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**LABOUR RELATIONS, EMPLOYMENT
CONDITIONS AND PARTICIPATION
IN THE HEALTH SECTOR**

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This document presents the available evidence on labour relations in health systems in terms of objectives, models and results.

The document considers:

- Health care sector reform and re-organization: “efficient” labour relations.
- The various models of employment and labour relations in health care; their implications and their impact on organizational efficacy.
- The types of employment and labour conditions in the health sector, and the changes that have occurred during reform processes.

Introduction

Health care sector reform and re-organization

The health care sector is an important employer in every country. An estimated 35 million people currently work in the health sector (1), approximately 9 million in Latin America alone (2). Although overall employment in health sector has stagnated in Latin America, employment in the public sector is likely to increase in the near future. This will be due primarily to efforts to increase health care coverage, to changes in models of care, and to changes in epidemiological conditions, with poverty and infectious diseases coexisting with chronic and degenerative diseases.

The labour component of health care is crucial to the successful adaptation of services to new requirements. At the same time, the labour component is affected by various structural modifications. The purpose of this section is to analyse these interactions and their consequences for labour relations.

The 1980’s and 1990’s saw an unprecedented interest in health care reform worldwide. Despite the labour-intensive character of the health sector (labour-associated expenditures comprise 50% to 75% of the sector’s recurrent budget), insufficient attention has been paid to the repercussions of reforms on human resources and their management. One explanation is that WHO and other organizations identify issues related to human resources (e.g. remuneration and incentives) as “one of the most difficult aspects of the international health agenda” (3).

In Latin America, some health sector reform processes are derived from a general reform of the State or Constitution, some are due primarily to financial considerations, and some are influenced by both. Whether or not they were involved in national commissions on reform (4), Health Ministries have had little say in the design of those changes. In this region, few reforms have influenced all of the functions of the health sector or substantially modified the private-public mix. Most reforms have been limited in their reach (for example changes in service delivery but not in financing) or in their scope (including for instance only Ministries of Health and Social Security). Formal criteria for the national evaluation of health sector services and reforms (5) have been very restricted.

Even when health personnel have participated in the process of health sector reform, employee characteristics and their actions, whether for or against reform, tend to determine the viability and sustainability of the latter (6). Problems, policies and interventions related to human resources have received little mention within strategic agendas. Policy decisions related to human resources are subordinated to economic considerations. At most, personnel matters have received attention only insofar as they relate to

managerial concerns, as a part of a group of actions intended to improve efficiency and productivity. Paradoxically, this has occurred at a time when more general changes in the State, the economy and institutions have revolutionized the economic and labour conditions that obtained previously.

Generally speaking, the importance of employee action has been grossly under-estimated. Health sector workers, both individually and collectively, should be protagonists in the health sector reform. Failures in implementing reforms can often be explained by the tendency to consider workers as tools and to forget that their involvement and commitment are crucial to the success of reform.

Some cultural and managerial changes have been included in so-called second-generation reforms, such as the substitution of programme planning for project planning, the search for cost-benefit and cost-efficiency in determining interventions, and the incorporation of competition in assigning resources and in managing social actions. These are very significant changes within the health sector, with important consequences for human resources, as noted below.

Among the main *reform mechanisms with consequences on human resources*, the following can be identified:

Decentralization of personnel management

The decentralization of healthcare systems has generated most of the changes in personnel management within the public sector. This decentralization is taking place in all of Latin America and in many European countries (7). Among the Latin American countries studied, most have shifted resources and responsibilities to the intermediate level (State, provincial or regional governments) and, albeit to a lesser degree, to more peripheral levels (municipalities or their equivalent). This applies to services offered by the Ministries of Health (8) but not to those offered by the Ministries of Social Security. In developed countries, hospitals have acquired more autonomy in the management of their human resources (9), including the allocation of resources for wages

A new agenda for human resources management

Today two approaches or agendas occur in the management of human resources: the **old agenda**, which corresponds to a model of stable and protected labour relations, based on lifetime career; and the **new** or **flexible agenda**, which responds to a new regulatory model characterized by the flexibility of labour and employment (10).

