004, public expenditure on health care as a percentage of GNP exceeded 5% in the 15 EU Member States before May 2004 and a similar share was found in the majority of the new EU Member States since May 2004.

Public expenditure on health, 2000–2004, total amount, sources and percentage of gross national product (GNP)²⁰²

	2000	2001	2002	2003	2004
Total (PLN million)	27 586.9	30 605.5	327 757.7	33 313.6	34 937.7
of which:					
– Sickness funds (PLN million)	23 009.3	26 415.4	28 675.9	29 213.6	30 487.4
– (% of total)	83.4	86.3	8.7	87.7	87.3
– State budget ^a (PLN million)	3622.3	3266.1	3078.8	3146.1	3191.5
– Self-government budgets ^b (PLN million)	955.3	924.0	1021.0	953.9	1258.5
– Percentage of GNP	3.81	4.02	4.20	4.08	3.95
– Public expenditure on health (PLN per month per capita)	50.0	61.6	62.1	71.5	74.4

Source: Ministry of Health data (2005).

²⁰² Overall public expenditures were defined as the sum of the sickness funds' expenditures (financial adjustments excluded), expenditures from both the state budget and budgets of self-governments (after excluding funds flow from the state budget to self-governments as well as between them, and health insurance contributions together with the cost of health services for individuals not covered by the mandatory health insurance).

In 2002, total expenditure on health in Poland as a percentage of GDP only reached 6.1%, which is 2.6 percentage points lower than the EU average of 8.7%, and 0.3 percentage points below the average of new EU Member States.

Total expenditure on health care, 1995–2002, in US\$ PPP per single inhabitant in Poland and in selected European countries

	1995	1996	1997	1998	1999	2000	2001	2002	% Change 1995–2002
Czech Republic	876	910	914	918	932	977	1083	1118	28
France	2025	2091	2163	2231	2306	2416	2588	2736	35
Germany	2263	2410	2416	2470	2563	2640	2735	2817	24
Greece	1269	1317	1367	1428	1517	1617	1670	1814	43
Hungary	674	677	692	775	820	847	961	1079	60
Poland	423	491	505	563	571	578	629	654	55
Portugal	1080	1147	1219	1290	1424	1570	1662	1702	58
Slovakia	n.a.	n.a.	543	559	578	591	633	698	29 ^a
Spain	1195	1250	1287	1371	1467	1493	1567	1646	38
United Kingdom	1393	1461	1535	1607	1725	1839	2012	2160	55

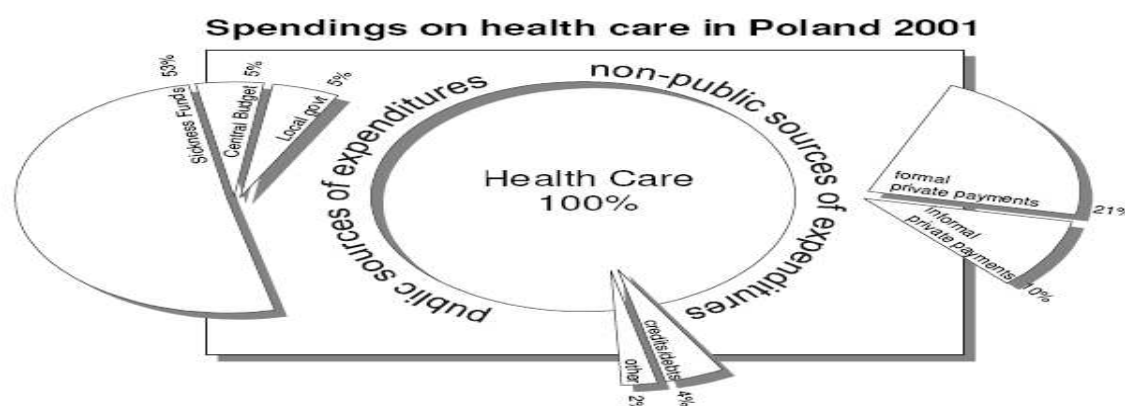
Source: OECD health data, 2004.

Note: ^a (1997–2002)

Private expenditure accounted for 28–30% of total expenditure on health care, thus Poland spends more on private health care than any other country in central and south-eastern Europe.

While public expenditure in health for Poland increased in nominal terms from US\$ 23.2 billion (1998) to US\$ 34.1 billion (2002), when taking inflation into account the increase in public health care expenditure has been very small, from US\$ 27 billion in 1999 to US\$ 28.7 billion in 2002 (1999 as base year), so the growth in health care expenditure has been mainly due to an increase in private expenditure for health.

Approximation of total spending on health care in Poland 2001²⁰³



²⁰³ http://ec.europa.eu/employment_social/social_protection/docs/poland_final.pdf

In 2003 there were 732 public hospitals and 72 non-governmental and private hospitals. Trends in the delivery of care include a decrease in the number of hospital beds from 6.6 per 1000 population in 1990 to 4.7 per 1000 population in 2002, and a decrease in the average number of hospital stays; this was accompanied by a significant increase in the number of hospitalizations from 120 per 1000 population in 1990 to 164 per 1000 population in 2001.

Primary health care

Primary care and family medicine are relatively new concepts in Poland and were relatively undervalued until 1991 when a strategy to improve the status and quality of primary care was developed under the name of “family medicine”. This was followed by the creation of the College of Family Physicians in Warsaw in 1992 and the introduction of postgraduate specialist training in family medicine. With 5.5 outpatient contacts per person per year in 2001, Poland’s outpatient services intensity was somewhat lower than the average of 6.2 for countries belonging to the EU prior to May 2004 and substantially lower than the average of new Member States with 8.3 outpatient contacts per person per year.

Secondary and tertiary care

In 2003 there were 732 public hospitals in Poland. Until 2005 hospitals were categorized by reference level. A new classification system is currently being developed. The first reference level hospitals are mainly established by county self-governments and provide services in internal medicine, surgery, obstetrics and gynaecology, and paediatrics. The second reference level hospitals, mostly established by voivodship self-governments, provide services in other specializations: cardiology, dermatology, oncology, urology and/or neurology. The third reference level hospitals, mostly clinical, university or ministerial hospitals, provide highly specialized medical care by top medical specialists, e.g. the National Institute of Cardiology, the Maria Skłodowska-Curie Memorial Cancer Centre and Institute of Oncology and the National Mother and Child Institute. The number of hospitals in private, confessional or NGO ownership in Poland is low. In 2003 there were 72 non-public hospitals in total.

In Poland, the emergency medical service has always been independent. Its organization is territory-based. A national network of 270 hospital emergency departments throughout the country is planned to be operational by the end of 2005.

Reforms and decentralisation of the healthcare system

The tendency to decentralise collective bargaining at the company or enterprise level is reported in almost all Member States. However, many different solutions are adopted in countries and the functions assigned to decentralised agreements are not a static feature, but something that can change rapidly. In **Poland** decentralisation coincided with the emergence of free trade unions – *Solidarnosc* in particular – agreements. Unions have recently requested to have wider control over decentralised bargaining.

Over the past seven years, the public healthcare system in Poland and its funding have been subject to radical change. Until 1999, healthcare services were controlled and funded by central government. On 1 January 1999, the centre-right government brought in the National Healthcare Insurance Act. This Act envisaged a shift from a centrally-controlled, budget-based system to a decentralised insurance-based system, operating through multiple regional funds and a special fund with nation-wide coverage (covering employees from the defense, interior, justice and railway sectors). At the same time, the government launched a reform of the local administration that resulted in the creation of 16 new and bigger regional administrations (voivodeships). With this decentralisation, the health insurance funds were placed at regional level and given autonomy. As a result, the conditions were set for private sector service provision: medical practitioners in private practices concluded contracts with

the regional health insurance funds - institutions based on the German model (and referring to Polish pre-War tradition) - to provide medical services funded by insurance contributions. This new health insurance system was oriented towards primary care services and thus strengthened the role of employer organisation of general practitioners (GPs) as gatekeepers. Specialist treatment is only provided on the basis of a referral from a GP.

The National Healthcare Insurance Act generated widespread criticism, as, for example, it did not cover secondary health provisions sufficiently. Most medical practitioners agreed that the reform required more consultation on their part. As the leftist opposition condemned the Act leading to the set-up of the health insurance funds, it was not surprising that, in autumn 2001, when they came to power, they announced further radical changes of the Polish healthcare system, including the closure of the health insurance funds. The funding of healthcare was centralised again. The National Health Fund (Narodowy Fundusz Zdrowia, NFZ) (close to the British model) was established at the beginning of 2003, and the independent health insurance funds were transformed into regional branches of the NFZ, reporting to it as well. It can be argued that the reorganisations of the healthcare system, which were implemented within such a short period of time, certainly did not improve its functioning.

Insufficient financial resources represented the main difficulty in changing the funding of the healthcare system in 1999. Furthermore, changing rates of health insurance contributions as well as discrepancy between the proposals on target rates weakened the financial support of the reformed healthcare service. The revenue from contributions, which originally amounted to 7.5% of a person's income, appeared to be insufficient (as health insurance funds pointed out), from 2001 onwards, the contributions were set to increase by 0.25 percentage points per year. In 2002, however, contributions remained the same, but raised again by 0.25 percentage points in 2003 (up to 8%), although this time contributions were not tax-deductible. Up to 2005, health insurance contributions gradually increased, reaching 8.5% of a person's income after the deduction of social insurance contributions.

Establishment of the Zielona Góra Agreement

The lack of financial resources led to unsatisfactory contract rates between primary healthcare providers and the NFZ. This became a characteristic feature of the healthcare system in Poland and subject of a prolonged dispute, flaring up anew each year, between the interested parties. In general, GPs claimed that the rates proposed by the NFZ were too low, and the conflict allowed for legitimised negotiation and became an instrument of financial management in the healthcare service.

The Federation of Health Protection Employer Unions (Federacja Związków Pracodawców Ochrony Zdrowia Porozumienie Zielonogórskie, PZ) is the result of an initiative by a group of GPs, aimed at creating a forum which would offer them support in contract negotiations with the NFZ. According to the signatories of the Zielona Góra Agreement, one of the reasons why they opted for this agreement was related to their worry that a centralised funding system of the healthcare service would negatively affect the position of practitioners from the provinces in their negotiations with the central office. Thus, the agreement was to play the role of a powerful lobby.

Current health policy reforms²⁰⁴ are primarily aimed at: tackling the demographic challenges of population ageing; reducing hospital debts; restructuring the health sector; introducing alternative sources of revenue for health care financing; and improving the control of rising health expenditures. A comprehensive health information technology programme on

²⁰⁴ <http://www.euro.who.int/Document/E88670.pdf>

a national scale is planned to better inform health policies with routine health services statistics.

Among the reforms discussed is the Law on Financing Health Services from Public Resources passed by the parliament in August 2004. Other policies discussed are looking at the ways to control pharmaceutical expenditures and to address the demographical challenges faced by the country. Examples of these reforms are the Insurance Law that mandates an increase in the health insurance contribution rate from 8.5% in 2005 to 9% in 2007, and changes to hospital restructuring, which will be looking at further developing rehabilitative care and strengthening the national networks of hospitals. New legislation aimed at tackling the challenges of increasing hospital debts is also examined, such as the Law on Public Help and Reorganization of Public Health Care Institutions and how it may impact on the current amount of debt accrued by hospitals.

Outline of system of industrial relations

In 2004, the total union membership was 1,900,000 or 6% of the adult population.

The (weighted) average employer rate of organisation is approximately 55 to 60% in the EU. In other words, on average a considerable majority of private sector employees in the EU-25 work in a company which is a member of an employers' organisation. A low density rate, compared to other EU Member States, is found in Poland, where employers' organisations density is only 20%.

Full freedom of collective bargaining is granted by the 1997 Polish constitution and followed by the 2000 substantial amendment of the Polish labour code.

The Minister of Labour may extend the application of supra-establishment collective agreement to employees to whom no agreement applies, when the overriding social interest so requires, upon the demand of an appropriate trade union or employers' organisation. However, the practice of generalising the binding power of branch agreements has not occurred so far. Reservations to this procedure are presented by some social partners and by a part of the legal doctrine, saying that it is not fully compliant with the freedom of collective bargaining. Anyhow, sector agreements are a rare exception in Poland.

Collective bargaining exist at inter-sectoral (tripartite wage coordination or national bilateral agreements between peak federations) and sectoral level. However, the most common level of collective bargaining is that of the enterprise.

Social partners and social dialogue in the hospital sector

Trade unions

For the health care sector as a whole, the most representative union organisation is FZZ, accounting for more than 33% of unionised employees. Forum's health care unit assembles organisations such as the Nationwide Union of Nurses and Midwives (Ogólnopolski Związek Zawodowy Pielęgniarek i Położnych, OZZPiP), the Nationwide Union of Administrative and Service Health Care Employees (Ogólnopolski Związek Zawodowy Pracowników Administracji i Obsługi Służby Zdrowia), the Nationwide Union of Operating Bloc, Anaesthesiology, and Intensive Therapy Workers (Ogólnopolski Związek Zawodowy Pracowników Bloku Operacyjnego Anestezjologii i Intensywnej Terapii), and the Nationwide Union of Medical Diagnostics and Physiotherapy Employees (Ogólnopolski Związek Zawodowy Pracowników Diagnostyki Medycznej i Fizjoterapii).

The second most numerous union organisation is the Federation of Health Care and Social Aid Employee Unions (Federacja Związków Zawodowych Pracowników Ochrony Zdrowia i

Pomocy Społecznej, FZZPOiPS), a member organisation of OPZZ, accounting for 14.3% of all unionised health care employees in 2005. The FZZPOiPS assembles single-entity, multi-entity, and regional union organisations of health care employees; it is the legal successor of the Union of Health Care Employees (Związek Zawodowy Pracowników Służby Zdrowia).

The Health Care Secretariat (Sekretariat Ochrony Zdrowia) of NSZZ 'Solidarność', finally, accounted for some 8% of unionised health care employees in 2005. The Secretariat is subdivided into five sections. The two sections of relevance to the hospital sector, namely the Nationwide Ambulance Service Section (Sekcja Krajowa Pogotowia Ratunkowego) of NSZZ 'Solidarność' and the Nationwide Health Care Section (Sekcja Krajowa Służby Zdrowia) of NSZZ, are umbrella organisations for what are known as the regional sections. This organisation groups employees representing various specialisations within the category of 'health care'.

An important union organisation in the hospital sector not affiliated with any of the above is comprised in the Doctors' Trade Union of Poland (Ogólnopolski Związek Zawodowy Lekarzy, OZZL), which assembles physicians and dentists retained on the basis of employment contracts. The basic units of this union are established on a grassroots basis - at the initiative of the physicians themselves, who set up union organisations covering a single hospital/clinic or a number of such entities. According to figures provided by the union itself, its membership presently stands at approximately 22,000.

Employers

Probably the largest employer organisation in the sector is the Health Corporation (Korporacja Zdrowia), an affiliate of the Confederation of Polish Employers (Konfederacja Pracodawców Polskich, KPP). This is a relatively new organisation, established in 2006 through the merger of three hereto independent organisations – the Nationwide Union of Private Health Care Employers (Ogólnopolski Związek Pracodawców Prywatnej Służby Zdrowia, OZZPPSZ), the Nationwide Association of Non-Public Hospitals (Ogólnopolskie Stowarzyszenie Szpitali Niepublicznych, OSSN), and the Nationwide Association of Non-Public Local Self Government Hospitals (Ogólnopolskie Stowarzyszenie Niepublicznych Szpitali Samorządowych, OSNSS). The Health Corporation assembles a total of 170 hospitals; its establishment was motivated by a desire to somehow consolidate employers in the sector.

No analogous organisations operate in the public hospitals; this state of affairs follows from the legal characteristics of public hospitals. As a result, the directors of such entities are partners vis a vis the trade unions on the one hand but form associations falling short of the status of organisations operating pursuant to the 1991 legislative Act regarding employer organisations on the other. The Polish Association of Hospital Directors (Polskie Stowarzyszenie Dyrektorów Szpitali, PSDS), for instance, pursues its activities on the basis of the legislative Act regarding associations, and its principal objectives lie in the exchange of information and experiences with a view to ensuring modern, effective operation and management of independent health care entities in Poland, with due heed for European Union standards.

Key issues for the hospital sector

Key issues include staff retention and difficulties in adapting to ongoing changes in the organisation of the hospital sector.

PORTUGAL

Economic and labour market context

The Portuguese recent economic growth began in early 1994 and real GDP growth increased to an estimated 3.2% in 2000.

In 2005, the population in employment aged 15-64 amounted to 4,800,000 persons while the employment rate (% population aged 15-64) was 67.5 %.

On the other hand, the total unemployment for the same year amounted to 420,000 persons and the unemployment rate (% labour force 15+) reached 7.6%.

In a gender perspective, total male employment in 2005 amounted to 2,708,000 persons and the male employment rate (% population aged 15-64) to 73.4%. The total male unemployment in 2005 affected 197,000 persons while the unemployment rate (% labour force 15+) reached 6.7%. The total female employment reached 2,309,000 persons and the female employment rate (% population aged 15-64) 61.7%. As far as unemployment is concerned, total female unemployment in 2005 affected 33,000 persons while the unemployment rate (% labour force 15+) reached 7.0%.

Structure and organisation of the hospital sector and recent reforms

The health care system is organised on the basis of the division of the country into five Health Regions, each of which may, if necessary, itself be divided into various sub-regions. Each Health Region is administered and managed by an autonomous „Regional Health Administration“ (RHA). The regions/sub-regions are made up of various „local health units“, which comprise their own „health centres“ (in principle, one per municipality, though a health centre may have one or more extensions) and hospitals.

The Portuguese health care system is characterized by three co-existing systems: the National Health Service (NHS), special public and private insurance schemes for certain professions (health subsystems) and voluntary private health insurance.

The Ministry of Health

The central government through the Ministry of Health is responsible for developing health policy and overseeing and evaluating its implementation. It is also responsible for the coordination of health-related activities of other Ministries, such as Social Services, Education, Employment, Sport, Environment, Economy, Housing and Urban Planning. The core function of the Ministry is the regulation, planning and management of the NHS.

Regional health administrations (RHAs)

The NHS, though centrally financed by the Ministry of Health, has had since 1993 a strong regional structure comprising five health administrations: North, Centre, Lisbon and Vale do Tejo, Alentejo and the Algarve. In each region a health administration board, accountable to the Minister of Health, manages the NHS. Their management responsibilities are a mix of strategic management of population health, supervision and control of hospitals and centralized direct management responsibilities for primary care/NHS health centres.

