

**SECTORAL ACTIVITIES PROGRAMME**

Working Paper

**Social dialogue in the health sector:  
Case study Bulgaria**

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Working papers are preliminary documents circulated  
to stimulate discussion and obtain comments

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## Preface

Concern about public health and the increasing cost of health care have made the subject of health one of the most debated political issues in many countries. The vital role of governments, employers' and workers' organizations and the importance of social dialogue among them in addressing these issues have only been recognized recently. There is now wide recognition of the role of social dialogue in advancing and sustaining reform processes in many areas of the health sector, hence improving health care and mitigating any negative impact on public health. In order to ensure better delivery of health services, the institutions and capacity for social dialogue need to be strengthened.

The Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness was held from 21 to 25 October 2002 at the International Labour Office (ILO) in Geneva, under the Sectoral Activities Programme. The Meeting participants recognized the great potential of social dialogue to contribute positively to the development and reforms of health services, by enabling governments, employers' and workers' organizations to draw upon their knowledge and experience. In its conclusions, the Joint Meeting agreed on a framework for practical guidance to strengthen social dialogue in the health services. It further proposed action to be taken by the ILO.

The Joint Meeting's recommendations for action led to the commissioning of this case study in Bulgaria so as to research the existing capacity and institutions for social dialogue in this country.

As a sectoral working paper, the study is to be circulated in order to stimulate discussion and obtain comments. We hope that it will contribute to an understanding of how social dialogue presents a clear opportunity for governments, employers and workers to reach common ground in identifying and implementing solutions.

Norman Jennings,  
Deputy Director,  
Sectoral Activities Programme.



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## Executive summary

This paper on social dialogue in the Bulgarian health sector identifies the key problems related to its development, describes its main successes and best practices and suggests measures for its future improvement.

Bulgaria is a parliamentary republic still in the process of transition to a market system after 45 years as a socialist economy. Since reforms were first introduced in 1989 the country has undergone profound political, economic and social changes. After years of deep economic crisis, relative macroeconomic stability was achieved with the introduction of a Currency Board. Nevertheless a number of acute economic and social problems remain and, along with political instability, this has had a negative impact on the development of an economic environment conducive to social dialogue. Bulgaria has high unemployment, the lowest incomes and the smallest gross domestic product (GDP) per capita of all the new EU member States and candidate countries. The economic growth reported in recent years (between 4 and 6 per cent) has not led to the creation of new jobs or higher incomes. Real wages are half what they were at the beginning of the transition period. The irregular and delayed payment of wages in many sectors, including health, has continued and a substantial army of “working poor” has been created.

During the mid-1990s a number of public sector reforms were initiated. However, effective health-care reforms began only in 2000. Health reforms have been introduced without sufficient consultation with the social partners or public debate on the health insurance model and health sector restructuring. The inadequate degree and direction in reforming all structures of the national health-care system has led to declining employment conditions. Conflicts caused by huge differences in financing and remuneration arose between different structural units in the health system and different professional categories.

Health-care reform is an integral part of overall economic and social reforms. The stated objectives of the health-care reform include higher living standards, free access for every Bulgarian citizen to modern, high-quality and efficient health care, lower morbidity rates and higher life expectancy. Fifteen years after the start of the economic reforms that were inspired by the international financial institutions (IFIs), the country is witnessing declining incomes and employment, spreading poverty and social exclusion, and higher rates of morbidity and mortality.

There is concern about the perceived commercialization of health care at the expense of the social functions, financial instability of the health system, demotivation of health workers and tension between professional groups. In addition, the dangers of corruption cannot be ignored.

The restructuring of the health sector is accompanied by a drastic reduction in the number of jobs and the provision of hospital beds. Between 1990 and 2002 the sector witnessed more than 47,500 job losses with paramedical personnel (nurses, midwives, etc.) the worst affected. Salaries in the public health-care sector are lower than in the public sector as a whole and are below the average wage for the country.