The old agenda includes problems that personnel administration has not been able to deal with and that still persist – the continuation of a rigid norm makes changes in management difficult everywhere. The new agenda refers primarily to situations and problems arising from the reforms.

Reforms, players and strategies

Certain critical issues related to human resources in health care have regained importance and attention. The existence of multiple dynamics and conflicts among the social actors as well as corporate interests are of primary note in this regard.

In addition, views that take employees and their work as merely instrumental are being questioned and are being replaced by integral social and institutional views. These reflect various policy perspectives, emphasizing the right to health care for all, the status of health workers as citizens, new organizational paradigms with regard to human capital, and the role of knowledge as a productive force.

The old style of management, planning and education is also criticized. The individual-management point of view subordinates administration and emphasizes organizational, social and institutional relations and matters of power. The new perspective values strategic vision and workers' constructive participation within a planning process adapted to local realities.

The following table attempts to illustrate the reform processes as well as the changes in human resources they may bring about.

| Table I: Impact of reforms on health sector workers | |
|---|--|
| Substantive processes of reforms | Implications for workers |
| <ul style="list-style-type: none"> ✓ Decentralization ✓ Changes in the Ministries, both structural and functional ✓ Changes in finance and payment modalities ✓ New management modalities: externalization, outsourcing, buying of services, autonomy, etc. ✓ Changes in care models, at primary and complex levels ✓ Extension of coverage ✓ Concern with quality | <ul style="list-style-type: none"> ✓ Greater resolution of services and interventions ✓ Changes in functions and new competencies ✓ Demand for quality and productivity ✓ Organizational changes and a preference for teamwork ✓ Labour flexibility: new and more precarious contracting mechanisms ✓ Emphasis on performance and evaluation ✓ Changes in incentives ✓ Process regulation, human resources development ✓ Professional accreditation and certification |
| Source: PAHO/WHO. Human Resources Development Program, 1999 | |

Management of human resources within sector reform

Despite transformations in the sector, few countries have developed or strengthened specific units to improve human resources or have set up programmes to prepare themselves to face the challenges posed by health care sector reform. All agree that public sector reforms are taking place in Latin America, but there is no systematic commitment to guide the process as regards human resources. Several countries have introduced policies to link incentives to performance and improvement in productivity, yet few have developed far-reaching and integral approaches to labour performance.

When it comes to **services**, most developing countries are redefining public health care services, particularly ambulatory networks, dispensaries, and health care centres. This is commonly associated with the creation of programmes for vulnerable groups. Yet little has been done to improve the secondary and tertiary level (11). Changes in models of health care, particularly at the basic level, require improvements in workers' preparation, with emphasis on skills for health care promotion and prevention, for general practice and for effective teamwork.

Changes in models of health care and the challenges they involve (e.g. organizational transformation and major changes in work content) are forcing institutions to lead professionals and technicians in redefining their profiles and in acquiring a greater commitment to integration within the changes taking place in their services. In several countries, coping with change and developing new responsibilities have led to

the emergence of relevant new educational components within projects of institutional strengthening and investment, in order to support ongoing reforms. The current rich experience of “in-service education”, based on new educational perspectives, decentralized execution and forms of competitive management, must be evaluated.

Various models of employment and labour relations in health sectors

Employment models and labour relations in health care (both public and private) and their impact on organizational efficiency are part of a network of changes extending far beyond the institutional limits of the health sector. “Paying attention to the changes in labour and employment relations caused by **state reform and the corresponding changes in labour administration acquires great importance**. It is important to keep in mind situation changes as well as changes of the norms for employment of national economies, which are the ones to produce **labour reforms**. The health sector, with all its singularities, is subject to mechanisms of interconnecting links between sectors and subsectors regarding labour markets and wages” (12).

For that reason, examination of the models of labour relations in the health sector must be introduced along with the analysis of labour regulation models within the economic framework, sector reform, and public administration reform. Those factors combine to determine the specifics of labour relations in the sector.

Labour regulation models.