The regional health administrations (RHAs) are responsible for the regional implementation of national health policy objectives and coordinate all levels of health care. They work in accordance with principles and directives issued in regional plans and by the Ministry of Health. Their main responsibilities are the development of strategic guidelines, coordination of all aspects of health care provision, supervision of management of hospitals and health

centres, establishment of agreements and protocols with private bodies, and liaison with government bodies

Local government

Below the region and sub-region are the municipalities. Health issues at this level are under the jurisdiction of the Municipal Health Commission. For the purposes of health care provision, boundaries are based on geographical proximity rather than administrative areas, so some communities may be included in neighbouring municipalities. This ensures that services are provided more quickly and easily. In some cases the larger urban communities have their own system of health care organization in order to meet the specific needs of the population.

Private hospitals, and other privately provided services

In 1999, 41% of hospitals in Portugal were privately owned. Of these almost half belonged to for-profit organizations.

Private health insurance companies

On the financing side, the main private actors are the private health insurance companies. Voluntary health insurance (VHI) was introduced in 1978. Initially only group policies were offered, but individual policies have also been available since 1982. Approximately 10% of the population was covered by private insurance in 1998. Most policies are in the form of group insurance provided by the employer: fewer than 10% of people with private health insurance have individual policies.

Primary health care centres (described under Primary health care) are directly under the managerial control of the RHAs through the sub-regional coordinators.

Decentralization of the health care system

Decentralization is formally a key word of the NHS constitutional framework.

The Law on the Fundamental Principles of Health (1990) states that the NHS is managed at the regional level, with responsibility for the health status of the corresponding population, the coordination of the health services provision at all levels and the allocation of financial resources according to the population needs.

Main system of financing and coverage

Like most European systems, the Portuguese health care system is a mix of public and private financing. The NHS, which provides universal coverage, is predominantly funded through general taxation. The health subsystems, which provide either comprehensive or partial health care coverage to about a quarter of the population, are funded mainly through employee and employer contributions (including state contributions as an employer). A large proportion of funding is private, mainly in the form of direct payments by the patient and to a lesser extent in the form of premium to private insurance schemes and mutual institutions, which cover respectively 10% and 6.5% of the population

Public expenditure, which comes mainly from taxation (over 90%) includes funding of direct provision within the NHS and subsidies to the health subsystems for public sector employees. Private expenditure basically includes out-of-pocket payments and voluntary health insurance.

Although there is currently no available updated information on expenditure by specific agents, out-of-pocket payments in Portugal are perceived to be among the highest in Europe

Main sources of finance by funding agents (as % of total expenditure on health care), 1990 – 2001

Source of finance	1990	1991	1992	1993	1994	1995	1997	1999	2000	2001
Public	65.5	62.8	59.6	63.0	63.4	61.7	64.8	67.6	68.5	69.0
Private	34.5	37.2	40.0	37.0	36.6	38.2	35.1	32.4	31.5	31.0

Source: OECD Health data, 2003, 2nd edition.

Public financing

The NHS is mainly financed directly by general taxes. Tax revenue also funds the employer contribution for state and public sector employees.

The health subsystems, which pre-date the establishment of the NHS, account for about 5% of total health expenditure and are normally financed through employer and employee contributions, with the largest portion paid by the employer.

Like most European systems, the Portuguese health care system is a mix of public and private financing. The NHS, which provides universal coverage, is predominantly funded through general taxation. The health subsystems, which provide either comprehensive or partial health care coverage to about a quarter of the population, are funded mainly through employee and employer contributions (including state contributions as an employer). A large proportion of funding is private, mainly in the form of direct payments by the patient and to a lesser extent in the form of premium to private insurance schemes and mutual institutions, which cover respectively 10% and 6.5% of the population

Although there is currently no available updated information on expenditure by specific agents, out-of-pocket payments in Portugal are perceived to be among the highest in Europe, having accounted for over 44% of the Total Health Expenditure in 1995.

Main sources of finance by funding agents (as % of total expenditure on health care), 1990 – 2001

Source of finance	1990	1991	1992	1993	1994	1995	1997	1999	2000	2001
Public	65.5	62.8	59.6	63.0	63.4	61.7	64.8	67.6	68.5	69.0
Private	34.5	37.2	40.0	37.0	36.6	38.2	35.1	32.4	31.5	31.0

Source: OECD Health data, 2003, 2nd edition.

Health care expenditure

Total health care expenditure in Portugal has risen steadily from as little as 3% in 1970 to its present level of 8.2% of GDP, fairly close to the European Union average of 8.7% (2; see Fig. 3). Portugal now spends more than both Italy and Spain, despite having spent considerably less than they in 1970. Table below also shows that the amount spent on health care has risen in both absolute and relative terms over the last three decades. It appears that Portugal has not contained health care expenditure growth as successfully as other southern European countries. One plausible explanation lies in the political reluctance to impose cost control measures after it was assumed that investment was needed in order to build up new facilities and to promote the expansion of NHS coverage.

Trends in health care expenditure, 1970 – 2001

Total expenditure on health care	1970	1980	1990	1995	1996	1997	1998	1999	2000	2001
Per capita in current prices (euros)	3	40	312	639	699	752	812	896	995	1 065
Per capita in constant prices (1995) euros	103	307	464	669	708	740	775	809	863	888
Per capita (US \$PPP)	40	265	611	1 134	1 195	1 341	1 365	1 469	1 519	1 613
Share of GDP (%)	2.6	5.6	6.2	8.3	8.5	8.6	8.6	8.7	9.0	9.2
Public as % of total expenditure on health care	59.0	64.3	65.5	61.7	64.7	64.8	65.4	67.6	68.5	69.0

Source: OECD Health data 2003, 2nd edition.

Portugal's GDP spent on health care is near the European Union average of 8.7% and in line with the many member countries. However, expenditure presented as a percentage of GDP is susceptible to fluctuations due to economic growth and does not account for differences in population size.

Reforms of the health care system

Decentralization is formally a key word of the NHS constitutional framework.

The Law on the Fundamental Principles of Health (1990) states that the NHS is managed at the regional level, with responsibility for the health status of the corresponding population, the coordination of the health services provision at all levels and the allocation of financial resources according to the population needs.

Over these last 30 years a sustained effort to improve health and health services can be clearly identified. To a large extent these efforts have focused on increasing funding for the health sector, expanding the public health service infrastructure (both facilities and technologies), providing easier access to pharmaceuticals and improving the organization and management of the NHS. However well intended, reforms were often incompletely implemented, due to managerial limitations, resistance to change or political discontinuity. In fact, over this period of time it was frequently observed that within a single political cycle, under the same prime minister, changes of ministerial teams led to considerable changes in the political agenda.

1995 – 2001: A “new public management” approach to NHS reform

This reform had the following priorities:

- Health strategy: From 1996 to 1999 a broad “Health Strategy for the Turn of the Century” was developed, including 5-year and 10-year targets for health gains and service development. The strategy was discontinued when a new ministerial team took office by the end of 1999.
- Public entrepreneurship in hospitals and organizational development of health centres: It was decided in 1996 that all new hospitals would adopt a new more autonomous and flexible public enterprise managerial style. From 1996 to 1999 three new hospitals adopted this status. A series of experimental projects in PHC reorganization were initiated: small teams of GPs and PHC nurses were set up in more dispersed and community-accessible facilities.
- These experiments were evaluated positively and stimulated the adoption of GP performance-related pay on an experimental basis, new contracting practices, quality

requirements and information infrastructure. In 1999 legislation was passed to reform health centres, but this reform process stopped in 2000 and it was not implemented.

- Quality assurance: A new approach to promoting quality in the health sector was designed and institutions (National Health Quality Council, Institute for Quality Development) were created to implement it.
- Human resource policy: In 1998, the Council of Ministers adopted a resolution establishing two new public medical schools, strengthening nursing training, promoting more health research capacities and better coordination among health care, health education and training institutions.
- The implementation of this resolution in the following three years was incomplete.
- Improving the Public Health infrastructure: Five Regional Public Health Centres have been created since 1999 to strengthen both regional and local levels through epidemiological expertise and leadership in health promotion and health care management.
- Introducing a purchaser – provider split: In 1996 regional health authorities initiated a process establishing regional contracting agencies, which would develop expertise in analyzing, negotiating, and deciding the allocation of public financing of health services, and appropriate information and monitoring tools for those purposes. The agencies were established in 1998, but their power has been limited because of their very small budgets and insufficient influence over providers.
- Local health systems: 1999 legislation established these to create an integrated framework for hospitals, health centres and other health care providers, but the legislation was not implemented.
- Decentralization: The implementation of decentralization strategies in Portuguese health sector has faced problems for several reasons, such as a strong tradition of centralized management and a lack of adequate human resources.

Current reform agenda

Current changes are set out to achieve the following:

- A set of legislative measures was agreed in 2000 aiming at the rational use of pharmaceuticals, including generics promotion was adopted.
- The use of NHS Identity Card became mandatory.
- The norms for the licensing and evaluation of private clinics and dentist private practices were published in 2001.
- A framework for the implementation of public/private partnerships for the building, maintaining and operation of health facilities was created in 2002, along with the identification of the basic principles and instruments.
- A new law on the management of hospitals was issued to enable the changeover of some institutions into public enterprises as well as the set up of a series of entrepreneurial principles such as freedom of choice by the patient, budget contracting, and activity based payment of professionals.
- 34 hospitals, corresponding to about 40% of all NHS hospitals were transformed into public enterprises.
- In November 2002, the new government issued legislation initiating progressive change in the management model of all public hospitals into entrepreneurial schemes of different types, ranging from the standard public status to private for-profit

organizations. A public enterprise model is expected to be the dominant solution. A group of 34 hospitals of medium dimension (between 150 and 600 beds), corresponding to about 40% of all NHS hospitals, were selected to be transformed into public enterprises at the beginning of 2003. In addition to the intended greater flexibility and accountability in resource use, a major implication is the progressive change of the NHS personnel status from salaried civil servants to private employees working under negotiable contracts.

Outline of system of industrial relations

The total union membership in 2003 was 1,165,000 or 13% of adult population.

As far as national employers federations are concerned, Portugal witnessed a (renewed) attempt by the trade associations AEP and AIP to gain more influence within the institutionalised social dialogue. They created in 2004, the Entrepreneurial Confederation of Portugal (Confederação Empresarial de Portugal, CEP).

The (weighted) average employer rate of organisation is approximately 55 to 60% in the EU. The density rate of employers' organisations in Portugal is 35%²⁰⁵.

The legal status of collective bargaining is the new Labour Code of 2004. As far as extensions procedures are concerned, employers, their associations and unions have opportunity to object to the decision (but not to stop it). This is only allowed if there are economic and social circumstances that justify such an exceptional measure.

The inter-sectoral level of collective bargaining is an existing level of bargaining, the enterprise level is an important but not dominant level of bargaining while the sectoral is a dominant level of collective bargaining.

Actors involved in collective bargaining in the hospital sector²⁰⁶

Employers

Public/private non profit: hospital employers are represented by the 'Department of Public Administration'. Employees are represented by two general national trade unions and by specific health care trade unions by profession (doctors, nurses, technicians, pharmacists,...), which are entitled to negotiate and conclude collective agreements at the national level. The government acts as an employer and negotiates with trade unions through its central departments. It determines the budget and the functioning of hospitals (which only have administrative independence). The government also has the obligation by law to consult and negotiate with the trade unions when defining social legislation.

Private profit: hospital employers are represented by the 'Portuguese Association of Private Hospitalisation', which also is entitled to negotiate and conclude agreements with trade unions, which are the same as for the public sector. For the non member hospitals, each private hospital negotiates directly with the unions. The government is not directly involved except if the parties (employers/employees) do not reach an agreement. Then the government has a conciliatory role. The government does however control, supervise and regulate hospital activities.

For both the public and the private non profit making sector there is one annual meeting of the 'Economic and Social Committee' which settles the framework principles of collective negotiations to be followed by employers' and employees' representatives in their

²⁰⁵ Density = % of employees working in the country for an employers, which is member of an employers' organisation.

²⁰⁶ <http://www.hope.be/07publi/07newpublics/socdial/portuga.htm>

negotiations. This Committee is a joint committee, co-ordinated by the government and consists of: 3 confederations of employers' associations and 2 confederations of trade unions. Negotiations in this 'Economic and Social Committee' influence the hospitals indirectly. For the private profit making sector negotiations are conducted between the 'Portuguese Association of Private Hospitalisation' and the trade unions. At present there are two collective agreements ('92 and '95) which regulate the private profit making hospital sector. In hospitals (public as well as private) themselves no real negotiations take place but there are bodies to advise management: the health and safety committee, the trade union representative and an ethical committee.²⁰⁷

Trade unions

There are three main trade unions representing workers in the hospital sector:

- Sindicato Nacional dos Trabalhadores da Administração Local (STAL) with 40000, the trade union for local authority employees in variety of sectors.
- Sindicato dos Quadros Técnicos do Estado (STE) with around 12000 members (not only in the hospital sector).
- Sindicato dos Trabalhadores da Administração Pública (SINTAP), the union of public administration workers with around 9800 members.

Key issues in the hospital sector

Changes in the organisation of the health care system and associated changes in status of employees.

²⁰⁷ <http://www.hope.be/07publi/07newpublics/socdial/portuga.htm>

ROMANIA

Economic and labour market context

The modern state of Romania was formed by the merging of the Danubian Principalities of Moldavia and Wallachia on January 24, 1859. The state united with Transylvania in 1918. Romania joined NATO on March 29, 2004, and the European Union (EU) on January 1, 2007. Romania has the seventh largest population and the ninth largest territory in the EU.

The country's real GDP annual percentage growth was 5.1 in 2007. The employment rate was relatively low at 57.6 in 2005 (63.7 for men and 51.5% for women). Unemployment stood at 7.7% in 2005, with little difference between male and female unemployment.

Employment trends in hospital sector

The most recent Ministry of Health data indicate that Romania has one practicing physician for every 580 people, or 17.7 per 10,000 people. In 2005, the healthcare system in Romania employed more than 340,000 workers, who received a monthly net wage of approximately €186, or 90% of the national average wage. As a result of low wages, in recent years the sector has been confronted with the migration of skilled workers to other European countries in search of better pay. In the period 2002–2005, data provided by the Sanitas Federation (Federatia Sanitas) of healthcare workers and the Healthcare Workers Solidarity Federation reveals the following geographic distribution of Romanian medical staff: over 2,500 workers in Italy, more than 1,200 in Hungary, over 500 in Switzerland and Germany, and more than 600 in the United Kingdom. Moreover, in Germany official records indicate the presence of 1,000 Romanian medical doctors, mostly general practitioners, while around 550 doctors work in Hungary.

Structure and organisation of hospital sector and key recent reforms

Health care expenditure was 3.9% of GDP in 1999, but data on total expenditure is limited because private expenditure is not accurately calculated even though it plays a significant role. The country still has a low proportion of its GDP spent on health.

Private practice is permitted, although hospitals are publicly-owned (with a few small exceptions). In 1996, there were approximately 12 000 people employed by private health care enterprises, with pharmacies making up the lion's share of this employment.

In 1998, Romania has seen a substantial change in the way its health-care sector is financed, namely, a shift towards the funding of health-care by means of an insurance system. The introduction of health insurance increased the amount of public funding available for that sector. Yet despite this positive development in terms of revenue, at least half the users of the health services report making additional out-of-pocket payments.

Moreover, although the budget has benefited from a surplus of revenue from the health sector, the quality of service is increasingly viewed as inadequate, and the system's performance is poor in terms of equal access.

There are four main categories of hospitals in Romania:

- Rural hospitals, which have a maximum of 80 beds and provide internal medicine and pediatric services and gynecology-obstetrics.
- Town and municipal hospitals, with at least 150-400 beds, respectively, and departments of internal medicine, surgery, gynecology-obstetrics and pediatrics.
- District hospitals in larger have, in addition, departments for orthopedics, intensive care, ophthalmology and otorhinolaryngology.
- Specialized units for tertiary care such as the Institute for Mather and Child, the Institute of Oncology, The Neurosurgery Hospital, the Institute of Balneophysiotherapy and Recovery, the Institute of Pneumophysiology and a number of cardiovascular and other surgery departments in teaching hospitals.

In terms of ownership, except for few small hospitals, all hospitals are publicly owned and are under state administration. They are led by a council board and a general manager who holds executive power. This appointment is made by the Law of organization and functioning of the hospitals and is usually held by a physician or economist or jurist. There are two deputy directors, a physician and an economist. The council board is appointed by the general manager and usually includes representatives of the different departments within the hospital plus a health care director (medical assistant) in case of the hospitals with over 400 beds .

Organizational structure and management

The financing of the health insurance system is established by law and it is based on the contributions of the employee, employers and from the state budget. The working population pays a 6.5% payroll tax and the employer another 6.5% payroll tax to the fund. The self-employed, farmers, pensioners and the unemployed pay a 7% contribution (in 1998, these percentages were 5% for the employed/5% for the employer and 4% for pensioners, respectively). The mandatory health insurance scheme covers the whole population. Children, the handicapped, war veterans and dependants have free access to health insurance from the state budget. Contributions for soldiers are covered by the Ministries of Defence. Contributions for the prisoners that are not insured are covered by the state budget. The state budget contributes with almost 20% at the health care financing. Having responsibility for funding public health services and capital investments, as well as priority preventive activities. Complementary sources of finance It is believed that out-of-pocket payments are considerable. It is difficult to calculate private expenditure on health, but is estimated that these comprise approximately 29% of total health expenditure (1996 data from individual household surveys). An important part of this sum goes to the public providers or their staff through charges for services or under-the-table payments. The

largest identifiable share was for drugs (33%), and while formal co-payments are required for drugs under the new legislation, contracted providers can also charge co-payments for other services, suggesting that out-of-pocket payments have increased since 1996. Significant funding is also provided by international organizations through bilateral support and private

sources. The influence over the health care system by these external sources, such as the World Bank, is apparent (e.g. primary health care).

The Ministry of Health no longer has direct control over the financing of a large part of the network of providers. It is responsible for developing national health policy, regulating the health sector, and dealing with public health issues. However, legal changes of roles and responsibilities have not yet been associated with significant changes in skills and competencies. The representative bodies of the Ministry at the district level are the district public health authorities. As of 1999, the 42 district health insurance Houses - Funds (DHIFs) are

responsible for collecting contributions, contracting services from public and private providers and reimbursing providers. There are also two countrywide funds, of the Ministry of Transport and of The Ministry of Justice, that have status of district public health house (funds). Also as of 1999, the National Health Insurance Fund sets the rules and regulations for the DHIFs and has the right to reallocate up to 25% of the collected funds towards underfinanced districts. The NHIF elaborates the framework contract on the health care services. The CoPh has important

responsibilities regarding all areas of concern for physicians, who should be registered with the college in order to practice. The CoPH has an influence – through negotiations on the framework contract – over the content of services package, the type of reimbursements in place, which drugs are compensated, etc. These normative papers are under the consultation with the social partners: the professional organizations (CMR, OAMMR, CFR), the trade union and employer's organizations. In order to practice the physician profession or the medical assistant profession, it is necessary to be a member of these professional bodies. Private practice is permitted, although hospitals are publicly-owned (with a few small exceptions). In 1996, there were approximately 12 000 people employed by private health care enterprises, and pharmacies formed the most important private segment of health care services providers.