After democratic change began in Central and Eastern Europe in 1989, the trade unions were among the first organizations to transform themselves, and in many countries they were the most powerful motor of change. In Bulgaria this process was strongly manifested. 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

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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. Social dialogue in Bulgaria grew from nothing and had no traditions or experience. 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 at different levels.

At national level the institutional and legislative framework for social dialogue is in place and it is well-developed despite some difficulties and bottlenecks. At sectoral level, social dialogue is developing more slowly due to various factors that hinder its implementation. However, in contrast to the other European Union candidate countries, dialogue at sectoral level, especially in the health sector, is becoming a more and more effective instrument for the protection of workers' rights and interests. This is due to the development of independent and representative health trade union federations, mutual recognition, cooperation and respect among all the actors involved in tripartite or bipartite dialogue at different levels of the health system.

Social dialogue should be further developed at every level of the health system including all types of health-care establishment in the public and private sectors. If the quality of health services and the provision of decent working conditions for staff are to be the main outcomes of the reform, trade unions representing health workers must be fully included in its formulation and implementation through meaningful and effective social dialogue.

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## Abbreviations

BIA	Bulgarian Industrial Association
BCCI	Bulgarian Chamber of Commerce and Industry
BCP	Bulgarian Communist Party
CEEC	Central and Eastern European Countries
CITUB	Confederation of Independent Trade Unions in Bulgaria
ESC	Economic and Social Council
DCC	Diagnostic Consulting Centre
EPSU	European Public Servants Union
EU	European Union
FTUH-CITUB	Federation of Trade Unions in Health-CITUB
GP	general practitioner
GDP	gross domestic product
IFIs	international financial institutions
IMF	International Monetary Fund
ISTUR	Institute for Social and Trade Union Research
MPHAT	Multi-profile Hospital for Active Treatment
MCTC	Municipal Council for Tripartite Cooperation
CEMA	Centre for medical emergency aid
MF Podkrepa	Medical federation Podkrepa
MRTU Podkrepa	Medical Regional Trade Union Podkrepa
NAEH	National Association of Employers in Health
NCTC	National Council for Tripartite Cooperation
NFA	National Framework Agreement
NHIF	National Health Insurance Fund
NMSS	National Movement Simeon the Second
NSI	National Statistical Institute
NSSI	National Social Security Institute

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PSI	Public Servants International
Podkrepa CL	Podkrepa Confederation of Labour
RMTU	regional medical trade unions
SCA	sectoral collective agreement
SCTCH	Sectoral Council for Tripartite Cooperation in Health
TCC-CITUB	Territorial Coordinating Council-CITUB
UPEB	Union of Private Entrepreneurs in Bulgaria
UEI	Union for Economic Initiative

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# I. Background

## Introduction

Bulgaria is an eastern European country located in the south-east of the Balkan peninsula. It has a population of about 8 million and a territory of 110,994 km<sup>2</sup>. The major ethnic groups are: Bulgarians – 84.5 per cent; Turks – 9.6 per cent; and Gypsies – 4.1 per cent. Most of the population are Christians belonging to the Eastern Orthodox Church. At the end of the Second World War (1944) the new coalition Government, included the Bulgarian Communist Party (BCP) and the Bulgarian Agrarian People's Union. By 1947, the BCP had emerged as the leading political force in the socialist development of the country. In the 45 years prior to 1989, Bulgaria was a centrally planned socialist economy. The transition to a market system began at the end of 1989. The country is undergoing deep political, economic and democratic changes, and the health sector is being transformed. The Constitution of 1990 defined Bulgaria as a parliamentary republic.

The aim of this study is to provide an overview of the present state and development of social dialogue in the health sector in Bulgaria, outlining the main structures, actors and procedures as well as the main achievements and difficulties. By giving examples of good practice at different levels it aims to provide practical information and recommendations on how social dialogue can be strengthened in the health services.