Three labour regulation models have been identified among developed countries: that of continental Europe, the Anglo-Saxon and the Japanese. Economic orthodoxy has considered the USA as a paradigm of productivity and competitiveness because it has few regulations, whereas continental Europe embodies the opposite. Japan has very strict labour regulation and social protection, but collective negotiation is decentralized.

Orthodox apologists of the American model emphasize the productivity growth of their economy in the 90’s and take it as proof of superiority of the model. Yet this statement has been questioned by diverse studies. For instance, it has been stated that none of the three great blocks in the world is globally superior to its competitors – each has comparative advantages and disadvantages (13). OECD research on specific institutions has led to similar conclusions on the efficiency of each model when taking into account working time, contracts, minimum wages and worker representation rights (14). The link between fundamental labour norms (freedom of association and collective negotiation) and commercial flows confirms that labour laws have a very limited impact on trade performance (15).

Another study concludes that the available evidence does not show a statistical correlation between economic performance and collective negotiation. There is one exception: economies with higher centralization/coordination in their collective negotiation show higher income equality than those that are more decentralized or non-coordinated. Another tendency observed is that the more centralized/coordinated systems register lower unemployment levels (higher employment rates) than those that are less centralized/regulated. The countries that have moved towards a more decentralized/less coordinated model during the 1980’s have suffered sharper falls in their employment rates than those more centralized or coordinated (16). In 1998 OECD concluded that countries with relatively high minimum wage regulation had smaller income inequalities and lower incidences of low income (17). In 1999 OECD presented another paper exploring Employment Protection Legislation (EPL) and the performance of the labour market (18). The data therein describe protective legislation on regulation of redundancy compensation in time limited employment contracts, and its practice in 27 countries between the late 1980’s

and the late 1990's. Consistent with prior studies, little or no relation was found *between strict EPL and global unemployment* (Author's emphasis).

It is worthwhile recalling Richard Freeman's memorable study and his conclusion: "Does labour market idiosyncrasy and/or employment policy significantly affect economic performance? My answer is yes. Institutions associated to collective negotiation and other forms of institutional determination substantially reduce disparities in income distribution. But the impact of those institutions on efficiency is weak and uncertain. A suggested null hypothesis is that institutions have an insignificant effect on efficiency at the national level, at least as far as the developed countries' experience goes" (19).

Among underdeveloped countries there are two opposed models: Latin America and South-East Asia. Orthodoxy has considered the first one as over-regulated, deepening structural dualism and preventing the labour market from adapting well to changes in market forces. On the other hand, in recently industrialized countries of South East Asia the labour market is very de-regulated, and this is considered to be a cause of the success of their export-oriented strategy of growth. It has been argued that this success has contributed to the repression of trade unions, particularly in their wage-negotiation function. This orthodox perspective on the South East Asian model has been criticized on the grounds that:

- Growth emerged within an environment of rising wages (20)
- In Korea it was necessary to discipline both the labour force and the companies, intervening to ensure working conditions corresponding to the level of development achieved (21), so that workers would also profit from the fruits of growth
- The evolution registered in the mid 1990's saw new measures of protection with no interruption of those countries' growth levels (the crisis had a financial origin).

"The normative evolution in Asia reveals that for export markets to succeed it is not indispensable to have a fully liberalized labour market or repression of the defense of workers protection " (22).

The orthodox argument is well known in Latin America: tariff barriers and strong State intervention alter the relative rents of sectors leading to economies with little capacity for growth and high sensitivity to macroeconomic instability. Labour norms, in particular, reduce market flexibility, raising wage costs and increasing (sometimes excessively), the bargaining power of trade unions. In the 1990's most countries introduced measures "to reform the legal system of labour protection, easing the dismissal of workers and creating flexible contracts ... (that) did not translate into employment growth, and had the opposite effect, due to the increase of dismissals and temporary contracts" (23). In the same sense, regarding collective negotiations: "the evidence suggests that, in Latin America, during those periods in which collective negotiation was not restricted or relatively free, the degrees of wage disparity and centralization of collective negotiation are inversely but loosely correlated, reproducing the OECD characteristic pattern" (24).