Health care reforms

The changes that have taken place to date largely as well as those in 1006 by the Law 95 on the reform in the health field reflect the country's history and influences by different actors. The intention was to take into account positions of all concerned partners, and the resulting changes show clear traces of influence from these different actors, such as the World Bank (primary health care), Germany (health insurance system) and United Kingdom (capitation). The process of decentralization and moves to diversify the sources of funding started in the early 1990s, but the big change took place in 1997, when the Health Insurance Law transformed the system from a state financed model to an insurance based system. Like any major reform, there have been problems and obstacles. Coordination of the process has been complicated, in part due to multiple actors, in part to turnover and change.

Health legislation is complex and changes frequently, the state budget spent little on health in the 1990s and the social health insurance system has been limited as a solution for increased funding due to collection problems. The contribution at the social insurance fund represents the guarantee that the Romanian health care system is on the right way, with the condition of

remuneration in accordance with the social importance of the work for the personnel in the health field in order to diminish the phenomenon of the working force.

Social partner organisations in the hospital sector

Trade unions

Romanian Trade Union Federation (SANITAS) has 120000 members in the sector.

Medical-Sanitary and Pharmaceutical Trade Union Federation Hipocrat (Federația Sindicală Medico-Sanitară și Farmaceutică Hipocrat, Federația Hipocrat)

National Free Trade Unions Federation Technic – Economic and Administrative from Healthcare and Balnear Units (Federația Națională a Sindicatelor Libere Tehnic-Economic și Administrativ din Unitățile Sanitare și Balneare, Federația Sindicală TESA din USB)

Employers

Romanian Hospital Association (Asociația Spitalelor din România) is affiliated at European Hospital and Healthcare Federation.

Key issues facing the sector

Perceived low levels of health care funding leading to gaps in service provision.

SLOVAK REPUBLIC

Economic and labour market context

Since its independence in 1993, Slovakia has gone through a series of political changes and socio-economic reforms which had an important influence on the economic and labour market conditions. The combination of a favourable economic situation and reforms achieved a steady and increasing GDP growth rates since 2000. While in 2000 the real GDP growth was very poor (0.7%²⁰⁸), in 2006, Slovakia was one of the best performing EU economies, in terms of GDP growth, attaining 8.3%. Thanks to the improved confidence of foreign investors following the political changes in 1998 and the announcement of Slovakia's accession to the EU, and supported by a rather aggressive policy to attract funding, the country has benefited from important investments in industry but also services. This was further supported by tax and labour code reforms.

At the same time the labour market situation improved. From nearly one fifth of the active age population unemployed in 2001, the unemployment rate dropped to 13.4% in 2006²⁰⁹. Nevertheless, high unemployment remains a major problem in the country. The average unemployment rate is nearly double the EU average and the long term unemployment rate is three times as high as the average EU rate²¹⁰. When it comes to gender differences in employment and unemployment rates, the overall proportion in Slovakia is very similar to the EU 27 average. In Slovakia 51.9% of women are employed (compared to 67% of men) while 14.7% of women are unemployed, compared to 12.3% of men.

Table Employment and unemployment rate EU 27 and Slovakia

	EU-27	proportion female/male	SR	Proportion female/male
Unemployment				
Total	7.90%		13.40%	
Males	7.10%		12.30%	
Females	8.80%	123.94%	14.70%	119.51%
Employment				
Total	64.30%		59.40%	
Males	71.60%		67.00%	
Females	57.10%	79.75%	51.90%	77.46%

Employment trends in the hospital sector

The health and social sectors are currently employing 6.71% of the active Slovak population. As shown in the table below, the overwhelming majority of employees in the sector are women (80.58%). In Slovakia, the risk of aging workforce in health care is even stronger than in the remainder of the EU. There are very little young people joining health care professions. Only 5.57% of those employed in health care sector are below the age of 25. In addition over 28% of the population employed in the sector is 50 years and over. As will be discussed

²⁰⁸ Data source: Eurostat

²⁰⁹ Data source: Eurostat

²¹⁰ Long term unemployment rate in Slovakia: 10.2% in 2006. Long term unemployment in EU: 3.6% in 2006. data source: Eurostat

further in section 0, the low level of young people joining health care professions is due to two factors mainly: low wages compared to the other sectors and important emigration of young skilled professionals.

It should be noted though, that the figures available represent both health care and social sector. Since the feminisation is even stronger in social care, the figures are likely to exaggerate slightly the reality in health care.

Table Employment in health care and social sector per sex and per age category²¹¹

	2000		2006	
	as % of total active population	as % of total employment in HC	as % of total active population	as % of total employment in HC
Total (15 years and over) - Sex -Total				
EU-27	8.63%		9.54%	
Slovakia	7.03%		6.71%	
Total (15 years and over) – Sex - Males				
EU-27	3.43%	22.51%	3.79%	22.07%
Slovakia	2.35%	18.10%	2.31%	19.35%
Total (15 years and over) – Sex Females				
EU-27	15.43%	77.49%	16.76%	77.93%
Slovakia	12.51%	81.90%	12.32%	80.58%
Between 15 and 24 years – Sex - Total				
EU-27	6.14%	7.95%	6.99%	7.52%
Slovakia	5.65%	9.84%	3.87%	5.57%
Between 15 and 24 years – Sex - Male				
EU-27	1.91%	1.34%	2.28%	1.35%
Slovakia	unavailable	Unavailable	unavailable	unavailable
Between 15 and 24 years – Sex – Female				
EU-27	11.19%	6.60%	12.74%	6.18%
Slovakia	9.67%	8.33%	7.30%	4.47%
Between 25 and 49 years – Sex – Total				
EU-27	9.19%	70.98%	9.62%	65.84%
Slovakia	7.09%	72.88%	6.46%	66.41%
Between 25 and 49 years – Sex - Males				
EU-27	3.61%	15.67%	3.66%	13.82%
Slovakia	2.26%	12.43%	2.01%	11.39%
Between 25 and 49 years – Sex – Females				
EU-27	16.33%	55.31%	16.94%	52.02%
Slovakia	12.65%	60.45%	11.95%	55.02%
50 years and over – Sex – Total				
EU-27	8.22%	21.07%	10.41%	26.63%
Slovakia	7.82%	17.28%	8.82%	28.03%

²¹¹ Data source: Eurostat

50 years and over – Sex – Males				
EU-27	3.62%	5.50%	4.71%	6.90%
Slovakia	3.19%	4.17%	3.74%	6.93%
50 years and over – Sex – Female				
EU-27	14.89%	15.57%	18.03%	19.74%
Slovakia	14.51%	13.11%	15.94%	21.10%

Structure and organisation of hospital sector and key recent reforms

The Slovak health care system has evolved from a tax based system (before 1990) into a social insurance based system with several public and private insurance companies. This happened through series of continual reforms. The major objective of changing the system into an insurance based system was to achieve budgetary independence from the state. This however, has only been achieved very partially and the government is still very present in negotiations over health care financing.

Financing of the system

While better financing of health care was often the major objective of reforms the results remain still below the EU average. Indeed, with 5.8% of total GDP in 2003, health care expenditure in Slovakia is close to two points lower than the EU average²¹². As in other social insurance based systems the source of financing are employers and employees contributions to social insurance funds.

The contributions are currently set on different levels for employees and employers. They are calculated as 4% of employees' annual taxable income for the employee and 10% of the same amount for the employer. The system is slightly regressive, given that a maximum contribution ceiling is set for people with higher wages. The minimum and the maximum contribution rates in 2006 were set at 966SKK per month (28,57€) and the maximum at 6646,5 SKK (196,6€)²¹³. Those citizens who are not economically active, such as the unemployed, children, retired and handicapped are covered by state contributions. These are lump sum payments from the government budget to health care insurances. They were set at 4% of the average salary in Slovak Republic, (approximately 750SKK (22€) in 2006²¹⁴), hence below the minimum contributions of economically active persons.

The Slovak system is based on multiple insurance companies and contributors have the right to freely choose to contribute to any of them. The original objective of having several insurance funds was to create market conditions and competition but this has never been achieved due to an important control of the Ministry of health over the insurance system. The insurance landscape is dominated by the General health Insurance Company, which is a public organisation insuring 65% of Slovak population. The Ministry of Health care has a member in the advisory committee of the General Health Insurance. Other public insurance companies exist, such as the Common insurance company which is under the remit of four ministries: defence, justice, interior and transport. The common insurance company covers mostly civil servants under these ministries and their family members. This originates from the historical fact that these ministries had their own health infrastructures in the past. These two

²¹² The EU-25 average in 2003 was 7.4%. Data source: Eurostat

²¹³ These numbers are for health care insurance solely. Additional insurances are compulsory these are social and sickness. Insurance administered by the Social Insurance. Sources: General Health care Insurance (<http://www.vszp.sk/showdoc.do?docid=168>) and Social Insurance : <http://www.socpoist.sk/index/index.php?ids=1469>

²¹⁴ This figure was calculated on the basis of Slovak statistics data on average wages for 2006 <http://www.statistics.sk/webdata/slov/tabulky/pmm/pmm07.htm>.

public insurance companies are guaranteed by the state and hence their budgets are agreed by the parliament. In addition there are several private insurance companies, which have a small share of contributors and are mainly active in additional voluntary health insurance packages.

Finance allocation

Several systems were adopted and replaced when it comes to financing of health care providers. The objective of this part is not to paint the historical evolution of the current system therefore we will only focus on the existing situation.

Insurance companies collect contributions and redistribute them to both public and private health care providers. Insurance companies have individual contracts with the different providers of all primary, specialised out-patient and in-patient care. Financing of GPs is based on age-structured capitation and fee-for service preventive care. Private office based specialist are remunerated on basis of fee-for service. Currently finances are allocated to hospitals on basis of budgets rather than interventions as it was the case in the past. Budgets are prospective but based on volume of acts from previous year.

Recent reforms concerning financing

In the past health care in Slovakia used to be free at point of delivery. However, out-of-pocket payments were continuously introduced since the nineties and mainly through the reforms in 2002 and 2004. Ever since out-of pocket payments in Slovakia have been object of animated debate. These were first introduced for dental care, some optical interventions and for some categories of drugs. In 1996 these constituted only 5.7% of health care expenditure. Their share increased to reach 10.9% in 2002²¹⁵. The 2002 and 2004 reforms, adopted by the centre-right coalition in power between 2002-2006 lead by SDKU, introduced out-of-pocket payments also for many other medical interventions. According to this reform medical interventions were classed in two categories: priority diagnosis and other diagnosis. The priority diagnosis were fully covered by the compulsory health care insurance. In case of the other diagnosis co-payments were introduced at various levels. The priority diagnosis accounted for two thirds of total diagnosis, approximately 41% of cases and two thirds of health care expenses. The objective was twofold. On one hand it was raising the budget available to health care providers and on the other raising public awareness on health care costs. Raised out-of-pocket payments were severely criticised by the left-wing parties and direct payments to physicians and pharmacists were cancelled in 2006 by the current government, lead by the left wing party Smer.

Health care delivery system

In Slovakia preventive and curative primary health care is delivered by first-contact physicians, the vast majority of whom are private. The practices of primary health care have been privatised in early nineties. Their network is relatively dense and there are no major discrepancies as to accessibility between rural and town areas. These physicians usually employ one nurse. Primary health care physicians (general practitioners for adult, for children and adolescents, obstetrician-gynaecologists and dentists) have a gate-keeping role. They refer patients to specialist inpatient or out-patient care. Slovakia also has a dense network of secondary outpatient specialists. More than 50% of who are also private practitioners. The remaining specialists exercise within hospitals and policlinics.

One of the inefficiencies of the Slovak system is the very high rate of outpatient contact per person per year. While the EU-15 average was below 7, in Slovakia it was nearly double in

²¹⁵ Idem, p. 35

2001 (14.61). This rate decreased slightly following the 2002 reform, to reach 13 in 2004, but still remains one of the highest in Europe. The EU-15 average in 2004 was 6.83²¹⁶.

When it comes to inpatient care, Slovakia has inherited from the previous regime a relatively dense network of hospitals. With 2.67 hospital beds per 100.000 inhabitants in 2004, the country was little above the EU-25 average (2.65 in 2004). The country also has high numbers of hospital beds in secondary inpatient care with very low occupancy rates.

Table Data about the structure of Slovak health care system (2004)²¹⁷

	Slovakia	EU-25
Primary health care units per 100000 inhabitants	191.78	61.57
Outpatient contacts per person per year	13	7.82
Hospitals per 100000 inhabitants	2.67	2.65
Bed occupancy rate in %, acute care hospitals only	68.6	74
Acute (short-stay) hospitals per 100000 inhabitants	1.8	...
In-patient care admissions per 100 patients	18.6	20.65
Acute care hospital admissions per 100 patients	17.83	19.36
Average length of stay, all hospitals (days)	9.1	8.13
Average length of stay, acute care hospitals only (days)	8.4	7.99

Ownership and recent reforms in the structure of health care provision

The Slovak inpatient care is delivered by the following types of hospitals:

Type 1 – small polyclinics

Type 2 – polyclinics of higher type

Type 3 – specialized hospitals

Type 4 – teaching hospitals

In 2004 there were 24 Type 1, 37 type 2, 10 type 3 and 13 type 4 hospitals. The reform of 2002 brought important changes to hospital ownership. While prior to 2002 nearly all hospitals were state owned, by 2003 all type 1 and type 2 hospitals' ownership has been transferred. Type 1 hospitals were transferred to municipalities and Type 2 hospitals were transferred to regions. Since 2003, only the large regional and teaching hospitals together with some specialized inpatient care providers remain under state management. Further changes were brought with the 2004 reform with which the state became even less involved. Until 2004, the state was responsible for capital investments in health care infrastructure. Since 2004 it is the responsibility of the owners, i.e. municipalities or regions. It should be mentioned that though regions and municipalities gained important responsibilities (also financial) through the decentralisation process, their revenues remain very limited. While before the decentralisation reform these taxes accounted for 0.6% of Slovak GDP (2002 figure) they only increased to 0.7% in 2006²¹⁸.

With the transfer of hospitals to regions and municipalities, most changed their status. While the infrastructure remains to be under the ownership of municipalities or regions, the hospital staff and management have organised itself in two possible legal forms, as an NGO or as a

²¹⁶ Data source: WHO regional office for Europe: European Health For all database

²¹⁷ Idem

²¹⁸ Slovak Ministry of Finance – information on tax reform: <http://www.finance.gov.sk/Default.aspx?CatID=3996>

private company (typically as an equivalent of an Ltd). In consequence, hospitals usually rent the infrastructure from regions/ municipalities.

While this reform enabled the state to significantly reduce its investment in health care it also put a lot of pressure on hospitals, municipalities and regions. Besides the lower involvement of the state in health care management, another objective of this reform was to rationalise the health care provision network and to eventually lower the numbers of in-patient beds available. It was expected that some of the very small hospitals would close down after a result of important financial difficulties.

Key challenges facing the health care sector

The finance allocation system which existed in late nineties and was based on fees-for-service payments, created little incentives for practitioners to reduce the costs. On contrary it contributed to maintenance of frequent contacts in outpatient care. The system also created very little incentives for hospitals to improve the effectiveness of their management. In addition, health insurance companies' incomes were in deficit. This was mostly due to unpaid debts of companies which went bankrupt in the nineties and have never covered the health care contributions for their employees. Another factor which reinforced the negative accounts of the system was low rate of state contributions, while the numbers of people dependent on these contributions were high.

The combination of high spending and little incomes had inevitably led to important debts in health care.

A crisis situation broke out in 2001-2002 where most hospitals and pharmacies were deeply indebted. Some even became insolvent. As several attempts to settle the debts failed, the SDKU government created "Creditor" ("Veritel" in Slovak) a state incorporated company designed to clear debts. The clearing process was quite complex as most of the actors in Slovak health care owned money to the other actors. As a result, the debt relations were simplified and "Creditor's" creditors became only insurance companies from which these debts were progressively claimed. Together with the reform of health care coverage, the systematic approach to clearing debts managed to bring the debt rise under control and to actually reduce the overall debt in 2005.

However after the success of 2005, the debt continued to increase in 2006 and attained 6,821mld SKK (0,201.8mld €) at the end of 2006. Therefore financing of health care is still the major difficulty the actors have to face. The overall spending on health care remains low compared to EU average and such incomes are not sufficient to maintain competitive salaries (as will be discussed later), nor to invest in the equipment and infrastructures.

Another difficulty the Slovak health care system is currently overcoming is the restructuring of ownership and the thread of hospitals closing down. The governments' intention to reduce hospital numbers has been obviously very badly perceived by most of health care staff and social partners in the sector (both on employers' and employees' side). Important strikes have been launched to which both employers and employees participated. Though for the moment no major cut-backs have taken place, instead some hospitals have merged and have been reorganised, the thread of hospitals closing down is still perceived as a major problem by the staff.

Though less discussed among the general public, the staff shortages are becoming a major issue in Slovakia. While around 2000, Slovakia had actually a surplus of medical staff, currently, medical staff is difficult to find and to retain, especially in some regions where wages are low. This trend concerns mainly young qualified staff, be it doctors or nurses. While some do never enter the medical profession after having finished their initial training, many are also leaving abroad, namely to English speaking countries, but also to the Czech Republic.

Industrial Relations

While Slovakia had tripartite negotiations since its independence, the tripartite relations in the nineties were not formalised and were lacking the necessary engagement of the government. The tripartite system, which was established during the federal period with the Czech Republic, lapsed in 1997 and 1998, because of the government's lack of support. After the change of government in 1998 the tripartite negotiations were renewed and embedded in national legislation.

In 1999, the Act on Economic and Social partnership²¹⁹ founded the Council of Economic and Social Agreement of the Slovak Republic as the main tripartite concerting body. The Council had 21 members equally divided among employers, employees and the state. The Council mainly:

- concerted standpoints and recommendations in the areas of economic development and social development and on state budget
- concerted standpoints to drafts of generally binding legal regulations, concerning important interests of employees and employers, mainly economic, social, labour, and wage conditions
- established its advisory bodies, composed of experts, acting in their profile areas; social partners are represented in them proportionately

Though the 1999 legislation established the Council as a body which had to be consulted and had the power to delay adoption of legislation. However the Council's decisions were not binding. As this arrangement was considered too rigid by the government, since it mainly resulted in delays of legislation, the status of the Council has been modified in 2004, when it became a consultative organ. Today the Council is the high-level platform for social dialogue in Slovakia. The Council meets at least every three months, but it can meet more often if it is necessary. It deals with legislation which is to be submitted to and debated in parliament. These tripartite negotiations can either lead to joint agreement and a joint text going forward to parliament or a lack of agreement, in which case the government decides on the text to go forward with the remarks of the social partners.