The methodology for information collection included:

- A review and analysis of the literature, the relevant legislation and the main documents of the social partners' organizations.
- Informant interviews (semi-structured) with participants in social dialogue at different levels: representatives of the Government, the Federation of Trade Unions in Health (FTUH)-Confederation of Independent Trade Unions in Bulgaria (CITUB), the medical federation Podkrepa (MF Podkrepa) (sectoral and local level), as well as representatives of the National Association of Employers in Health (NAEH), carried out in 2003 and 2005.
- A survey including 50 chairpersons of trade union organizations in health-care establishments in Sofia, Smolyan and Stara Zagora.
- Secondary analysis of the information in other surveys carried out by the Institute for Social and Trade Union Research (ISTUR) in the health sector.<sup>1</sup>

This research constitutes the first attempt to describe the Bulgarian health sector with regard to the development of social dialogue, and to document practical information, best practices and recommendations to improve its effectiveness in the future.

<sup>1</sup> *The health-care reform – Expectations and reality*, ISTUR, 2002; ILO, ICN, WHO, PSI Joint Programme on Workplace Violence in the Health Sector, 2001; *Work stress in the context of transition*, ILO, SRO, Report No 26, 2003; *Collective bargaining 2002: Characteristic and new trends*, ISTUR, 2002; *Patients' rights*, ISTUR, 2002; *Health-care reforms and privatization – Social and economic consequences. Case of Bulgaria*. Global policy network (GPN) joint project on privatization in public services, 2005.

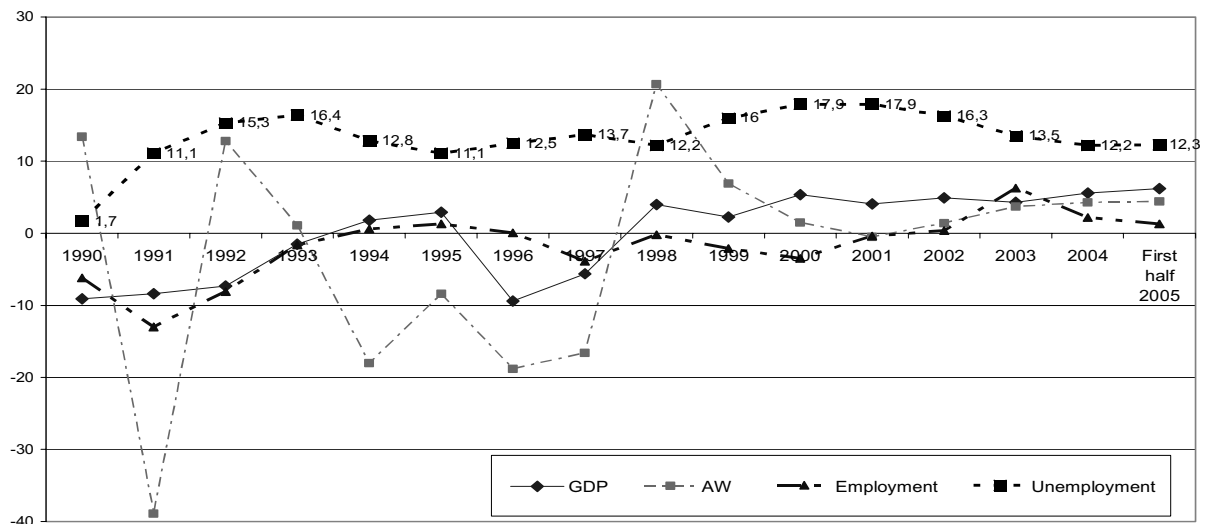
# 1. Macro-environment, socio-economic and political situation

## 1.1. Key macroeconomic indicators

The development of social dialogue must be examined in the context of reforms in the economy and in society as a whole. One of the major features of the Bulgarian transition is that the reforms in the different sectors did not happen at the same pace. The political changes initiated in 1989 and they were generally completed in one year, resulting in the adoption of the new Constitution of the Republic of Bulgaria and with the establishment of the pluralist party system. The economic reform that started at the beginning of 1991 led to the liberalization of prices and to inflation shock. The social reforms were fragmented and their theories were often changed.