To summarize: the models of labour relations oriented to increase flexibility, de-regulate and decentralize do not appear to be more successful than their alternative – more protective – model in terms of national economies. On the other hand, the latter seems to offer better distributive behavior.

Models of public administration reform

Public sector reform in developed countries has been based on the idea of competition and economic incentives. In underdeveloped countries, public sector reform included three main aims as promoted by the World Bank at least well into the 1990's (these aims were strongly influential in determining the nature of health sector reform in emerging economies):

- Reduction of personnel paid with public funds
- Introduction of wage differences as incentives
- Restoration of the key elements of traditional bureaucracy: order, hierarchy, formal procedures and increased responsibility.

Experience with this model of public sector reform has been uneven, particularly because of resistance by the public sector, which strongly opposed reforms. Yet that resistance was mostly passive, leading to nearly indefinite delays in the implementation of norms (25). This resistance considers that reductions in personnel represent a direct threat to the means of livelihood of most public sector employees, while the wage options will benefit only a few at the higher levels (26).

The tendency of public sector reforms to modify the legal status and resources of employees has been observed everywhere. Countries like Austria (where health sector personnel are covered under the general labour law), Brazil, Italy Switzerland and the former centrally planned economies of Central and Eastern Europe all introduced greater flexibility. In those cases in which legal status has not changed, there have been frequent changes in contract conditions, inspired by those of the private sector: decentralization, subcontracting, and privatization (27). Among the examples of privatization, decentralization and subcontracting came from the health care sector, indicating that this is the sector in which most reforms have started and have been most extensively applied (28).

Models for employment and labour relations

Sector reforms have many factors in common: privatization, de-regulation, decentralization and subcontracting. This is the model followed by the recent evolution in all labour relations, though without modifying their original features. This is not a coincidence. All factors were based on the same inspiration of orthodox economics and, particularly among developing countries, of Bretton Woods institutions. That is why the tendency recurrently goes towards individualization, decentralization, flexibility, and in many cases deregulation of labour relations. The impact of these changes, nevertheless, has not been sufficient to fully dissociate the labour relations models in the health sector from those of the rest of society. Labour relations in the health sector are, for that reason, similar to the main national or regional models and trends: in the case of industrialized countries: that of continental Europe, the Anglo-Saxon – particularly the North American – and the Japanese, each with its singularities. Among developing countries, Latin America and South East Asia models represent opposites in this regard.

Types of employment and labour conditions in the health sector

Health sector reforms – whatever their starting point – have leaned towards the introduction of competition in formerly integrated systems. The outcome does not differ much according to the different types of health systems (Beveridgian and Bismarckian systems) as defined by Bach (29) since, in all cases, the reforms tend to increase competition between the private and the public sector.

Significant organizational changes have been observed in the US along 3 main strands:

- Increased diversification in organizational types and products
- Changes in managerial configurations and traditional ownership
- Development of new institutional arrangements with structural stratification combining multiple organizations and requiring more complex hierarchies and decision-making (30).

Such patterns are emulated elsewhere. This is particularly the case in community hospitals because of mergers or take-overs. The tendency towards reducing the number of institutions and increasing their complexity and stratification has increased the emphasis on competition. This is also linked to the increased relevance of market mechanisms in replacing many nonprofit organizations, including changes in the way professional personnel are hired: doctors are behaving less like consultants than like wage workers due to matters of economics (31).

Competition and changes in the nature of hospitals have been reflected in a reduction of stability and coverage, in greater labour mobility, and in surpluses in the supply of some services (32). Analyses carried out in Western Europe and other countries (33-34) show that increase in competition greatly affects working practices and that consequently “a larger share of personnel is hired under more precarious contracts (fixed time, temporary)” (35).