Besides what is called in Slovakia "the large tripartity", i.e. the work of the Council on general socio-economic issues, there are also tripartite negotiations at sectoral level, so called "small tripartity". At sectoral level the social dialogue takes place among the relevant ministry, the sectoral trade union and the sectoral employers' union(s). Sectoral reforms are negotiated at this level.

In addition to tripartite negotiations, Slovak social partners also engage in bilateral negotiations. The outcomes of bilateral negotiations can be:

- Higher collective agreements (at sector level among the trade union federation and employers' federation). The higher collective agreements can:
 - Shorten working time below the maximum working time without pay reductions
 - Extend employees' holidays beyond the minimum level
 - Raise pay tariffs
 - Lengthen the dismissal notice period beyond the minimum required period
 - Set the level of redundancy payment higher than twice the effective salary
 - Set the retirement benefits beyond the effective salary level

²¹⁹ <http://www-8.vlada.gov.sk/data/files/1363.doc>

Set the level of employers' contributions to complementary retirement schemes

Set the level of contributions to the "social fund"²²⁰ beyond the minimum level

- Lower level collective agreements (at company level between the employer and the trade union(s) active at the work place).

The lower collective agreement is valid for all employees independent on their membership in a trade union. It has to be signed by all the trade unions active in a company. The lower agreement can agree on equal or better conditions than those set in the higher collective agreement. If lower conditions are agreed these are invalid.

Collective agreements can only be signed for a limited period of time and this duration is agreed among the partners.

Currently, collective bargaining and agreements at sectoral and company level cover about 50% of Slovak employees.

Legal framework

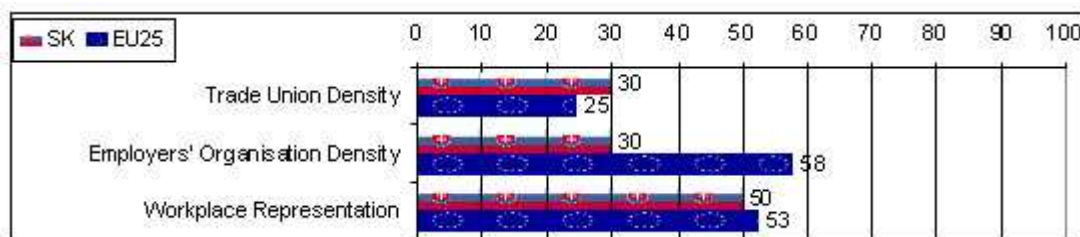
The *tripartite* Economic and Social Concertation Council, which was replaced by the **Economic and Social Partnership Council**, established by common declaration of the social partners in 2004.

The new **Labour Code** in April 2002 gave the collective bargaining parties greater rights to negotiate on the structure of industrial relations, in particular on working time. The principle of regulation by negotiation was strengthened, and upper limits on some provisions (such as severance payments) are no longer set by law.

The **law on collective bargaining** (2002) regulates the procedure for concluding agreements at sectoral as well as at company level and for selecting and using professional conciliators in collective bargaining. It also has provisions for resolving industrial disputes.

Actors

Representation²²¹



As shown in the table above the trade union density in Slovakia is higher than the EU-25 average but the numbers of unionized employees are dropping. The same table also shows that employers are significantly less organised in Slovakia than in the rest of the EU.

The main employees' trade unions are:

- The Confederation of Trade Unions of the Slovak Republic (Konfederácia odborových zväzov Slovenskej republiky, KOZ SR) which consists of 37 branch-level unions with a membership of about 570,000 employees (2004) – more than 90% of all union members.

²²⁰ The "social fund" is a fund created at the level of a company, financed by a percentage of the benefits (between 0.6%-1%) and it serves to finance various benefits such as: canteen, transport, holidays, etc.

²²¹ EIRO : http://www.eurofound.europa.eu/eiro/country/slovakia_1.html

- The Independent Christian Trade Unions of Slovakia, with about 13,000 members
- The Confederation of Art and Culture (KUK) which is the smallest trade union in Slovakia

The main employers' confederations are:

- The Federation of Employers' Associations of the Slovak Republic (Asociácia zamestnávateľských zväzov a združení Slovenskej republiky, **AZZZ SR**). Until 2004 AZZZ SR covered 60% of employers, including 40 associations in 19 branches from the business, cooperative and public sectors. Currently AZZZ has 235,000 members.
- The National Union of Employers of the Slovak Republic (Republiková únia zamestnávateľov Slovenskej republiky, **RUZ SR**) was established in 2004. About half of AZZZ members and affiliated organisations moved over to RUZ SR. This confederation, has a focus in manufacturing industry, commerce, and SMEs, combines 19 member organisations, which now represent more employees (270,000) than AZZZ.
- Slovak Craft Industry Federation (Slovenský živnostenský zväz, **SZZ**) which brings together 23 associations of crafts and self-employed workers.

The first two employer confederations cover about 30% of Slovak employees.

Social partner organisations in the hospital sector

Collective bargaining in health care sector takes place at several levels.

National

At national level, there are cross sectoral tripartite negotiations and sectoral tripartite negotiations

The tripartite sectoral Council of Economic and Social Agreement on health care is made up of 12 representatives, equally divided among the Ministry of Health, employers' and employees' organisations.

The Slovak health care employees are represented by the Slovak Association of trade unions for health care and social sector (Slovenský Odborový Zväz Zdravotníctva a Sociálnych Služieb, SOZZaSS). SOZZaSS is a member of EPSU.

The Slovak Trade Union of Workers in Services (SOZPS) is also a member of EPSU.

Employers' organisations are:

- The Associations of Hospitals of Slovakia (Asociácia nemocníc Slovenska - ANS - <http://www.ans.szm.sk/> – covering 55 hospitals
- The Association of Private physicians (Asociácia súkromných lekárov Slovenska – ASL SR - <http://www.aslrs.sk/>)
- The Association of University Hospitals (Asociácia fakultných nemocníc - AFN) – covering 18 hospitals

Contrary to the employees, employers' representation is fragmented, which creates difficulties for negotiations at tripartite but also at bilateral level. While the scene was rather unified until the year 2006, when ANS was the only representative of hospitals, it broke down in 2006, when the association of university hospitals was created. This division between the large university hospitals and the smaller municipal and regional hospitals is quite symptomatic for the entire health care system, as will be discussed later.

The tripartite health care council discusses legislation and policy affecting the health sector and can lead to joint agreement. If the partners fail to reach agreement, it is the government's proposal which goes forward and the social partners' only option of influencing parliamentary outcomes is then through lobbying of Members of Parliament.

The Slovak health care sector is currently covered by several higher collective agreements. These are negotiated at national bilateral level. In 2007 the following four collective agreements were in place:

- Between SOZZaSS and ANS. This collective agreement has been signed on 9 May 2006 and covers 53 hospitals.
- Between SOZZaSS and AFN. This collective agreement has been signed on 19 April 2006 and covers 15 university hospitals. This collective agreement was amended in June 2007 to and comported a clause on 10% pay raise from June 2006 onwards.
- Between SOZZaSS and other trade unions and private physicians for nurses.
- Between SOZZaSS and other trade unions and the government for health care workers with civil servant status.

These collective agreements mainly relate to the annual indexation of wages and are binding for all member organisations.

Regional level

Currently negotiations at regional level are weak, despite the fact that regions are responsible for investment in healthcare infrastructures.

Hospital – local level

As noted in the previous section, the negotiations at company level can agree to better conditions than those agreed in the higher collective agreement. Collective bargaining at company level mostly deals with specific questions of working conditions and working time, additional (non-salary) benefits, overtime working compensations and the use of the social fund.

Key issues for the hospital sector and the sectoral labour market in particular

Though there are numerous issues which are being currently discussed within the social dialogue in Slovakia, a few key themes can be identified: financing of the system; privatisation; staff retention; skills and training.

Financing of hospitals

The under-financing of Slovak health care system is mentioned as a main problem by both employers and employees.

The overall health care expenditure has not been raised despite the fact that it is low compared to the rest of the EU. The contributions for people covered by the state still remain significantly below the contributions of economically active citizens (see 0). In addition the out-of-pocket payments, which were introduced in 2004, were abandoned by the new government despite protests of medical staff and pharmacists. The management of finances raised through contributions also shows several deficiencies. For example, insurance companies did not provide sufficient incentives to motivate hospitals towards better management of resources.

The insufficient level of financing is mentioned as the main obstacle for employers to meet the demands of trade unions in terms of wages. Most employers, and this is particularly the case for small and medium sized hospitals outside the large towns, argue that they can not align themselves with the salary conditions of large university hospitals. In addition University

hospitals are the only ones whose solvability is still guaranteed by the state. They can hence afford to deepen their debts, and they do so. While small and medium sized hospitals can not afford to run the risk of debts as they would eventually have to close down like any other private company.

Despite the fact that the debt of health care is growing again, after having been mastered temporarily in 2005, it seems that the current government is, for the moment, not ready to enter discussions on financing of health care. In addition neither the current government, nor the previous ones have created a medium and long-term conception of health care. And this despite the fact that health care was among the priorities of all recent governments. A lack of such conception makes it very difficult for the social partners to negotiate as they have no governmental commitment to a particular plan. Therefore the social dialogue on this theme is currently unfruitful.

Privatisation

Though the explicit objective of the reform of ownership of Slovak hospitals was not privatisation, the goals were similar. Since 2006 hospitals are changing their status to a company or a NGO status as outlined above. Such measures were taken in order to create strict budgetary conditions and clear accountancy rules (such as an obligation of an external audit). In other words, the objective was to make hospitals' management more transparent and efficient. Otherwise, hospitals would face concourse, withdrawal of a licence and/or liquidation as any other company going bankrupt.

On the other hand, to prevent gaps in health care provision, the legislation established so called "minimum health care provision network". This minimum network defines the obligation of minimum numbers of units, doctors etc. per region which are contracted by at least one health care insurance company. In case where the minimum conditions are not satisfied, the ministry of health care together with the region or municipality and health care providers have an obligation to provide the necessary capacity.

Such measures are also backed by independent quality assurance controls.

While in most cases the transformation is an agreement between the three partners: the municipality/ region, the management of the hospital and employees' representatives, in some cases towns decided to sell health care facilities directly through public tenders which lead to important changes in staff and also orientation of these facilities. To avoid such drastic changes and prevent "wild" privatisation of facilities, there is an obligation that the state has to hold 51% of shares in transformed hospitals.

The transformation of hospitals status and the obligation of budgetary discipline in conditions of relatively low incomes, puts pressure on both employers and employees. It gives employers more freedom to negotiate wages but on the other hand it puts them in direct competition for staff with other providers. On employees' side, individual negotiations on wages, rather than collective negotiations, become more and more common, giving less guarantees to the majority of employed staff.

Staff retention

As shown above, Slovakia is currently suffering staff shortages and these are likely to deepen as an important proportion of the staff is over 50 years old and young people in the profession are scarce. Staff shortages can be observed among all types of hospital staff, from unqualified employees to the highly qualified ones.

Among the reasons of this shortage we can differentiate two types of barriers: those that stop people from entering the profession and those which affect retention.

As noted above Slovakia's health care system is lacking qualified but also non-qualified staff. For most people without qualifications, jobs in health care are much more demanding, in

terms of time requirements but also the physical and psychological aspects of the work. In addition, hospitals can not afford competitive salaries compared to, for example, manufacturing industry, which is also lacking unqualified labour.

But better opportunities elsewhere in the country are not only a barrier for unqualified staff to enter the profession. The majority of qualified nurses never enter the profession. After the harmonisation of medical training with EU requirements, nurses now leave education and training with a bachelor degree, while prior to the reform they were prepared in professional high-schools and left education with high school diploma (Maturita). A bachelor degree gives them much more possibilities on the labour market outside health care than the high school diploma did. The low level of qualified nurses actually entering the profession is seen as a major problem for the future availability of nurses in Slovakia. In addition Slovak hospitals have to compete in terms of wages with much more lucrative emergency health care, which has been privatised. Emergency health care also attracts many doctors and nurses.

As noted above, Slovakia also meets difficulties in retaining qualified health care professionals. Indeed the numbers of doctors and nurses leaving abroad are important (though no exact statistics exist). Their first destination is usually the Czech Republic where Slovak diplomas are fully recognised and where there is practically no language barrier. Though the Czech Republic also has difficulties with staff retention, the salaries there are more attractive than in Slovakia. Other favourite destinations of Slovak doctors and nurses are Anglophone and francophone countries. The motivations of such staff "leak" are obvious: much more competitive wages.

It should be noted here that in Slovakia the average wage in health care and social sector is nearly twenty percent below the global Slovak average wage. In 2006 the average salary in the sector was 15.130SKK (447€) while the global average pay was 18.761SKK (555€)²²². Such low salaries are the most important incentive for medical staff to leave work abroad. This is even more attractive for young professionals who are the beginning of their career.

On the other hand, experience shows that some of the staff who initially went abroad came back because of the fact that their diplomas and experience were not recognised at the same level as in their home country. In many cases the staff that leaves the country are highly qualified and often experienced and the positions which are given to them do frequently not meet their expectancies in terms of professional satisfaction.

Though the lack of staff is a problem recognised by all the partners in social dialogue, solutions are rare. The previous government used to "promise", to use the language of social partners, that doctors and nurses from more eastern countries or even further away, would come to Slovakia. However the barriers for these doctors are far too important. The most obvious barrier is the language, good knowledge of which is essential for medical staff. But besides the language there are even stronger administrative barriers. For example it is very hard for third country nationals to have their qualifications recognised and to be accorded the right of residence in Slovakia.

Skills and training

Qualifications and training of Slovak health care staff are also an important topic of social dialogue. On one hand the qualification requirements for health care staff with lower qualifications have been recently raised, in order to align Slovakia with EU requirements. On the other hand the requirements on the diversity of staff available in a hospital, together with the variety of existing qualifications are difficult to meet. In addition, employers have negative incentives when it comes to training of their staff.

²²² Source: Slovak statistics office: <http://www.statistics.sk/webdata/slov/tabulky/pmm/pmm07a.htm>

In the past the so called “middle health care personnel” (i.e. nurses, technical staff, etc.) was trained in professional high schools which resulted in high school general state examination, giving them access to the profession. The regulation of these professions has changed in view of harmonisation with EU rules. Today for most of these professions a bachelor degree is required. This raises questions of retraining of staff who acquired their qualifications according to the past regulations.

Though it is not an obligation for, for example nurses, who have been already exercising the profession when the legislation has been modified to update their diplomas, many of them do so. The main reason they mention for such further studies is their fear of possible future regulations and also the fact that they are afraid to be less paid than nurses with higher education diplomas in the future.

The main problem in this field is the lack of any regulation on arrangements for further training. Employers have no obligation to provide for their staff to attend courses if they desire so. Therefore everything is left up-to individual arrangements among employers and employees. It has been noted by Slovak trade unions, that many nurses, but also other medical personnel, do their further training in their free time.

Another challenge linked to staff training concerns the question of who is to financially cover the period of further training. The problematic aspect in this topic is the fact that any further training has to contain at least fifty percent of on-the-job training, but this can only be done in university hospitals. Hospitals are often encouraging their staff to be trained but at the same time such training is very costly for them. These employers have to bear the usual costs of employing the person in training, while the person actually works in a university hospital. In addition, examples of freshly retrained staff leaving their employers for a university hospital during their period of training are numerous. Such experiences do definitely not create incentives for employers to motivate their staff for further training.

Another challenge linked to qualifications of health care staff is the requirement on availability of particular professions within each unit and the multiplicity of basic health care qualifications in Slovakia. While most EU countries have around fifty basic health care professions, Slovakia recognises approximately eighty. This creates a problem of too narrow specialisation of some staff. It is also very difficult, especially for small hospitals, to comply with requirements on professions which have to be available in a unit. More flexible arrangements would be very much welcome by Slovak employers.

SLOVENIA

Economic and labour market context

Since the nineties the Slovenian economy is showing good performance in terms of real GDP growth but also when it comes to unemployment. As one of the best performing EU-12 member states, Slovenia's GDP growth has been above the EU average ever since the late nineties. In 2006, real GDP growth was 5.2%, which represents a 1.2 points increase since 2005.

Slovenia is also performing better than the EU average in terms of unemployment. In 2006, six percent of the Slovenian population were unemployed compared to the nearly eight percent EU-27 average. Though the unemployment rate is rather low, long term unemployment in Slovenia is slightly higher than in the EU-27. It is close to 49.3% of the unemployed compared to 45.6% in the EU.

Gender differences in unemployment in Slovenia are higher than in the EU-27. The unemployment rate of Slovenian women is nearly 2.5 points higher than unemployment of men. On the other hand the proportion of women in employment is better than that of the EU-27.

Table Employment and unemployment rate EU 27 and Slovenia in 2006²²³

	EU-27	Proportion female/male	Slovenia	proportion female/male
Total Unemployment	7.90%		6.00%	
Males	7.10%		4.90%	
Females	8.80%	123.94%	7.20%	146.94%
Total Employment	64.30%		66.60%	
Males	71.60%		71.10%	
Females	57.10%	79.75%	61.80%	86.92%

Employment trends in hospital sector

Although the health care and social care sectors represent an important employer in Slovenia the proportion of population employed in this sector is much lower than the EU-27 average. While in Slovenia nearly six percent of active population are employed in health or in social care in EU-27 this represents nine and half percent. Like the EU average the tendency is for this number to increase. Like in the rest of the EU the sector is very female dominated, but in Slovenia the difference between the proportion of male and female staff is smaller than in the EU-27 average.

Similar to the other EU-12 countries, Slovenia has a rather low number of young people joining the health care profession. Young people between 15 and 24 years represent only six percent of the total labour force in the sector. However their proportion is growing as in 2000 young people represented less than five percent. Though Slovenia has a lower proportion of health care staff aged 50 years and over than the EU-27, the proportion remains important (21.42%) and has been growing since 2000.