As in many other countries, the neo-liberal reforms imposed by IFIs in Bulgaria had a devastating impact on the GDP, with employment and real income leading to negative trends (chart 1). From practically full employment in the socialist period to present-day privatization and restructuring, the number of employed dropped by nearly 1.2 million people. Unemployment rose from 1.7 per cent in 1990 to nearly 16-17 per cent in 1996-97 and even exceeded 19 per cent, in certain months of 2000 and 2001. After a series of labour market measures under the programme for temporary employment in social works “From social benefits to employment” and the introduction of a mandatory registration of the employment contracts, which had an impact on employment in the grey economy, unemployment fell to around 12 per cent in 2004 and the first half of 2005. However there was no significant increase in the employment rate. To some extent this is also a consequence of maintaining a steady group of approximately 350,000-400,000 discouraged jobseekers (nearly equal to the number of registered unemployed), which indicates hidden unemployment.

**Chart 1. Real increase of GDP, average wage, employment and unemployment level in 1990-2005 (previous year =100)**



Source: NSI, own calculations.

After the introduction of the Currency Board in the middle of 1997, the country achieved macroeconomic and financial stabilization. Galloping inflation, which was typical for the first years of transition and which reached hyperinflationary values between

January and March 1997, was contained and conditions were established for lasting and relatively high economic growth.

Between 1999 and 2005, the consumer price index varied between 2 and 10 per cent with increases mainly in non-food products and especially in services.

**Table 1. Average yearly consumer price indices** (previous year = 100)

Commodity groups	1999	2000	2001	2002	2003	2004	2005 first half
Total	102.6	110.3	107.4	105.8	102.3	106.1	105.1
Food	92.5	110.1	106.3	100.0	99.1	106.6	103.5
Non-food	103.3	106.7	106.7	111.0	101.0	104.4	104.2
Services	125.8	115.4	109.9	111.0	108.7	107.3	108.2

Source: *Statistical Yearbook 2005*, NSI.

GDP has grown steadily since 1997 but the data indicate that this reflects a low starting point rather than a dynamically developing modern economy that provides conditions for a high standard of living. Bulgarian GDP per capita is the lowest among the new member States and countries applying for membership in the European Union.

**Table 2. Gross domestic product**

Indicators	1999	2000	2001	2002	2003	2004	2005 first half
GDP (in million leva*) at current prices	23 790	26 753	29 709	32 335	34 547	38 008	18 428
GDP growth (previous year = 100.0)	102.3	105.4	104.1	104.9	104.5	105.6	106.2
GDP per capita (leva)	2 898	3 274	3 754	4 108	4 416	4 885	2 368
GDP per capita (US\$)	1 577	1 542	1 718	1 978	2 548	3 101	1 555
Exchange rate: leva per 1US\$	1.8364	2.1233	2.1847	2.0770	1.733	1.575	1.533

\* Lev (pl. leva) is the Bulgarian currency.

Source: *Statistical Yearbook 2005*, NSI.

The macroeconomic indicators concerning net exports and investment generally display negative trends.

The privatization process and structural reforms were accelerated significantly in 1997. For a period of seven to eight years until the middle of 2005, the structure of employment and economic entities saw radical changes. Approximately 69.6 per cent of employees were in the private sector, producing 67 per cent of GDP and 77 per cent of gross value added.

## 1.2. Socio-economic situation

The macroeconomic indicators analysed show stability based mainly on the restrictions imposed by the Currency Board.<sup>2</sup> The Currency Board certainly has a positive,

<sup>2</sup> In essence the Currency Board is a system that does not allow the Central Bank to implement its own, independent fiscal and emission policy. The implementation of these restrictions is based on two main principles: the foreign exchange rate is fixed to one of the international currencies (in

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stabilizing function as far as the economy is concerned but it significantly reduces the opportunities for collective bargaining at national level, especially when state-funded activities such as public health care are concerned. An additional harmful factor is the existence of a significant foreign debt (EUR 6,067.9 m. as of May 2005). The standby agreements with the International Monetary Fund (IMF) on the one hand facilitate payment of the foreign debt, but on the other have a strong restrictive influence on the internal budget policy, and in practice have made the Government highly dependent on the IMF and the World Bank.