Employment and Contract Modalities

Employment

In terms of levels of employment, the ILO (36) identifies 3 situations linked to health reforms:

- Reforms that **reduce employment**. Among the examples mentioned are those of Chile and Latvia between 1974 and 1990 (recovering slightly with the reinstatement of democracy). In the province of Alberta, Canada, restructuring meant a 5% reduction in personnel. In Los Angeles, USA, 2800 jobs were cut in the first two years of restructuring (37). The reductions have not always had a global character; on the contrary, in many cases they applied to specific sub-sectors. According to an ILO survey, most job cuts took place among positions occupied by women. Mechanisms of internal restructuring between different health sub-sectors include lowering the number of people employed in pharmaceutical areas, especially in manufacturing, or decreasing personnel for geriatric care and the number of beds for psychiatric attention. These obviously represent a reduction in personnel for the subsector concerned.
- Reforms that create a rise in employment, as in Mexico, Sweden and Zambia. In Sweden, employment in the sector rose from 6.2% of employment in 1970 to 9.9% in 1980, then remained stable (38) until 1992.
- Reforms that restructure employment – the most common case. The ILO survey mentions Brazil as regards restructuring. Attention must also be paid to an important reduction in management personnel in some services, as was the case in the UK (39), where there was an overall increase in the number of staff expected to reorganize and reassign tasks. This creates a new structure in sector qualifications, replacing less qualified employees with others with better qualifications (40).

Regulatory framework and contract modalities

Flexibility emerged as the main instrument used by some companies to increase productivity and competitiveness. A British study (41) indicates that more than a third of health companies and institutions that hire nursing services from recruiting companies have seen a rise in flexible contracts, and more than a quarter (27%) have experienced a fall in full time permanent contracts. In France, even the public sector has hired a larger proportion of employees under more flexible contracts. Most of them are young workers with no qualification, hired under less favorable contractual conditions, sometimes paid below the minimum wage. It has been calculated (42) that 10% of clerical work at public hospitals in France is done under precarious conditions.

Part-time work has risen steeply everywhere in the industrialized world. Everything indicates that, at

least for the United Kingdom, full time personnel will be further reduced, and replaced by part-time workers. In African countries (43), on the contrary, part-time work is practically nonexistent. The rule in the public sector is still full time employment.

Despite this heterogeneous panorama, the ILO was able to state that flexible modalities of labour are gaining ground very fast in the private sector in industrialized countries. Although situations vary among countries, there is less employment security, overall (44) – for those who keep their jobs – whether in the public or in the private sector. Studies carried out in Latin America show important transformations in hiring modalities within the health sector. In some cases the need to expand coverage (45) has increased the number of non-typical contracts. This is the case in Brazil's "Health for Family" Programme and Peru's "Health for all" plan. A Brazilian study shows that different modalities of contracting are in use even for unlimited-time contracts. The coexistence of alternatives has interfered with the development of administrative strategies for human resources (46).

In Peru in 1996, 76% of health workers were hired under public employment terms, with stability and social security. But new modalities are on the rise. Workers assigned to "Health for all" (12% of all people employed in the health sector) have been hired without social security. Between 1992 and 1996 (47) the health professionals (physicians, nurses and technicians) were hired through temporary contracts (about 10 000 people). Brito Quintana (48) cites the case of Ecuador, where, along with a fall in wages, new forms of flexible contracts are being used and replace in law former contracts that included protection forms.

Argentina (49) shows a rise in precarious contracts, even fraudulent ones, that cover full time jobs under the label "autonomous professional". The data available for Latin America indicate the emergence of more autonomous types of work, less protected and stable (even considering the traditional heterogeneity of the sector). Forms of semi-dependent and pseudo-autonomous work can also be observed in the region.

This analysis considers a continuum of types, ranging from "typical waged work" to "typical self-employment", with diverse forms of non-typical or hidden wage employment. This phenomenon is linked to a blurring of the concept of "dependent employment", crucial for the classic school of labour law to distinguish between waged and independent work: "the pluralism of regulatory frames dilutes the borders between types (dependent and independent)" (50). It seems that this interpretation comes closest to describing the emerging modalities in the sector, particularly for professionals. But a question arises on the relation between these changes and the quality of the services offered. How do these new contracting situations affect the efficiency and quality of health care services? No specific studies are available, but it can be presumed that the interaction of the two variables is very significant.

Multiple employment

Another important feature detected in Latin America is that of multiple employment, particularly in Argentina, Brazil, Peru and Uruguay, and to a lesser degree in Chile (51). This also has been observed in El Salvador and in Panama (52).