²²³ Data source: Eurostat

Table Employment in health care and social sector per sex and per age category²²⁴

	2000		2006	
	as % of total active population	as % of total employment in HC	as % of total active population	as % of total employment in HC
15 years and over - Sex -Total				
EU-27	8.63%		9.54%	
Slovenia	5.19%		5.88%	
15 years and over - Sex -Males				
EU-27	3.43%	22.51%	3.79%	22.07%
Slovenia	1.93%	20.04%	2.10%	19.47%
15 years and over – Sex - Females				
EU-27	15.43%	77.49%	16.76%	77.93%
Slovenia	8.97%	79.74%	10.40%	80.53%
Between 15 and 24 years – Sex - Total				
EU-27	6.14%	7.95%	6.99%	7.52%
Slovenia	2.54%	4.96%	3.83%	6.19%
Between 15 and 24 years – Sex - Male				
EU-27	1.91%	1.34%	2.28%	1.35%
Slovenia				
Between 15 and 24 years - Sex - Female				
EU-27	11.19%	6.60%	12.74%	6.18%
Slovenia	5.50%	4.53%	6.93%	4.60%
Between 25 and 49 years - Sex - Total				
EU-27	9.19%	70.98%	9.62%	65.84%
Slovenia	5.41%	76.29%	6.24%	72.39%
Between 25 and 49 years - Sex - Males				
EU-27	3.61%	15.67%	3.66%	13.82%
Slovenia	1.90%	13.79%	2.19%	13.27%
Between 25 and 49 years - Sex - Females				
EU-27	16.33%	55.31%	16.94%	52.02%
Slovenia	9.16%	62.50%	10.69%	59.12%
50 years and over - Sex - Total				
EU-27	8.22%	21.07%	10.41%	26.63%
Slovenia	5.84%	18.75%	5.65%	21.42%
50 years and over - Sex - Male				
EU-27	3.62%	5.50%	4.71%	6.90%
Slovenia	2.95%	5.82%	2.05%	4.60%
50 years and over - Sex - Female				
EU-27	14.89%	15.57%	18.03%	19.74%
Slovenia	10.42%	12.93%	10.84%	16.81%

²²⁴ Data source: Eurostat

Structure and organisation of hospital sector and key recent reforms

Slovenia is spending an important part of its GDP on health care. In 2004 public health care spending reached 8.63%²²⁵ which is a nearly one point raise since 1999. It is also nearly one point higher than the EU-27 average for that period. The break down of Slovenian health care expenditure is presented in the table below.

Table Breakdown of health care expenditure in Slovenia²²⁶

	1996		1997		1998		1999		2000		2001	
	SIT	%GDP	SIT	%GDP	SIT	%GDP	SIT	%GDP	SIT	%GDP	SIT	%GDP
1. Public expenditures	175,4	6,88	198,8	6,84	254,5	6,90	247,1	6,80	280,5	6,88	325,6	7,17
<i>CHI</i>	<i>168,9</i>	<i>6,62</i>	<i>191,3</i>	<i>6,58</i>	<i>246,3</i>	<i>6,64</i>	<i>237,8</i>	<i>6,55</i>	<i>270,4</i>	<i>6,64</i>	<i>313,4</i>	<i>6,90</i>
Payments of health care services	117,0	4,58	133,5	4,59	148,8	4,57	166,1	4,57	190,4	4,67	217,5	4,79
Payments for drugs and technical aids	25,2	0,99	28,0	0,96	33,9	1,04	37,4	1,03	42,9	1,05	51,4	1,13
Other	26,7	1,05	29,8	1,03	33,6	1,03	34,3	0,95	37,1	0,91	44,5	0,21
<i>NATIONAL BUDGET EXPENDITURE</i>	<i>4,8</i>	<i>0,19</i>	<i>5,4</i>	<i>0,19</i>	<i>5,7</i>	<i>0,18</i>	<i>6,2</i>	<i>0,17</i>	<i>6,8</i>	<i>0,16</i>	<i>8,9</i>	<i>0,20</i>
For health care programmes	3,0	0,12	3,6	0,12	3,7	0,11	4,1	0,11	4,3	0,10	5,2	0,12
Investments	1,7	0,07	1,8	0,07	2,0	0,07	2,2	0,06	2,2	0,05	3,6	0,08
<i>MUNICIPAL BUDGETS</i>	<i>1,7</i>	<i>0,07</i>	<i>2,1</i>	<i>0,07</i>	<i>2,5</i>	<i>0,08</i>	<i>3,1</i>	<i>0,08</i>	<i>3,3</i>	<i>0,08</i>	<i>3,3</i>	<i>0,07</i>
2. VHI	21,4	0,84	25,7	0,88	32,5	1,0	37,5	1,03	46,4	1,14	57,9	1,28
- Vzajemna	21,4	0,84	25,7	0,88	29,5	0,91	33,8	0,93	41,7	1,02	48,0	1,06
- Adriatic	n.a.	n.a.	n.a.	n.a.	3,0	0,09	3,7	0,10	4,7	0,12	9,9	0,22
3. Total	196,7	7,70	224,5	7,72	254,0	7,81	280,9	7,72	322,2	7,91	383,5	8,45

Financing of the system

Slovenian health care financing is based on a centralized compulsory health insurance system which is administered by the National Health Insurance Institute of Slovenia (later referred to as NHI Institute). The NHI Institute collects contributions from employers, employees, self-employed, farmers and some other categories of insured. These contributions constitute the major system of health care financing, providing approximately 80% of funding. The remaining part is covered by finances from private expenditure such as voluntary health insurance and out-of-pocket payments.

The contributions are proportional to the individual's income and shared between the employer and the employee. The parliament determines the contribution rates based on an annual proposal by the NHI Institute. In 2002, all employers and employees were paying a total of 13.45% of gross income: 6.56% by employers and 6.36% by employees, plus an additional 0.53% by employers to cover occupational injuries and diseases. The contributions of employers and employees were raised in 2000 as the income was no longer sufficient to cover the total expenses. This is mostly due to an increase of costs, such as on medication, but equally due to increasing demand.

When it comes to individuals outside employment, the National Institute for Employment pays a fixed contribution for each registered unemployed person. Other people with no income are registered in self-governing communities, which are obliged to pay a fixed contribution into the

²²⁵ Source : National Report on Health Care and Long-term Care in the Republic of Slovenia; June 2005; p.22

²²⁶ Source: Source: Study on the Social Protection Systems in the 13 Applicant Countries – Slovenia; p.132

http://ec.europa.eu/employment_social/social_protection/docs/slovenia_final.pdf

national fund. Pensioners pay a contribution of 5.65% of their gross pension. Farmers and craft workers contribute substantially less. Self-employed people, the fifth largest category of insured people in Slovenia, pay contributions according to a fixed proportion of their after-tax income.

In addition to contributions, some health care expenditure is covered by the national budget. This concerns mostly capital investment for secondary and tertiary health care facilities but also the national public health programme for prevention measures, education and training, research, information system, etc. Some groups of the population such as soldiers or refugees are also covered by the government budget.

Table Breakdown of health insurance revenues in Slovenia

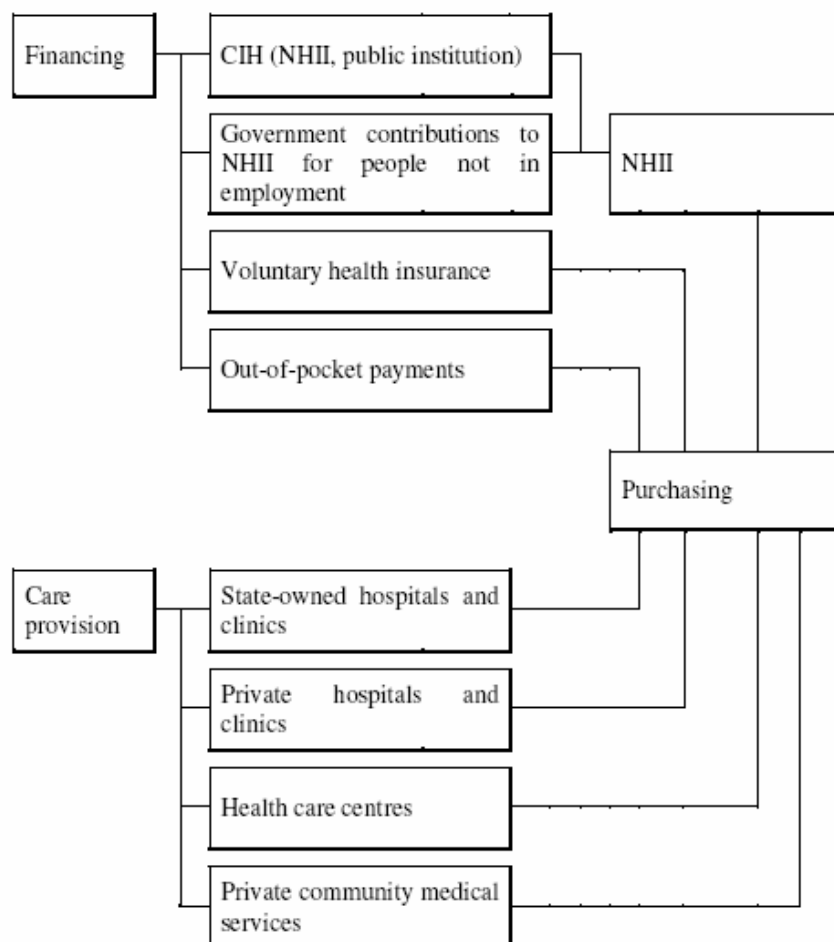
Source	Share in %
Employer, employee contributions	77,9
Contributions from the retired	16,3
Contributions from farmers	0,2
Other contributions	4,2
Other sources	1,4
<i>Total</i>	<i>100,0</i>

Finance allocation

In Slovenia finance allocation is based on annual prospective budgets. The total annual expenditure is negotiated by the government, the NHI Institute and the providers. Then, each type of provider negotiates the responsibilities and the rights of the partners. Finally, the NHI Institute negotiates annual contracts with each provider. However, the annual negotiations between the Ministry, the NHI Institute and the providers have proved difficult in recent years and sometimes agreement could not be reached.

These contracts specify a target activity level and a budget ceiling. Hospitals must meet their targets or else be liable to repay a proportion of their share. However, no additional payments apply if the target is exceeded. In practice, there have been occasions when the targets were revised during the year, or where a hospital experiencing financial difficulties received additional funding. This applies to hospitals as well as primary health care providers. The health care centres are paid a combination of capitation and fees for services.

Primary care physicians are reimbursed in full for their services only if the prevention programme has been fully implemented, if their referrals have not exceeded the national average by more than was agreed in the contract with NHI Institute, and if there are no long waiting lists. This is one of the measures of the Ministry of Health to stimulate primary practitioners to engage in prevention activities and to provide some degree of gatekeeping by discouraging unnecessary referrals to the secondary level. Such measures were introduced because in the past primary health care was underestimated and too many patients were being referred to secondary practitioners, causing unnecessary costs.

Figure 6- Financing, purchasing and provision in Slovenia²²⁷

Health care delivery system

Slovenian health care insurance is very comprehensive. The benefit package of the compulsory insurance scheme covers a full range of benefits, some of which are subject to co-payments.

The tertiary level includes university hospitals and institutes, performing highly specialized services, education, research, transfer of knowledge and development. Tertiary care services are generally organized at the national level.

Primary health care

At the primary level, health care centres provide health care to the population of one or several communities. There are both public and private providers of primary health care. Public providers include health care centres and health stations. The locations of healthcare centres correspond to the location of former self-governing communities (from before 1995), and the locations of health stations correspond to important local centres, which are small towns, hamlets or villages. Healthcare centres are operated by one or more self-governing communities, which also provide funds to maintain the premises.

Private care is provided by either individual health professionals acting as providers or by group practices with various combinations of services and specialties. Primary care providers

²²⁷ Source: Study on the Social Protection Systems in the 13 Applicant Countries – Slovenia; p. 127 http://ec.europa.eu/employment_social/social_protection/docs/slovenia_final.pdf

are contracted by the self-governing communities (concessions system). A concession is based on the agreement of the ministry of Health. Therefore, the Ministry maintains an important power to regulate the delivery network. A concession is the prerequisite for reimbursement of practitioner services by compulsory and/or voluntary health insurance.

As shown in the table below, Slovenia has a very small number of primary health care units per 100.000 inhabitants. This number is very low due to the small number of individual physicians in private practice. Indeed in Slovenia most primary health care is delivered within the above mentioned health care centres which are owned by the self-governed communities. Such a low number of primary units enables to control the delivery system and also succeeds in keeping the number of outpatient contacts relatively low.

In Slovenia, personal physicians have a gatekeeping role in the system.

Secondary and tertiary care

Specialist secondary care is performed in hospitals, polyclinics and spas. University hospitals and university institutes provide more complex tertiary health care services.

Most hospital polyclinics are under contract with the NHI institute and work within the public network of health care services. There are also a few purely private health care providers of secondary specialist care and diagnostic services, but most work on contract with NHI institute.

Hospitals provide about 75% of secondary care, either as inpatient or outpatient care. There are 26 hospitals, including nine regional and three local general hospitals and the main tertiary and teaching hospital, the University Medical Centre in Ljubljana. In addition, there are 12 specialized hospitals.

As shown below, the number of hospital beds declined recently as a result of a policy of moving from inpatient to outpatient care implemented mostly by reducing resources.

Table Data about the structure of Slovenian health care system (2004)²²⁸

	EU-25	Slovenia
Primary health care units per 100000	61.57	3.2
Outpatient contacts per person per year	7.82	6.98
Hospitals per 100000	2.65	1.45
Bed occupancy rate in %, acute care hospitals only	74	73.19
Acute (short-stay) hospitals per 100000	...	1.1
In-patient care admissions per 100	20.65	17.27
Acute care hospital admissions per 100	19.36	16.58
Average length of stay, all hospitals	8.13	7.5
Average length of stay, acute care hospitals only	7.99	6.16

Industrial Relations

A legislative chamber, the National Council, represents the plurality of the country's vested interests. Besides this, a tripartite Economic and Social Council (ESC) was set up for social concertation in matters of labour law, wages, and social politics as well as economic promotion. The legal basis of the ESC is a tripartite agreement reached in 1994.

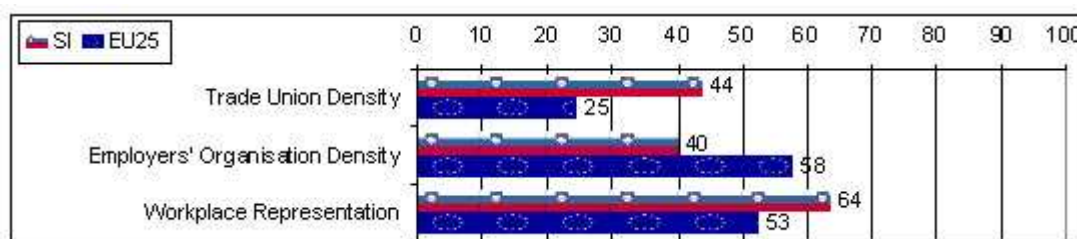
²²⁸ Source : European Health for all database <http://data.euro.who.int/hfad/>

A further major element of continuity is the system of partnership- and equality-based industrial relations. This includes company-level works councils, which are designed by law (since the Workers Participation Law, 1993) to serve as general representation alongside the trade union representatives at company level. These works councils have far-reaching rights of information, consultation, and negotiation of company agreements, with the exception of wage issues. They are also the proposing bodies for the employee representatives on the supervisory board as well as for the labour director in the executive management of companies with more than 500 employees.

The new laws on collective agreements as well as on Chambers of Commerce were adopted in spring 2006. The question of criteria of representation for social partners remains open and changes are expected in the composition of the ESC. The Chamber of Commerce and Industry is so far the dominating partner for trade unions negotiating sector-based collective wage agreements. The Independent Association of Slovenian Employers (ZDS), founded in 1994, will play a more important role following a transition period.

Actors

Representation



Employees

Slovenia is characterised by a plurality of organisations in both social partners. There are six representative trade union confederations and four national employer organisations. About 70% of the membership works in the public sector.

There are four main trade union associations, which are also members of the tripartite national ESC:

- Association of Free Trade Unions of Slovenia (Zveza svobodnih sindikatov Slovenije, ZSSS) consists of 21 organisations and has about 300,000 members. Its main sector is private industry, private services, and the public sector.
- Neodvisnost, Confederation of New Trade Unions of Slovenia (Neodvisnost, Konfederacija novih sindikatov Slovenije, KNSS) consists of 10 organisations and has about 38,000 members. It represents only private industry.
- The Confederation of Trade Unions of Slovenia PERGAM (Konfederacija sindikatov Slovenije Pergam, PERGAM) currently comprises eight organisations and is responsible for 87,000 members. It represents private industry as well as the public sector.
- The Confederation of Trade Unions '90 of Slovenia (Konfederacija sindikatov '90 Slovenije, Konfederacija '90) consists of 22 organisations and has about 40,000 members. Its main sector is private industry and private services.

Other confederations include the recently established confederations, Alternativa and Solidarity, which are mainly concentrated in the railway sector. They are recognised as

representative organisations according to the legal criteria (depending on membership only in a few sectors) but are not represented in the ESC.

A new Confederation of Public Sector Trade Unions (Konfederacija sindikatov javnega sektorja, KSJS), consisting of five formerly independent union federations, was established in May 2006 and will gain representation after a six-month transition. It is now the second largest confederation and represents more than half of all workers in the public sector.

Total union membership in 2004 was about 465,000. After a rapid decline in the 1990s, membership numbers seem to be fairly stable. According to recent surveys coverage has recovered to about 44%.

Dominating the confederations is the Association of Free Trade Unions, ZSSS, with more than 60% of all union membership and 20 affiliates, emerging from the former monopolist trade union. Nevertheless, ZSSS controls only two of the five seats in ESC. There is an evident tendency in this confederation to reduce the organisational segmentation through mergers of its affiliates in order to realise adequate sectoral collective agreements.

Employers

There are five main employers' associations:

- The Chamber of Commerce and Industry of Slovenia (Gospodarska zbornica Slovenije, GZS) is the biggest, with compulsory membership until the new law of 2006. It consists of 64,000 organisations and represents about 486,000 employees. Its main sector is private industry.
- The Association of Employers of Slovenia (Združenje delodajalcev Slovenije, ZDS) is a voluntary organisation of 1,200 companies and represents about 190,000 employees. Its main sector is also private industry.
- The Chamber of Crafts of Slovenia (Obrtna zbornica Slovenije, OZS), the second chamber, consists of almost 47,000 organisations and represents about 140,000 employees.
- The Association of Employers for Crafts Activities of Slovenia (Združenje delodajalcev obrtnih dejavnosti Slovenije, ZDODS) is the smallest. It consists of 2,950 organisations and represents about 15,800 employees. Its main sector is private industry and services in SMEs.
- The Association of Employers, ZDS, (founded in 1994) and the Small Companies and Crafts' Association, ZDODS, represent companies with nearly 40% of all employees in the private sector. ZDS has 12 sections for different industries. As chambers, GZS and OZS have mandatory membership for all employers and are leading parties in the employers' side in collective bargaining.