**Box 1**  
**Socio-economic situation in Bulgaria**

Economic growth and low inflation are not accompanied by an adequate improvement in the business environment and the standard of living of the population:

- Despite the increase from 75 leva (EUR 38) in 2000 to 150 leva (EUR 76) in 2005 the minimum monthly wage is far from providing a minimum standard of living. During the years of transition the minimum wage has devaluated by 58 per cent (compared to 1990) and is lagging behind that in other Central and Eastern European countries (CEEC).
- Concerning wage levels, Bulgaria is on the bottom when compared to the EU new member States and candidate countries. The trend of increasing poverty and the creation of a considerable number of "working poor" has been observed in 2005 as well. The country's average wage in September 2005 was about 160 EUR with a nominal growth of 7.9 per cent, compared to September 2004, while net wage real growth (taxes and social security excluded) was barely 2.3 per cent. The average wage in the country is still about 50.4 per cent of its 1990 level. Over the past three years the balance of household income and expenditure has been undermined, for example by a rise of approximately 40 per cent in heating costs and 95 per cent in electricity costs.
- Public sector salaries have seen permanent real growth since 1997 up to 399 leva in September 2005. The price of achieving this, however, is a reduction in public sector employment as a result of restructuring measures.
- The official wage statistics show significant differences between the public and private sectors. The average wage in the public sector was about 30 per cent higher than in the private (September 2005). These differences are to a large extent thought to be due to the systematic concealment of the actual levels of wages in the private sector. Many private enterprises (mostly small and medium-sized ones) declare pay levels near to the official minimum wage for their employees, but actually pay higher remuneration. The aim of the employers is, it is claimed, to reduce their tax and social insurance burden and thus cut labour costs. The effects of such practices are: unrealistic pay statistics; direct losses for the state budget and the social security funds due to lower contributions; and lower future pension entitlements for workers.
- The total number of poor households in the country is 409,000 or 1,113,000 persons. Only 5 per cent of the population are at the top of the income pyramid and have a high standard of living; 20-25 per cent constitute the so-called middle class, and the remaining people are poor, 40 per cent living below the absolute poverty level.
- The trend towards worsening of the demographic situation in Bulgaria over the past two decades was more pronounced in the years of transition. The key characteristics outlining the trend of exacerbation of the processes of depopulation and aging of the population are declining birth, deteriorating health, rising mortality and morbidity rates, intensive emigration and negative natural growth.

Source: NSI and ISTUR.

Bulgaria – as at the date of introduction on 1 July 1997 to the Deutsch mark, 1 BGL = 1 DM, and in the beginning of 2002 to the euro, 1 BGL = 0.51129 euro). The amount of money in circulation cannot exceed the amount of the fiscal reserve, which serves as an anti-inflationary measure taken from the period of the golden-dollar standard.

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### **1.3. Political situation**

The years of transition have been characterized by significant political instability and frequent changes of government. All of the nine governments which took power over a 15-year period failed to solve the main problems of the ordinary people. Political instability had a negative impact on social dialogue, which was often neglected by the ruling parties. This political instability had a negative impact on the social dialogue, which was often avoided and neglected by the ruling parties, and had to adapt to the changing socio-economic and political conditions in the country.

It is significant that most of the reforms were initiated and conditions were created for a successful and productive social dialogue during the first government which remained in power for a full mandate (1997-2001). But since then the established mechanisms of social partnership were not used to achieve a balance between the social and economic dimensions of the reforms and their social cost. The tendency to narrow the scope of problems that are discussed with the social partners in the National Council for Tripartite Cooperation (NCTC) and to replace cooperation with consultation has grown stronger. It has become common practice to adopt decisions unilaterally and to disregard proposals made by the partners. The introduction of the health reform without real involvement of trade unions is only one of such examples. The problems at microeconomic level are causing significant social tension. The Government maintains its firm policy on income and public spending using the Currency Board and pressure from the IMF and the World Bank as a pretext and a threat.