In Peru a study found that 71% of physicians hold at least two jobs (53), and in Uruguay (54), the ratio was stated to be 2.6 jobs per professional (especially medical physicians), and 2.26 amongst dentists in the early 90's, despite the growth in the number of professionals,

Several causes may lead to an increase in multiple employment. It is facilitated by the introduction of part-time positions, and reductions in remuneration for any given job may force individuals to seek additional sources of income. Finally, the development of a dual labour market makes way for multiple

employment, pitting better wages and working conditions in the private sector against social security and other benefits with lower salaries in the public sector. The remuneration differential leads to an important overall bias in favor of the private sector, with the public sector losing its most prepared and experienced professionals.

In Central and Eastern Europe, health care employees are also moving toward the private sector, though there is no clear indication of the extent or speed of this change. The tendency is also observed elsewhere in Europe, e.g. in Sweden. In several specialties, individual strategies to sustain income seem to bring about the accumulation of jobs. These strategies allow certain groups to maintain their incomes by diversifying their posts. Among nurses, multiple employment is much less common: this can be explained by the number of hours actually worked in each position. In Uruguay, where this problem has been studied systematically, the average was 1.34 positions per working nurse, half the figure observed for physicians.

Multiple employment has also been noted in China (55) although in a much lesser proportion of health workers: a growing number of health workers in rural areas work partly in public and partly in private hospitals

Generally speaking, it can be said that the tendency to multiple employment has expanded considerably.

Labour relations, organization and working conditions

Collective labour relations

The public and private sectors in health have evolved differently with regard to collective bargaining. Within the public sector negotiations used to be highly centralized. Now they have shifted to a more decentralized process, “lowering” the negotiating level. In the private sector there has been an individualization of labour relations.

Collective bargaining at national level is the predominant method to determine health care sector remuneration in Europe, and this is still highly centralized in most European countries. In some cases the response has been to decentralize to the local or company level, empowering the managers (56) so that they can negotiate and set wages. In the United Kingdom the formal structure of negotiation has not changed, yet there is a tendency to decentralize and create autonomous negotiating entities, particularly in order to determine wages. Incentives linked to individual characteristics, based on qualifications and other criteria (years on the job, number of hours worked, geographical areas, etc.), have been established (57). By virtue of their increased autonomy, hospitals and local authorities have also been able to negotiate wages and working conditions, which are now linked to productivity and other criteria. Remuneration on the basis of merit represents a substantial additional cost, and this has driven many hospitals to abandon the system.

In France, collective bargaining is still centralized in the public sector; this is also the case in Sweden (59). Generally speaking, the trade unions in the sector have little experience in local negotiation. Nurses have shown the strongest opposition both to decentralization and to changes in the remuneration system.

In the countries of Central and Eastern Europe, labour relations have become stormy. There are new employers, emerging professional associations and re-organized trade unions, and a lack of experience in dealing with labour relations in a market economy. Before the political transition there was no clear distinction between the State and the employer. Nowadays, without the State as monopolistic employer, it has become difficult to carry out centralized collective bargaining with employers (60), because the latter can not always be identified

In Argentina, traditional collective bargaining took place in the private sector, and only recently in the public sector; however, because of a budgetary crisis, the public health sector still has not entered into negotiations. In the private sector many agreements have been reached at the company level, introducing new negotiating topics, such as “remuneration for productivity”, “polyvalence” and changes in the way work is organized (61), including changes in work schedules.

Brazil is undertaking some interesting experiments in collective bargaining in the public sector, with the participation of all interested parties including the community. Those Brazilian examples that have been analyzed have been shown to allow, at the same time, flexibility in the position assignments of jobs and improvements in the quality of health care services (62).

Working conditions

Many hospitals and health corporations have adopted management ideologies that originated in the industrial sector. Using private industry methods, executives have tried to reduce the strength of the labour force, usually by incorporating non-professional workers and establishing a more flexible labour force, both professional and non-professional (63). From a positive perspective, managerial literature argues that the redesign of working methods offers an alternative to the old Taylorist system and the scientific organization of work, which divided work into tasks and subtasks to be carried out by non-qualified workers. From a critical perspective, it can be argued that the new methods focus excessively on increasing productivity and reducing costs, regardless of the satisfaction of the workers or the clients.