The employer organisations are thus characterised by a dual representation. On the one hand, there are the two Chambers of Commerce and Industry and of Crafts (representing 100% of entrepreneurs). On the other hand, there are autonomous confederations with voluntary membership. Together they are joint partners of the trade unions in the process of collective negotiations. This status will be revised by new collective bargaining legislation in 2006 in favour of autonomous employer confederations, according to usual EU procedures.

Based on this system (which is similar to the Austrian system) there is a complete coverage of sectoral agreements for all employees. However, a change to remove the chambers from their leading positions by new laws (concerning ESC and collective bargaining) has now emerged.

Collective bargaining is highly formalised and carried out at three levels.

National level

As a first step, the social partners and the government, at national level, (the national tripartite council, ESC) agree on the wage indexation mechanism to be followed by the social partners in negotiating wages at lower levels (i.e. compensation for a certain percentage of inflation as measured by consumer prices) as well as on the processes of recognising productivity gains by annual wage increases with regard to global competition aspects. In recent years the guideline of letting real growth in basic wages lag behind productivity gains by at least 1% was observed in the negotiating process. That means that the productivity rate minus 1%, plus a compensation equal to 80% of the current inflation rate, is agreed at sectoral and company levels as the maximum pay increase. This is the output of the tripartite social pact (2003–05) and the Pay Policy Agreement for private industries 2004–05, in order to meet the Maastricht and EMU criteria.

Sectoral level

The system of collective agreements covers all 28 industrial (business) sectors. Furthermore, there are separate collective agreements for some professions (such as journalists and physicians) as well as for civil servants. In all, there are 34 sectoral and subsectoral agreements. Up to now, the sectoral agreements contained nine categories of wage groups (with a scale of coefficients between 1 and 3 in accordance with different qualifications and tasks) differing only in specific absolute amounts in each sector. It is intended to replace this schematic procedure by more autonomous sector-specific adaptations concerning wage categories and regulations of working conditions. This tendency to decentralisation came about because there are large differences in economic performance in different sectors, which need to be considered in lower level negotiations.

The tripartite bargaining round of 2004 and different industrial actions organised by ZSSS (see the discussion on industrial conflict later in this document) led to a special solution. After years of centralised and restricted wage policy a new model was defined: only a minimal wage increase is agreed at national level while the final increase is fixed by the partners at sectoral level, considering the specific situation in the sector.

Company level

Agreements at company or plant level can grant workers an additional increase according to microeconomic results. They allow for a reduction of wages in cases of economic crisis in certain sectors (such as the textile industry).

The smaller trade unions favour centralising collective bargaining at national level because they fear a lack of influence especially in sectors with a weaker representation, whereas the ZSSS strongly promotes changes that would strengthen sectoral bargaining and agreements.

A new practice was recently introduced in the wage bargaining system in the private sector. The employer associations and trade union representatives reached a national wage indexation agreement (to compensate for inflation) without government involvement. This agreement provides for the full coverage of all workers in the private sector.

Coverage rate and extension of collective agreements

Just as all private employers are obligatory members of the bargaining chambers, all sectoral agreements are automatically extended to almost all employees. That is why the coverage rate reaches nearly 100%. With the new law on collective agreements, voluntary membership in the social partner organisations is foreseen after a transitional period of three years. It is

expected that this will have a strong influence on the coverage rate of future collective agreements.

Workplace representation

Workplace representation exists in a dual way: by classic trade union bodies (shop stewards) and works councils (introduced in 1994). Works councils have rights of information, consultation, and participation (referring particularly to changes in entrepreneurial status or manpower politics). In 2001 there were works councils in 76.7% of surveyed companies with more than 200 employees. A 2004 survey of larger companies showed them in 63.9% (according to researches for the Cranfield network, reported by M. Stanojevic, University of Ljubljana). With respect to the high proportion of SMEs, an estimate by ZSSS that about 50% of Slovenian employees are represented by works councils and/or local trade union organisations seems to be realistic. Both kinds of representation (institutional and trade union) are cooperative because of a clear division of targets between participation in personnel and social matters at company level (particularly concerning labour organisation or working-time schedules) on the one hand and collective bargaining on the other. The collective bargaining is based on a high degree of unionisation, especially in mid-sized and larger companies. In addition to these shop-floor institutions the law provides for employee representation at higher levels in supervisory boards (between one-third and half the seats are allocated to worker representatives) and a labour director is nominated by the works council in companies with more than 500 employees.

Policy concertation

There is a long tradition of tripartite social pacts. The most important issue of tripartite concertation is wage coordination, with its normative results for wage negotiations, and the national minimum wage, which is fixed by law. Social pacts also cover a range of social and economic issues that fall under the interest of social partners, e.g. taxation, employment, competitiveness, health and safety, and welfare. Other matters of consensual tripartite concertation are the preparation of social and economic legislation issues and the field of social administration (e.g. the social insurance system) as well as the control of political implementation (e.g. through labour courts).

Social partner organisations in the hospital sector

Several trade unions represent the interests of health professionals, covering one or several professions:

Union of health care workers of Slovenia (Sindikat zdravstva in socialnega varstva Slovenije – SZSVS <http://www.sindikatzsvs.si/>) which is a member of EPSU;

FIDES – the Slovenian Union of Physicians and Dentists;

the Slovenian Health Service and Social Welfare Union (SZSS);

the Healthcare Trade Union (SDZNS);

the Association of Trade Unions in Health (SZS)

Public health institutions are members of the Society of Health Institutions of Slovenia (Združenje zdravstvenih zavodov Slovenije – ZZS <http://www.zzs.si/>), which individuals may also join. This society is one of the partners that represent the interests of health providers in negotiations with the payers of services. ZZS does not participate in collective bargaining in hospital sector. Employers are represented by the government (Ministry of Health).

The main body for social dialogue in health care is the Economic and Social Council which is the main tripartite body. Formally, the council is made up of 15 members, five from the

government, trade union confederations and employer organisations respectively. Other trade unions are often informally involved. Council's field of activity is limited and concerns mainly industrial relations, conditions of work, labour legislation, social rights and employment policy, as well as other broader economic and social issues which concern the interests of workers and their families, employers' interests and government policy. In relation to health care, the Council debates any major reforms such as restructuring, working hours or financing of the system.

In relation to health care there is no social dialogue at sectoral at regional or local level.

Key challenges for sectoral social dialogue

The key challenges for social dialogue in health care are:

- privatisation of structures
- working hours
- staff shortages

Privatisation

After the change of government in 2004, there have been continued debates about how to introduce more private initiatives into health care. While at the same time opposition is opposed to continuation of this tendency. The opposition is joined by several trade unions, managers of some publicly owned health care providers and some academics in challenging these principles. In the previous term, the government continued with the policy of very cautious granting of concessions to private practitioners. This is what trade unions address as "silent reform" as there is no explicit reform process in place. During the last years concessions were being delivered without any planning or limits. It should be noted that these concessions mostly concern primary and specialized secondary health care but not hospitals. The new act on concessions intends to facilitate the process of privatization of health care delivery, but also more clearly define it. Still, this is seen by many as a push to a more determined privatization.

As this form of privatization is not a open reform process there is no formal social dialogue on this theme. Therefore social partners created a *Movement for preservation of public health care* (Gibanje za ohranitev javnega zdravstva). It mainly operates through a website: www.ohranimo.si .It is openly supported by the opposition. Several members of the board of the movement are influential politicians (including the former minister of health prof. Keber), representatives of centre-left political parties, trade unions and managers of primary health care centers. The Movement would like to see a serious brake on further privatisation of health care delivery, if not a reconsideration of the entire process so far. Private practice should only be made available there where public interest is lacking or public providers do not find it financially sustainable.²²⁹

More than 100.000 people already supported objectives of this movement by signing to its petition. The main arguments of trade unions are:

- privatization creates inequalities in access to health care
- privatization does not lead to more effective delivery on contrary in long term health care becomes more expensive
- in addition the state loses its capacity to control expenses on health care

²²⁹ Source: Tit Albreht. "Public debates on privatization". Health Policy Monitor, October 2006. Available at <http://www.hpm.org/survey/si/a8/2>

Staff shortages²³⁰

Though many EU countries have to face staff shortages in health care numbers of Slovenian doctors per 100.000 people are much lower than the EU-25 average. The country is attempting to tackle this problem in two ways:

- by increasing the capacity of medical faculties to accept more students and to educate more doctors;

In the past Slovenia applied numerus clauses on entrance to universities for medical studies. These limitations do not apply any more.

- by employing more doctors from other countries (especially from countries which were part of former Yugoslavia).

Trade unions are included in discussion on both above issues.

Working hours

Maximum working hours are one of the topics of social dialogue within the Economic and Social Council. Because of the acute shortage of doctors, this issue has become increasingly critical.

The duration and organisation of doctors' working time is regulated by the Law on the Doctor's Service (LDS). Following the 2002 amendment of this law, doctors were allowed to work 32 hours without interruption. In order to work more than 16 hours a day, each doctor needed to sign a written consent. While trade unions prepared a format for such consent which included a clause on payment provision most directors did not use it and replaced it by a form with no provisions for payment. As a result, the doctors refused to sign it. According to Trade Union of Doctors and Dentists of Slovenia (Sindikat zdravnikov in zobozdravnikov Slovenije, FIDES), many doctors worked night shifts and were on call in a way that was not in accordance with the law. In the end, the controversy escalated into a warning strike.

It was the main topic of controversy between the ministry of health care and FIDES. The trade union protested against the dangers of doctors working very long hours such as:

- doctor shortages;
- doctors being overburdened with overtime;
- lack of financial means for healthcare;
- mismanagement of healthcare institutions.

The conflict between the trade union and the government resulted in a warning strike by in May 2004.

²³⁰ Source : <http://www.eurofound.europa.eu/eiro/2005/07/feature/si0507301f.htm>

SPAIN

Economic and labour market context

The Spanish economy attained a 3.9% growth rate in 2006, 0.3% more than in 2005. The labour market also performed well in 2006. A total of 571,800 jobs were created. Women accounted for more than half of these new jobs. The male unemployment rate was 6.1% and the female rate was 10.5%.

Structure and organisation of hospital sector and key recent reforms

Spain has a National Health Service funded from general taxation which is administered at the regional level. The 17 autonomous communities are responsible for health care planning and delivery, with the central Ministry of Health retaining responsibility for overall policy planning and education.

The share of out of pocket payments in funding the health care system has increased steadily and reached 23.7% in 2003.

In 2003, Spanish health care expenditure was 7.4% of GDP.

Primary health care is delivered in health centres and by GPs and is predominantly publicly funded and run. GPs play a gatekeeper role and are generally the first point of contact between the population and the health care system. However, over the years, the number of patients directly entering via hospital emergency departments has increased.

The delivery of secondary and tertiary care differs between autonomous regions but is largely provided through public hospitals.

Recent reforms have focussed on better governance and clinical management as well as further decentralisation of responsibilities.

Outline of system of industrial relations

Since the 1970s, the Spanish system of industrial relations has undergone important socioeconomic changes driven by economic liberalisation, integration into the European Union, radical processes of political democratisation, and regionalisation. Social dialogue emerged only after the end of Franco dictatorship, in the second half of the 1970s. Political parties, trade unions and employer organisations got legal status only in 1977.

Collective bargaining is regulated by the Spanish Constitution of 1978. The law guarantees the right to collective bargaining between workers' representatives and employers and protects the binding power of the agreements.

Since the end of the Franco regime, Spain has struggled to reform its labour market and model of employment relationship. Forces seeking deregulation are counteracted by corrective efforts to get more regulation. Opinions are mixed on the impact of the industrial relations system, which was created since the democratic transition. Spain now has an advanced, recognised, and institutionalised system of bargaining and concertation. Echoes of the past regime have been mostly overcome and adjusted to a modernised economy, which recently created a lot of new jobs and established a constant flow of social pacts between 1994 and 2004.

Membership in Spanish trade unions is one of the lowest in Western Europe: only 16% of employees are trade union members compared to 25% of European employees.

Two major trade union confederations represent most workers. Starting from a diversified and pluralistic union landscape in the democratic transition period of the 1970s, UGT and CC.OO now hold a dominant position and are recognised at the national level as truly representative. The public sector also has other important unions. The Trade Union Confederation of Workers' Commissions (CC.OO) has about one million members. It was formerly closely associated with the Spanish Communist Party. The General Workers' Confederation (UGT) also has about one million members. This trade union is traditionally linked to the Socialist political party and is seen as more moderate. Since the end of the 1980s, unions usually cooperate closely at the political level.

There is only one important employer umbrella organisation nowadays, the Confederación Española de Organizaciones Empresariales (CEOE). It has an associated confederation for SMEs, the Confederación Española de Pequeñas y Medianas Empresas (CEPYME).

The collective bargaining structure is highly fragmented. Spain has a very large number of agreements – more than 4000 – and a rather decentralised structure, with agreements on the level of companies, on the level of groups of companies, but also on the provincial or national level of a sector.

There is some institutionalised tripartite social dialogue.

Social partner organisations in the hospital sector

Trade unions

Health Federation of CC.OO (Federación de Sanidad y Sectores Sociosanitarios de Comisiones Obreras) is a member of EPSU.

Public Services Federation of the General Workers' Confederation (Federación de Servicios Públicos de la Unión General de Trabajadores) is a member of EPSU.

Nurse Trade Union (SATSE Sindicato de Enfermería)

Independent Trade Union Confederation (Confederación Sindical Independiente-CSI)
Independent Trade Union Confederation Of Public Servants (Confederación Sindical Independiente de Funcionarios-CSIF)(CSI-CSIF)

Cesmsatse is an organization which was formed by two union confederations: National Confederation of Doctors Trade Unions (CESM Confederación Estatal de Sindicatos Médicos) and Nurse Trade Union (SATSE Sindicato de Enfermería) which have traditionally represented jointly doctors and nurses. However, since few years ago these two unions have decided to participate in unions election separately in some regions.

Employers

The sector is mainly public so the most representative employer association is the public administration through its regional branches (because competences were transferred from the central State to regions in 2002).

In the private sector, there is not any employer association which represent private hospital interests collectively.

Collective bargaining and social dialogue in the hospital sector

The sector is largely governing by public sector collective bargaining. Responsibility for this was transferred from the central to the regional level. Collective agreements reached at regional level affect the whole region and the rate of collective bargaining coverage is high. In addition, there are national framework working conditions which have to be integrated into collective bargaining at lower level.

The government has an obligation to consult social partners with more than 10% representativity of the sector. This covers all trade unions with exception of the nurses' federation and the regional employers organisations.

There are currently no tripartite or bipartite bodies dealing with sector-specific issues outside of wage bargaining.

SWEDEN

Economic and labour market context

Sweden is a highly industrialised country. Extensive forests, rich iron ore deposits, and hydroelectric power are the natural resources which, through the application of technology and efficient organisation, have enabled Sweden to become a leading producing and exporting nation. Since the mid-1990s, Sweden's export sector has grown significantly as the information technology (IT) industry, telecommunications, and services have overtaken traditional industries such as steel, paper, and pulp.

The Swedish economic picture has brightened significantly since the severe recession in the early 1990s. Growth has been strong in recent years, with an annual average GDP growth rate of 2.5 per cent for the period 2000-2004 and 2.7 per cent in 2005.

The employment rate, particularly among women, is considerable above the EU average and the unemployment rate is still under the EU-wide average, though unemployment has risen in recent years. The unemployment rate held steady for a longer period at about 5 per cent but in 2005 reached 7.8 per cent.

Figure - Employment and unemployment rates in Sweden and in the EU-25, 2000/2005

	Sweden in 2000	Sweden in 2005	EU-25 in 2005
Employment rate – total	73.0%	72.5%	63.8%
Employment rate – male	75.1%	74.4%	71.3%
Employment rate – female	70.9%	70.4%	56.3%
Unemployment rate – total	5.6%	7.8%	8.7%
Unemployment rate – male	5.9%	7.9%	7.9%
Unemployment rate – female	5.3%	7.7%	9.8%

Source: European Commission (2007) *Employment in Europe 2005*.

Employment trends in hospital sector

In real terms, the number of health care staff has decreased since the beginning of the 1990s, with the exception of physicians, nurses and midwives. The number of staff employed in the health care sector, expressed per 1000 people, dropped from 46.7 in 1992 to 31.9 in 2002. The main reason for this reduction in staff was a shift from hospital care towards primary care. The total number of hospital beds was reduced by more than 40 per cent between 1993 and 2003, and this reduction caused a decrease in the average length of stay²³¹.

If we look at statistics from the Swedish Statistics office in more detail, the statistics imply the reduction in employment took place in the early nineties as employment in the health sector increased by 13 per cent between 1995 and 2004. Particularly the number of dental hygienists has grown (49 per cent) as well as the number of doctors (22 per cent). There has also been a 13 per cent growth in the number of midwives and a 11 per cent increase in the number of nurses. The number of dentists has reduced by 13 per cent.

Figure – personnel in the Swedish health care sector

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Midwives	5,734	5,806	5,822	5,957	6,045	6,041	6,170	6,226	6,352	6,468
Nurse	85,203	84,908	84,670	86,091	87,127	87,940	89,344	90,793	93,366	94,959

²³¹ Glengård, A. (2005) *Health Systems in Transition*.

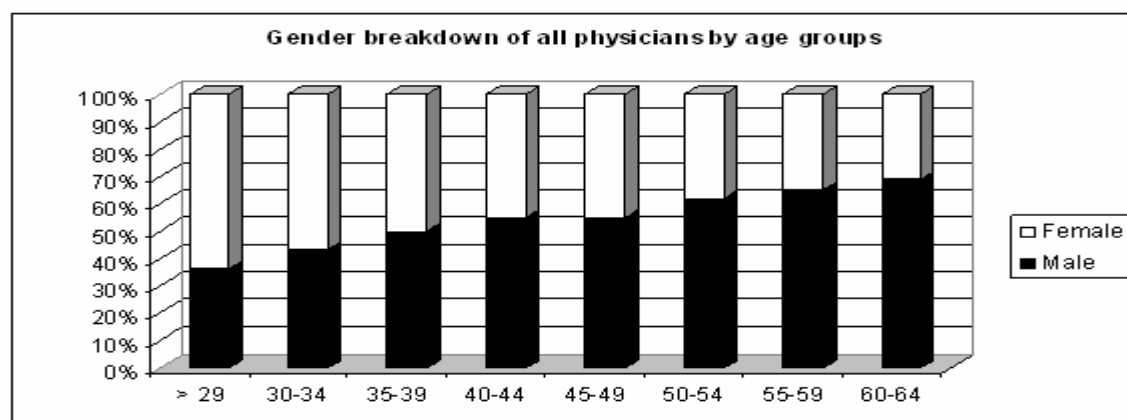
Doctor	23,427	23,571	23,773	24,263	24,646	25,213	26,064	26,873	27,790	28,501
Dental hygienists	2,031	2,079	2,101	2,230	2,359	2,509	2,665	2,771	2,925	3,034
Dentist	7,644	7,457	7,305	7,305	7,291	7,205	7,211	7,269	7,264	7,396

Source: GHK Consulting, 2007, on the basis of statistics from the National Board of Health and Welfare.

The health care sector workforce is ageing rapidly. For example, the number of over 60 year old doctors and nurses has more than doubled over the past decade; a significant share of the workforce will retire within the next decade.

At the same time the share of male nurses has slightly risen (from 7.8 per cent in 1995 to 9.3 per cent in 2004). The gender breakdown of doctors is also slowly changing with over 60 per cent of new doctors being female (see figure 3 below). The share of female doctors has increased from 35 per cent in 1995 to 41 per cent in 2004.

Figure – Gender breakdown of Swedish physicians



Source: GHK Consulting, 2007, on the basis of statistics from the National Board of Health and Welfare.

Sweden has a relatively high proportion of physicians working in hospitals in comparison with the other Nordic countries. More than 60 per cent of all doctors work in hospitals.

A significant majority of personnel in the healthcare and social welfare sector work in the public sector: 90 per cent work directly for municipalities and country councils; 2 per cent work in enterprises owned by county councils; and 8 per cent work in the private sector²³². Only 3 per cent of the workers in Swedish hospital sector work for private hospitals.

Structure and organisation of hospital sector and key recent reforms

Sweden has an integrated public healthcare system in which the majority of financing and almost all the delivery is provided by the public sector.

Organisational structure and management

Overall responsibility for the health care sector rests at national level, with the Ministry of Health and Social Affairs. The National Board of Health and Welfare, a semi-independent public authority, acts as the Government's central advisory and supervisory agency for health and social services. The Board supervises the implementation of public policy matters and legislation on health care and social welfare services²³³.

²³² However, the proportion of practitioners employed by private providers increased from 14.9 per cent to 17.5 per cent between 1993 and 1999 (National Board of Health and Welfare).

²³³ European Observatory on Health Systems and Policies: Health Care Systems in Transition Sweden.

The Ministry of Health and the National Board of Health and Welfare collaborate with other central governmental bodies, the most important of which are the Medical Responsibility Board, the Medical Products Agency, the Swedish Council on Technology Assessment in Health Care, the Pharmaceutical Benefits Board and the National Institute of Public Health.

Sweden is divided into 20 county councils (18 counties and 2 regions)²³⁴. They own and run most hospitals and are responsible for the delivery of primary and hospital care, including public health and preventative care. Counties usually divide themselves into several healthcare districts, each of which is run by an elected board. The counties are grouped loosely into six medical care regions that are designed to improve co-operation in highly specialised care, research and training. Each region has a population of 1-2 million and includes at least one university hospital²³⁵.

The counties also regulate privately run but publicly financed healthcare providers. They control the establishment of new private practices and the rules about the number of patients that private practitioners can see each year and set the fee schedule that must be adhered to if a private provider wants to be reimbursed by the social insurance system²³⁶.

At local level, there are 290 municipalities with their own areas of responsibility, such as long-term psychiatric care and care of the elderly and the disabled.

Health care delivery

There are over 1,100 local medical centres, doctors' surgeries and district nursing clinics throughout the country. Together these form the **primary** care structure, which is the foundation of the Swedish healthcare system. At the local medical centres, patients can be treated for all the health problems that do not require the technical and medical resources of the hospitals.

Most primary care is publicly provided. Only a quarter of outpatient consultations are conducted in private facilities, and most of those are in the larger cities and have contracts with the county council²³⁷. 'Purely' private primary care is rare.

Secondary / inpatient care is provided by hospitals. There are over 70 hospitals at the county level and 9 regional/university hospitals. The highly-specialised care has been concentrated on university hospitals. Only a few hospitals are privately run in Sweden, and even in them an overwhelming proportion of the activities are financed by public money, i.e. they are purchased and contracted by county councils. Public hospitals are larger than private hospitals and have more highly specialised sectors and equipment

Health care expenditure

Sweden witnessed one of the largest increases in health expenditure in Europe between 1995 and 2003. The expenditure rose by one percentage point during this time, from 7.5 per cent of the gross domestic product (GDP) in 1995 to 8.5 in 2003. Both figures are significantly above the EU averages.

²³⁴ Swedish Association of Local Authorities and Regions, 2007.

²³⁵ Rae, D. (2005) Getting Better Value For Money From Sweden's Healthcare System; Economics Department Working Papers No. 443. OECD.

²³⁶ Ibid.

²³⁷ The number of private physicians and health centres vary widely among the county councils. In some urban county councils, up to 60 per cent of primary care physicians may be private practitioners, whereas in other county councils only a few private practitioners can be found.

In comparison with other European countries, in Sweden a relatively large proportion of the resources available for medical services is allocated to the provision of care and treatment at hospital level²³⁸.

Funding

Healthcare is largely tax-financed in order to guarantee that people have access to the same high level of care irrespective of where they live. The principle of local self-government gives the county councils and regions the right to design and structure their activities on the basis of local conditions. They also have the right to levy proportional income taxes on their respective populations. This means that patient fees may vary. On average, patient fees account for 3 per cent of the revenues of the county councils²³⁹. In addition to these, the financing is supplemented by state grants.

In 2003, 72 per cent of the county councils' revenues originated from regional taxes. The remainder consisted of state grants (18 per cent), user charges (3%) and other sources (7 per cent). The share of local taxation as a way of financing the health care has increased considerably over the last 20 years (e.g. during the last 5 years, user fees – as a proportion of total municipality revenues – decreased by 0.6 per cent, whereas local taxes increased by 3.7 per cent²⁴⁰).

As already stated, there are only a few privately run hospitals in Sweden and most of their activities continue to be financed by public money as a significant share of their treatments are purchased by county councils.

Reforms

The Swedish health care sector has undergone several important reforms in recent decades. The most significant reforms, those that have had an impact on the health care system, have focused on three broad areas: the responsibilities of provision of health care services; priorities and patients' rights in the health care sector; and cost containment.

Decentralization of responsibilities has been a central element of reforms. The responsibility for health care has been decentralized to regional and local governmental bodies, with the exception of overall goals and policies, which are determined at national level. Decentralization of responsibilities within the Swedish health care system does not only refer to legislative devolution between the central and local governmental bodies, but also involves decentralization within each county council.

Reforms in the future will be focusing on²⁴¹:

- Improving access to primary care and better integration of hospital care, primary care and institutional care especially in the provision of services for the elderly, people with disabilities and those with mental illnesses;
- Cost containment;
- Further definition of responsibilities (of the central government, county councils and municipalities) for the provision of health care services.

²³⁸ European Observatory on Health Systems and Policies: Health Care Systems in Transition Sweden.

²³⁹ Swedish Association of Local Authorities and Regions, 2007.

²⁴⁰ Rae, D. (2005) Getting Better Value For Money From Sweden's Healthcare System; Economics Department Working Papers No. 443. OECD.

European Observatory on Health Systems and Policies: Health Care Systems in Transition Sweden.

²⁴¹ European Observatory on Health Systems and Policies: Health Care Systems in Transition Sweden.

Furthermore, it is expected that there will be a more diverse mix of providers in the future. The previous government claimed to have been in favour of more diversity among providers, through county councils entering into contracts with co-operative and voluntary care providers. But policy is currently unclear regarding how the public and private systems should interact. Traditionally the public (and the government) has been reluctant to see any expansion in for-profit providers.

Outline of system of industrial relations

Main actors

The three main organisations for employees are

- The Swedish Trade Union Confederation (LO) with two million members (mainly blue collar workers).
- The Swedish Confederation of Professional Employees (TCO), the confederation of unions of salaried employees, with 1.3 million members.
- Swedish Confederation of Professional Associations (SACO), which organises almost 570,000 civil servants and professional employees with academic degrees. A majority of employees in the hospital sector are members of unions affiliated to SACO.

The most important employers organisations are:

- The Confederation of Swedish Enterprise (*Svenskt näringsliv, SN*), which represents employers in the private sector and has 50 member unions.
- Swedish Association of Local Authorities and Regions (*Sveriges kommuner och landsting SKL*) that represents municipalities, regions and county councils.
- Swedish Agency for Government Employers (*Arbetsgivarverket*), a state agency responsible for the employer policy of agencies in the central government sector.

Level of bargaining

Today there are two levels of bargaining in Sweden: sectoral bargaining at national level and local bargaining at company level.

Since the eighties central agreements have been made in Sweden at the sectoral level, between each employer organisation and the unions that organise employees within that industry. During the 1990s, unions and employers signed agreements at the industry level about the framework for wage bargaining at the local level. They provided a set of rules for the local bargaining process and stated how the process should continue in cases when representatives at the local level cannot reach an agreement. However, unions and the employer at the local level can decide not to follow the industry level recommendations.

The most recent industry level agreements only include general guidelines on wage formation. This means, for example, that unions and employers at the local level can decide that wages should be set in wage bargaining between the employee and the manager. They can also decide that wages should be set in traditional negotiations between unions and employers²⁴².

In addition, the confederations (SN on the employers' side and LO, TCO, and SACO on the employees' side) conclude occasionally certain types of cross-industry agreements, namely on pensions and collective insurances.

²⁴² Granqvist, L. & Regner, H. (2004) The individual outcome of decentralized wage formation in Sweden.

Coverage rate

The trade union membership rate stood at around 77 per cent in 2004, while the employer organisation density rate was 55 per cent in 2001.

The coverage rate of collective agreements varies between 80 per cent and 100 per cent according to the different sectors (in 2001 the average was 92 per cent)²⁴³.

Policy concertation

Tripartite negotiations are rare. In general, the social partners do not accept the government or any other party intervening in collective bargaining.

Social partner organisations in the hospital sector*Trade unions*

The Swedish Medical Council SLF is represents around 38,000 doctors and other health care professionals.

The Swedish Municipal Workers Union (*Kommunal*) has a total of 586,930 members of which 65,000 work in the hospital sector.

The Swedish Union of Local Government Officers SKTF represents 152,179 municipal workers. Around 24,000 work in the hospital sector.

Akademikerförbundet SSR has just under 33,000 members. It is not known how many of them work in the hospital sector.

Vårdförbundet, the Swedish Association of Health Professionals

The Swedish Association of Health Professionals SAHP is the largest trade union in the hospital sector. It represents 105,635 workers of which 71,000 work in Swedish hospitals.

Sveriges Psykologförbund: Swedish Psychological Association

Förbundet Sveriges Arbetsterapeuter (FSA): The Swedish Association of Occupational Therapists

Legitimerade Sjukgymnasters Riksförbund: The Swedish Association of Registered Physiotherapists

Sveriges Farmaceutförbund: The Swedish Pharmaceutical Associations

Akademikerförbundet SSR: Association of Graduates in Public administration.

Ledarna: the Swedish Organisation for Managers

Employers

The Swedish Association of Local Authorities and Regions (SALAR) is the employers' organisation in the sector representing 290 municipalities, 18 county councils and regions Skåne och Västra Götaland. The Association of Private Care Providers (Vårdföretagarna) represents the interests of private providers.

Structure of collective bargaining and social dialogue in the hospital sector

Collective bargaining in the health (hospital) sector takes place both at sectoral and local levels, but local (workplace) level bargaining is increasingly predominant.

Sectoral agreements are usually concluded between trade unions and SALAR for different occupational groups within the health sector. Separate agreements are normally concluded for doctors on one side and for nurses, midwives and other healthcare professional on the other. The sectoral agreements in the health sector tend to be fairly long being often valid for 4-5 years. These agreements cover both public and private providers.

²⁴³ EIRO: Sweden - Industrial relations profile.

It has been a part of the bargaining strategy of the trade unions to demand local negotiations at workplace level, even though some members would prefer sectoral agreements with more detailed regulations, for reasons of equity. Due to the decentralised model of bargaining the sectoral agreement usually only stipulate that bargaining is to be carried out at the workplace level. For example, a five-year collective agreement for nurses, midwives and biomedical analysts signed in 2004 only guaranteed a pay rise of at least 2 per cent per year for the whole group (with an extra 0.5 per cent in 2000) – actual increases were negotiated at local level, linked to results achieved by individual workers.

This means that sectoral agreements in the health sector rarely contain an individual guarantee; pay increases are based on skills, aptitudes and performance of each individual.

Given that the wage setting is local and differentiated, the health care sector experiences some wage dispersion; salary levels differ considerably from one person to another. But individualised and differentiated salaries are seen as an instrument with which to combat high staff turnover, and attract qualified nurses by offering them both higher starting salaries and possibilities for further increases depending on their performance.

The widespread ongoing discussion around pay and working conditions in the Swedish healthcare sector has often been based on a general assumption that workers in private hospitals are much better paid than workers in the public sector. However, a study by Statistics Sweden (published in May 2002) concluded that pay in the Swedish private healthcare sector is generally around same level as in the public healthcare sector (though the situation varies between different occupational groups). The study also found that there are no significant wage differences between male and female workers in various female-dominated occupational groups, such as assistant nurses. However, the study found that female doctors' pay in the public sector is 16 per cent lower than male doctors' pay in the same sector.

Collective bargaining at local level usually covers not only negotiations on wages but also on other terms and conditions such as work obligations, working hours, holidays, sickness and leave benefits, insurance and pension benefits and emergency standby and on-call compensation.

Social dialogue between employers and the unions on other issues than the terms and conditions of employment is widespread. The unions and SALAR have several different working groups on matters concerning, for example, employment in the sector and patient safety. Both parties also collaborate closely with the National Board of Health and Welfare.

Key issues for the hospital sector and the sectoral labour market

Shortage of specialist nurses

The trade unions pointed out that there is a shortage of specialist nurses in many Swedish hospitals, mainly as a consequence of limited pay difference between general and specialist nurses. Few are interested in studying an additional year (or two) to specialise if they are not going to gain from it in monetary terms.

Migration to work in countries with higher wages is not regarded to be a particular problem. The most common foreign destination for Swedish nurses is Norway, but most Swedish nurses who end up going abroad only go for a relatively short period, and they are usually nurses from the Swedish-Norwegian border region. At the moment there are in the region of 1,500-2,000 Swedish nurses working abroad.

Recruitment challenges

Better integration of hospital care, primary care and institutional care has been put forward by several parties as one of the most important areas of reform - especially in the provision of services for the elderly, people with disabilities and those with mental illnesses. The care

sector (particularly care for the elderly and people with disabilities) faces a severe recruitment problem, having indirect effects on the hospital sector. Wage levels are relatively unattractive so staff turnover is high. There has also been a surge in the number of care workers absent on sick leave or retiring early. In addition to trying to retain the current workforce, municipalities need to expand employment in line with the increase in the number of elderly under their care.

The National Board of Health and Welfare foresees a need to recruit 200,000 people over the coming decade to work in the health and social sector (to put this in perspective, around 280,000 people are employed in the sector today)²⁴⁴. This suggests that wages for care workers will need to increase faster than in other sectors, adding to the financial pressures that municipalities will face in the future.

The National Agency for Higher Education in Sweden has estimated that the number of medical students needs to be increased by 30 per cent in order for Sweden to be self-sufficient in meeting the population's future needs for physicians.

Integrating foreign healthcare professionals into the Swedish medical labour force

The labour market integration of asylum seekers - qualified nurses, doctors and other healthcare professionals in particular - has been high on the political agenda during the current decade. Indeed, during the past few years a substantial proportion of the new certificates issued to Swedish physicians have been given to people that have graduated in other countries. This is a consequence of significant tripartite collaboration between employers, trade unions and public sector bodies to find methods to identify, recognise and validate the skills and qualifications of third country nationals.

The procedure to obtain a permit to work in Sweden as a healthcare professional is challenging for those who have not obtained their qualification in the EU. The National Board of Health and Welfare assesses the medical competence of each individual applicant and decides on what conditions need to be fulfilled (i.e. what complementary training is needed) for registration as a doctor in Sweden. Before the Board assesses the medical competence, individuals must present evidence of sufficient knowledge of the Swedish language. After that, they must either undergo an examination of medical competence or complete a probationary period of clinical service lasting at least six months. Normally, it is doctors without a specialist qualification who are required to undergo an examination of their medical knowledge and skills, while specialists with considerable professional experience do the period of probationary work. Before applying for registration, individuals must have attended a course and passed an examination on Swedish medical legislation.

Several different pilot projects have been implemented for example in Stockholm, Göteborg and Malmö which bring together different parties to design programmes that allow foreign qualified healthcare professionals to acquire a permission to work in the Swedish healthcare sector. For example, special language courses have been designed as a way of shortening the route to employment. Furthermore, different programmes have been implemented that have allowed Swedish healthcare professional to evaluate the skills of foreign healthcare workers, and then design short, tailored training courses that allow individuals gain experience in fields in which they do not match the experience required to work in Sweden. These projects, overall, have been successful at creating and shortening routes to employment for foreign healthcare professionals.

²⁴⁴ Rae, D. (2005) Getting Better Value For Money From Sweden's Healthcare System; Economics Department Working Papers No. 443. OECD.

UNITED KINGDOM

Economic and labour market context

The UK's economic performance has been positive over the last decade and labour market participation rates are high at 74.5%. Unemployment is 5.4% of the working age population in 2007.

Employment trends in the hospital sector

Since the introduction of the "NHS Plan – Modernisation and Reform" there have been increases in the numbers of frontline staff. Between September 1997 and September 2003 the number of doctors increased by 19,400 (22%) and the number of nurses increased by 67,500 (21%)²⁴⁵. Statistics indicate that the NHS workforce has increased by an average of 3.6% every year over the past five years.

Structure and organisation of hospital sector and key recent reforms

The UK health care system is a predominantly publicly financed system based on the Beveridge model. Established in 1948, the National Health Service (NHS) introduced the principle of state responsibility for public health, delivering health care free to be point of use. Its founding principle is to provide care to all on the basis of need rather than the ability to pay.

No stranger to ongoing reform, a series of fundamental changes have been introduced to the UK health care system, reorganising the structure of the NHS and how relevant agencies work together²⁴⁶. Patients are placed at the core of its services, with greater attention given to their needs and views on service provision.

Today, the UK health care system combines various organisational models, including:

- It largely remains organised under the Beveridge model, with strong state intervention and state provided health care;
- It uses public funding (partly from social insurance contributions) to finance health care services;
- It combines public and private care, including private for-profit hospitals; and,
- It increasingly offers the use of a choice of hospitals to patients.

Funding and expenditure

Total expenditure on health care in the UK was estimated at 7.7% of GDP in 2002. Total spending amounted to GBP 80.6 billion in 2002. Public expenditure amounted to 83% in the same year²⁴⁷. By 2008 expenditure will have risen to GBP 92.6 billion per year.