The application of these methods in the health sector highlights these contradictions. Some authors (64) argue that the changes aimed at redesigning the organization of work for better health care services should be praised. Yet the strategies to re-design organizations are aimed at reducing costs and at minimizing workers’ power. Other strategies tend to decrease the presence, power and importance of the professional level and to destroy labour-oriented institutions that interfere with the “rationalization” of labour. In fact, Bach (65) states that “there are reasons to believe that the intensity of work of health workers is growing”. Among the reasons Bach mentions is the average reduction of patient stay, which means that the workers must pay even closer attention to the patients. Budgetary constraints also force health services institutions to leave positions vacant or to eliminate them, intensifying the workload for the rest of the health workers.

An ILO survey of health workers (66) seems to indicate that the normal duration of the working week has not changed after reforms, particularly in the public sector and in the health sub-sector. Nevertheless, in some cases, yearly measurement of work has detected programmed increases in the total number of hours to be worked by individual workers during the year. The length of the working day and the excessive number of extra overtime hours are also a problem for the health sector. A study in Europe (67) points out that although 70% of workers work between 37 and 45 hours per week, 1/4 work between 46 and 72 hours. Among physicians, 67% work more than 5 extra hours per week. In Japan, nurses have denounced an excessively long working day and an “impossible” rhythm of activity. In Austria, physicians work 55 hours a week. In Romania, the effective duration of the working day for male health staff is one hour longer than that of average workers, and nurses work three more hours a day than this average.

The greatest problem seems to be the work-load, more because of due to deficits in human resources, unfilled vacancies, reductions in the number of “on call” workers, and the need to supervise less qualified personnel (68), than because of the actual number of hours worked. In Latin America, there is little information in this regard, although data on multiple employment suggest that the real working day is very different from what is legally defined for the public sector, when the effective practices of professionals with multiple jobs are taken into account.

Participation in management

Although information on “new management” for the health sector is scarce, it is presumed that managerial capacity has acquired greater importance. There has been a shift from “administered” to “managed” services. This is due to the changes introduced by reform and to the greater emphasis on the inclusion of physicians and other professionals in the management process (69). In the UK, the system of participation has become a legal – and quasi-moral – imperative, although with varied outcomes because of discrepancies between initial objectives and daily practice. Other cases point out the difficulty of establishing priorities between the demands of physicians and those of patients (70). In Latin America, significant administrative changes have been introduced. In some countries (Chile, Costa Rica, Peru) the public sector has developed participatory management modalities (called management contracts), that imply a greater degree of commitment by the workers. A tendency to introduce participatory mechanisms in health care reform has been observed in 20 Latin American countries, particularly at the intermediate and local levels. Citizen participation and health care evaluation are increasing in importance(71).

Conclusions

Two sets of conclusions emerge from this study:

1. In almost every country, reform priorities appear to be changing the way in which the system is financed, cutting costs and incorporating market mechanisms. Reforms have improved coverage in a few cases, but the issues of human resources have been neglected, to say the least. In those few cases in which attention was paid to human resources, changes have focused on incentives and remuneration systems, not on a systematic action in human resources management. This neglect is highlighted by the surprising dearth of systematic literature and specific studies – surprising in view of the fact that the health sector is labour-intensive: This also affects economic and other studies of innovation mechanisms, given the importance of knowledge for professional practice. From that perspective, countries undergoing reforms differ only in the degree and depth of the reforms introduced and in the degree to which these reforms affect those employed in the sector.
2. Regardless of the direction of reforms, experience shows them to have been mostly negative in terms of human resources as Bach (72) states. Changes in contract modalities have only made employment more precarious, with consequent increases in segmentation and also in the intensity of work.

Available information does not suffice to show the full consequences of those transformations in the organization and content of work. More systematic studies are needed to analyse the effects of the main reform-related changes on human resources, on the quality of health care services and on the health of the population.

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