National Insurance (NI) contributions and income tax finance the health care system. They are paid according to an individual's level of earnings, with employers also making contributions.

²⁴⁵ NHS Improvement Plan 2004: Putting People at the Heart of Public Services
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4911408

²⁴⁶ How the NHS works <http://www.nhs.uk/aboutnhs/howtheNHSworks/Pages/HowtheNHSworks.aspx>

²⁴⁷ National Statistics, Total UK Health Expenditure
<http://www.statistics.gov.uk/CCI/nugget.asp?ID=669&Pos=1&ColRank=2&Rank=224>

Organisational structure and management

England

The Department of Health (state) regulates and holds overall responsibility for the structure, management and financing of the health care system.

At a local level, the health care system is operated by a series of authorities and trusts. England is divided into 10 Strategic Health Authorities (SHAs) which hold responsibility for improving health services in the local area and ensure they are performing to a satisfactory standard.

Within each SHA a range of trusts are responsible for managing health care services in the local area. These include; Acute Trusts, Foundation Trusts and Primary Care Trusts (PCTs).

Primary Care Trusts (PCTs) hold responsibility for local health care and provide the first port of call when people are ill. Services include GPs and dentists. PCTs are a critical component of health care services and control 80% of the budget. It is considered that as they are local organisations, PCTs are in the best position to deliver services to meet the needs of the local community.

Public hospitals are run and managed by acute trusts. They are responsible for the efficient spending of finances and improving services. The majority of health care personnel (doctors, nurses, pharmacists, midwives, health visitors and other medical staff) are employed by acute trusts.²⁴⁸

Foundation trusts, a fairly recent development, also exist. Developed in 2004, they are a new type of public hospital operated by managers, staff and members of the public, which deliver services tailored to the needs of the local population.

Other areas of the UK follow similar organisational structures, although there are some differences. These are outlined below.

Northern Ireland

Health care in Northern Ireland is regulated by the Department for Health, Social Services and Public Safety. It ensures the provision of health and social care in primary and secondary care settings²⁴⁹.

There are five health care trusts, which have overarching responsibility for health care and community services including GPs, hospitals, social services and community care. A mixture of 50 acute and district hospitals exist across the trusts.

Four Health Boards are accountable for assessing the needs of their populations and commissioning services to meet those needs. They establish objectives to meet the health and social needs of local populations and develop policies and priorities to address such objectives²⁵⁰.

Scotland

General responsibility for health care services rests with the Scottish Executive, Health Department. Its duties include overseeing NHS Scotland and funding health care services.

²⁴⁸ NHS Choices

<http://www.nhs.uk/aboutnhs/howtheNHSworks/hospitals/Pages/HospitalsSummary.aspx>

²⁴⁹ Department for Health, Social Services and Public Safety (DHSSPS)

http://www.dhsspsni.gov.uk/index/about_dept.htm

²⁵⁰ Health and Social Care, Health Boards <http://www.n-i.nhs.uk/index.php?link=boards>

Fourteen health boards provide a range of health care including health improvement, acute and primary services across the country. Regionally organised, they are able to design and deliver services designed to meet the needs of local populations. They have recently developed Community Health Partnerships (CHPs), which form a central element of the modernisation of health care services in Scotland.²⁵¹

CHPs are responsible for partnership development, integration and redesigning services. They will be a central point for integrating primary and specialist services, ensuring that local community members are involved in planning and service development.

Wales

Established in 2004, the Health and Social Care Department, part of Welsh Assembly Government, is responsible for the development and scrutiny of health care policy in Wales. Three regional offices and 36 statutory NHS bodies deliver health care services and are accountable to the Department.

There are 14 NHS trusts, which manage 135 hospitals and 15,000 beds. Generally people access District General Hospitals, which provide a range of outpatient, inpatient and day case services. Smaller community hospitals also exist and provide a smaller range of services.

Funding is distributed to Local Health Boards and then to NHS trusts. Finances are divided into those used to pay for hospital and community health services (HCHS) and those used to pay GPs, General Medical Services (GMS)²⁵².

Providers

Primary, ambulatory and community care

Doctors, dentists, nurses and other salaried staff in hospitals deliver primary and secondary care.

General Practitioner (GP) services are free to the point of use. Other primary care services, such as those provided by dentists, opticians and pharmacists have charges attached and are also provided outside the NHS on a private basis. Persons on low incomes may be exempt from such charges.

Recent additions to primary care services include NHS Direct; a 24 hour nurse led multi-lingual helpline offering information on health, illnesses and health care services. Callers are directed to health care services at the most appropriate level and are able to make informed decisions about their problem.

Ambulance trusts provide emergency health care. There are three ambulance categories, these are:

- Category A emergencies, immediately life threatening illnesses; and,
- Category B or C for emergencies which are non-life threatening.

Additionally, transportation to and from hospitals is provided for patients when accessing treatment. In most areas, ambulance trusts are responsible for this provision.

Community care is generally defined as services provided in people's own homes. This encompasses a wide range of health care including services provided by nurses, midwives

²⁵¹ Partnership for Care, Scotland's Health White Paper 2003
<http://www.sehd.scot.nhs.uk/publications/partnershipforcarehwp.pdf>

²⁵² NHS Wales, Organisation and Structure, Distributing Money
<http://www.wales.nhs.uk/sites3/page.cfm?pid=11612&orgid=452>

and other professionals such as occupational therapists. Such services are often provided in partnership with local government agencies.

Secondary and tertiary inpatient care

Generally, hospitals in the UK are public and patients do not have to pay for treatment or services provided there. Private hospitals are available and members of the public who pay for services through private insurance funds. Some employers provide such private health care insurance for their employees.

Hospital care is provided on an inpatient, outpatient or day care basis. Differences sometimes occur between individual hospitals as some have specialist units for certain areas of treatment, such as burns or cardiology. Hospitals may also be attached to universities, giving them 'teaching' status.

Most hospitals within the public system provide two levels of care. These are:

- Elective care – planned surgery, follow-up appointments and,
- Emergency care – accidents and suspected life-threatening illnesses.

There are approximately 100 private patient units in NHS hospitals throughout the UK. Patients pay through private insurance companies or pay directly for the treatment. Most units are members of the NHS Private Hospital Association. This organisation supports private practice within the NHS, ensuring the service is mutually beneficial.

Reforms

Since its inception in 1948, the NHS has undergone a number of reforms and structural changes.

The most recent reform occurred in 2003. This established a smaller Department with six ministers, 2,245 staff and three executive agencies (Scottish Executive Health Department, Welsh Assembly Government and Northern Ireland Assembly Department of Health, Social Services and Public Safety)²⁵³.

The NHS Plan – Modernisation and Reform - was introduced in 2000²⁵⁴. This is a 10 year plan that included a number of proposals to change the delivery of health care services in England. Critical to its implementation were increases in service personnel, modernisation of delivery and administration methods – for example, the increased use of ICT – and a greater number of training places for those wishing to enter the health service²⁵⁵.

Greater patient involvement in the development and delivery of health care services was proposed in the plan. As part of the reform, control over health care services has been decentralised. Locally based authorities are now responsible for delivering and regulating health care in local areas.

²⁵³ Department of Health http://www.dh.gov.uk/en/Aboutus/HowDHworks/DH_0784813

²⁵⁴ Department of Health, The NHS Plan: A Summary, 2000
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010198

²⁵⁵ Department of Health, Health reform in England: Update and next steps, 2005
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124723

The White Paper 'Our Health, Our Care, Our Say' introduced in 2006 proposed further changes to the delivery of health care in England²⁵⁶. It aims to achieve four key goals:

- Better prevention and earlier intervention;
- More choice and a louder voice;
- Tackle inequalities and improving access to community services; and
- More support for people with long-term needs.

Changes in management systems and the redistribution of funding will facilitate progress towards these goals. GPs will be given greater responsibility over budgets allowing them to deliver services most suitable for the local community. Increased partnership working and the joining up of local services is proposed, envisaging a lead to more streamlined health care. Additionally, in some deprived areas, providers are permitted to compete for services.

This is a new process, made permissible by the White Paper. Barriers preventing the 'third sector' entering the health service have been removed. This will increase the quantity of primary care services in some local areas.

Contractual and working arrangement changes for GPs were introduced in 2004. Changes in the General Medical Services contract allow GPs make a choice between offering just essential care for patients and offering a wide range of services. It is considered that this will lead to a wider range of community based services, offered through GP practices.

Outline of system of industrial relations

Industrial relations in the UK have historically been described as 'voluntarism'. There is relatively little direct intervention from the state, with the preferred method of labour regulation lying dominant with voluntary collective bargaining²⁵⁷.

Trade unions, employers and the state consider voluntary agreements to be more stable and long-standing than those imposed by state intervention.

Main actors

Trade Unions

Trade union bargaining power, membership and coverage have experienced a sustained decline over the last few decades. This can be explained by aggressive reforms adopted during the 'Thatcher' era along with increased employer hostility, changes in the make-up of workforces and organisational deficiencies in the unions themselves.

As a result union membership decreased by 5.5 million to less than one third of the workforce. The Workforce Employee Relations Survey shows that collective bargaining coverage dropped from 70% to 37% in last two decades²⁵⁸. Collective bargaining is still strong in some sectors including the public sector. Only 50% of employees are employed in workplaces with a recognised union.

Membership is relatively low; only 30% of employees are members of a trade union.

²⁵⁶ Department of Health, White Paper, Our Health, Our Care Our Say, 2006
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453

²⁵⁷ United Kingdom industrial relations profile,
http://www.eurofound.europa.eu/eiro/country/united.kingdom_2.htm

²⁵⁸ 2004, Workforce Employee Relations Survey <http://www.dti.gov.uk/employment/research-evaluation/wers-2004/>

Trade unions are mostly organised at sector or branch level and affiliated with a confederation. A few unions are organised within companies. Large unions – with over a million members – are generally affiliated with one confederation – Trade Union Congress (TUC). This is considered representative at a national level.

UNISON, predominantly active in the public sector, and Amicus, also active in health services and other sectors of the economy are the largest unions.

Employers

On the employers' side, TUC, has a parallel organisation. Generally, it represents large employers in the private sector. It is considered by the government as key to communicating with the private sector at this level. Like TUC, the Confederation of British Industry (CBI) has no mandate to collectively bargain and bind its affiliates.

Compared to other, long-standing EU Member States, employer organisations in the UK have a much lower profile.

Collective Bargaining

Collective bargaining agreements made in the UK are not legally binding. This is consistent with the underlying principles of voluntarism. Agreements have moral force only, yet are no less successful than formal legal agreements. Details of collective agreements are often included in individual employment contracts which are legally binding.

Level of bargaining

Negotiations can take place at three levels: sectoral, company and plant/shop floor level. Bargaining at the whole economy level has never been central.

The lower bargaining levels are now the most frequently used. Most collective bargaining takes place at a company level. Negotiations at a sectoral level have decreased considerably over recent years. However, it is still commonplace in the public sector, where 75% of employees are covered by collective bargaining agreements.

Coverage rate

Collective bargaining coverage is very low²⁵⁹. Employers were not obliged to enter into collective bargaining until 1999 and there is no extension of collective agreements to ministerial decree. Since the 1980s there has been an increase in industry setting conditions directly rather than negotiating with the unions.

Only 35% of UK employees are covered by a collective agreement in the public sector. This rate is even lower in the private sector, with only 11% of employees covered by the agreement.

Policy concentration

Policy concentration has been infrequent. A tripartite National Economic Development Council existed between 1962 and 1992 and discussed economic policy. Consultation between government, trade unions and employers was growing in importance towards the end of the 1970s. However, the subsequent government sought to remove all forms of corporatism.

The current government acknowledges dialogue with employers' organisations and trade unions, consultation with these partners in the policy making process is rare.

²⁵⁹United Kingdom, industrial relations profile
http://www.eurofound.europa.eu/eiro/country/united.kingdom_4.htm

An exception to this is the national minimum wage. A tripartite Low Pay Commission meets to update the national minimum wage.

Social partner organisations in the hospital sector

Trade unions

Trade unions are most active within the public sector. Some represent specific delivery sectors such as nurses or teachers; others represent the public sector more broadly. Those most dominant in the health care sector are:

- **UNISON**²⁶⁰ – is the biggest trade union in the UK. It has over 1.3 million members, including 400,000 within the health sector. It represents employees working in the public services, private contractors providing for the public services and essential utilities. It operates at branch, regional and national level. It is the leading union at NHS local level. Recent campaigns and ballots include the NHS Agenda for Change – a review of pay for all staff.
- **Royal College of Nursing (RCN)**²⁶¹ – represents nurses and nursing as a profession on a national and international scale. Its work involves lobbying for improved patient care at a government level, supporting diversity in the nursing profession and promoting the continuing professional development of nurses.
- **GMB** – is a general union with membership in most sectors including health and social care.
- **UNITE** – UNITE is a new general union, created in 2007 as a result of a merger between AMICUS and TGWU.
- **Royal College of Midwives** – RCM represents the interests of midwives.
- **Society of Radiographers** – SOR
- **Hospital Consultants and Specialists Association** – HCSA represents senior medical and surgical staff.

Employers

NHS Employers was established three years ago (the employers function was previously provided directly by the Department of Health). It manages the communications that facilitate discussion on pay and terms and conditions for health service employees in England. Representing NHS trusts on workforce issues and negotiating on behalf of employers makes up its core responsibility.

Working alongside employers, it acts on four policy areas. These are:

- Pay and negotiations – including annual pay reviews, redundancy notifications, pension communications and discussions referring to specific professions such as Consultants.
- Recruitment and planning the workforce – including promoting the health service as an employer, maintaining productivity, large-scale workforce changes and flexible working arrangements.

²⁶⁰ UNISON http://www.unison.org.uk/healthcare/pages_view.asp?did=13

²⁶¹ Royal College of Nursing <http://www.rcn.org.uk/aboutus/mission.php>

- Healthy and productive workplaces – ensuring equal opportunities to all health service staff and promoting diversity in the workplace.
- Employment policy and practice – monitoring compliance with wider legislation such as EU Working Time Directive, TUPE, whistleblowing and disciplinary procedures.

The NHS Confederation is an independent body providing representation to all organisations that make up the modern NHS²⁶². Its members include all statutory NHS organisations and all independent NHS providers in England, Wales and Northern Ireland.

Its core tasks are to:

- Influence policy – including implementation and public debate;
- Support leaders – through networking, sharing learning and information; and,
- Promote excellence in employment in health care services.

Through working with senior managers such as Chief Executives and Managing Directors it identifies cross-cutting issues that require addressing to benefit patients and the wider health care service.

Structure of collective bargaining and social dialogue in the hospital sector

For many years, the Whitley Council System was in place for the negotiation of public sector wages. In 2004 this was reformed. Now, the NHS staff council provides the framework for the negotiation of wages, pensions and terms and conditions. National agreements are reached which are ratified by the Secretary of State for Health. Partnership structures exist at the national and local level. A partnership agreement has been signed between the Department of Health, NHS Employers and the NHS trade unions.

One of the key agreements reached within this framework in recent years was *Agenda for Change* which sought to ensure equal pay and introduced harmonised terms and conditions for NHS staff as well as a more developmental knowledge and skills framework. The negotiation of agenda for change involved 17 trade unions and professional bodies, NHS Employers and the Department of Health. It covers 1.2 million staff and added 1 billion pounds to the pay bill. Implementation of agenda for change (job evaluation and creation of pathways for progression) is now largely complete. Job evaluation covering all staff was done in partnership. Agenda for change also offers:

- Recruitment and retention premia
- Applies London weighting (weightings for other regions also being considered)
- Out of hours payments
- Harmonised terms and conditions (annual leave, hours of work)
- Knowledge and skills framework

This is a significant change from the previous 650 job grades and thousands of different allowances. The benefits of agenda for change have been improvements in recruitment and retention, better productivity and a decline in professional risks. There is now better team working resulting in better patient care. This could only be achieved through good partnership.

There is a strong emphasis on social partnership in the NHS. A Social Partnership Forum had been set up in 2002 and was operational until 2006. It jointly discussed the new NHS Plan. However, social partners argue that in the latter years it lost its way and became more of a “talking shop”. Membership had become too large and wide and following the implementation of the NHS Plan its role had become too unfocussed. There were no agreed terms of

²⁶² The NHS Confederation <http://www.nhsconfed.org/about/index.cfm>

reference and in 2005 the Government published a White Paper which would have been tantamount to the privatisation of many services. The Social Partnership Forum had not been consulted on this paper and as result trust was lost.

In 2006 the Government made efforts to re-engage stakeholders with the setting up of a National Stakeholder forum (with a wider membership covering more general health care policy issues) and a Social Partnership Forum (mainly aimed at workforce issues). The participation of the private sector on this remains an unresolved issue. The new SPF involves the Department of Health, NHS Employers and the trade unions. All partners are committed to an NHS which provides a universal service paid for from taxation with equal access for all and free at the point of use. All support an NHS which is accountable to Government and have a shared commitment to continuous improvement. All believe that the NHS should promote good practice in diversity and staff management and have a commitment to security of employment. Co-operation is built on mutual trust and respect for each other's roles and openness, honesty and transparency in all communications. It has top level commitment to ensure the early discussion of emerging issues and ensures confidential treatment of materials where appropriate. It aims to ensure a "no surprises" culture. There are monthly meetings at national level, as well as regional and local meetings.

Key issues for the hospital sector and sectoral labour market reform

A range of policies and reforms have been introduced to the health sector in recent years. Most notably, those associated with increasing the choice available to patients, such as selecting a hospital for their treatment, have become a visible policy development.

NHS Choices aims to assist patients in making informed decisions about their health care and the course of treatment appropriate for them²⁶³. Once treatment has been selected, it is possible, under some systems, for a patient to compare and select a hospital for their health care. Selecting hospitals has some limitations as it is a relatively new service. It is expected to grow in use in the near future, as the service expands and awareness has increased.

Greater efficiency in the provision of hospital services is a key area of reform. The NHS Plan makes a number of statements relating to changes in the way treatment and health care is carried out. It outlines changes in diagnosis and follow-up treatment procedures – testing and diagnosing patients in the same day, and booking follow-up appointments if necessary – reducing administration processes and costs²⁶⁴.

Centring services and health care on the needs of the patient is a critical area of reform. For example, travel to specialist centres, providing the most suitable care for patients with complex illnesses now takes place.

The Plan proposes to give increased autonomy and control to staff at grass-roots level. This includes giving responsibility of ward management to senior nursing staff, allowing them to pursue their knowledge and experience to make the most informed decisions.

²⁶³ NHS Choices <http://www.nhs.uk/aboutnhschoices/Pages/AboutNHSChoices.aspx>

²⁶⁴ The NHS Plan 2000
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960