After the general elections in June 2005, three parties – the Bulgarian Socialist Party (BSP), the National Movement Simeon II (NMSII) and the Movement for Rights and Freedoms (MRF) have formed a coalition Government. The new cabinet has stated its willingness to engage in social dialogue, after a period when it was seen as being mainly formal and inefficient. This will be the first such accord since the beginning of the democratic change in Bulgaria. The aim of the planned Social and Economic Development Pact is to achieve a broad public consensus on the realization of the country's efforts to respond to the requirements for Bulgaria's accession to the European Union (EU) on 1 January 2007. The parties declare their adherence to the principles of the European social model, the social market economy and social partnership. In the social dialogue area, the following changes are expected:

- changes to the mechanisms and criteria for the determination of the social partners' representativeness at the national level;
- encouraging the participation of the social partners and other non-governmental organizations in the design and implementation of state policies at various levels;
- preliminary coordination of the legislative acts that have to be discussed with the social partners.

## **2. Health reform**

### **2.1. Principles and legislative framework of the reform**

Health reforms brought about wide ranging changes in how health care is funded, organized and delivered and new type of relationship in the chain user-provider-payer has been established. Bulgaria experienced radical changes in health care during the socialist period initiated in the 1940s, based on the Constitution of the People's Republic of

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Bulgaria (1947). In 1948-49, private hospitals, clinics, dental associations and pharmacies were nationalized. After 1950, the principle of health insurance in financing the health-care system was replaced by a state health system financed through common income tax following the Soviet model “Semashko.” Until 1990 health care was an entirely public system based on the principles of full coverage and accessibility. Three major reform strands can be distinguished: reform of health-care financing, reorganization of primary care and rationalization of the network of inpatient and outpatient facilities. The most active part of the health sector reform was carried out after mid-1997 including:

1. Introduction of health insurance. As of 1 July 1997, the National Social Security Institute (NSSI) began collecting social contributions from employers and employees in order to generate financial resources for the actual implementation of the reform a year later. The mandatory health insurance system is designed as a state monopoly and is managed by the National Health Insurance Fund (NHIF) and its 28 territorial divisions established in 1999. The voluntary health insurance is optional. The health-care contributions of the employed (6 per cent of income) are shared between the employee and the employer in the ratio of 4.8 per cent to 1.2 per cent. Contributions for the unemployed are paid by the Vocational Training and Unemployment Fund. The State pays for public servants, pensioners, children, students, the poor, and the armed forces (about 3,500,000 people). Self-employed individuals make contributions on two to ten minimum monthly wages. At the start of the NHIF in July 2000, mandatory health insurance covered only outpatient care and one year later included also inpatient care.
2. Change of property: In 1992 municipalities were given the ownership of most health-care facilities, including municipal hospitals for acute care, some specialized hospitals and outpatient clinics, and diagnostic and consultative centers according to the Health Establishments Law. The newly established therapeutic establishments for outpatient health care are registered under the Trade Law as trade companies.
3. Privatization of outpatient care: With the exception of emergency care, private individuals or legal bodies could provide outpatient care as of 1 July 2000. The proposed privatization of hospital establishments was postponed with the passing of the Privatization and Post Privatization Control Law (2002). The Pharmaceutical and Pharmacies Law (1995) created the basis for restructuring and privatization of the production and distribution of pharmaceuticals. Hence most pharmacies are presently privatized.
4. Building of a “General Practitioner” institution: The health reform relies to a great extent on the building of a new institution in the outpatient care – that of the General Practitioner (GP). Before the start of the reform every citizen had to select a personal physician and a dentist. According to the legislation the GP had to be registered as a sole property trader. The GPs perform according to a defined package of activities and are believed to act as effective gatekeepers to specialized and hospital care, thereby reducing expenditure on costlier health care. Specialist outpatient care and medical investigations are made possible by referrals given by the GP.

## Box 2

### Legal framework, regulating different aspects and phases of the health reform

- Law on human medicines and drugstores (1995)
- Health Insurance Act (1998)
- Law on the professional organizations of physicians and dentists (1998)
- Law on therapeutic establishments (1999, supplemented in 2002)
- Law on privatization and post-privatization control (2002), which terminates the privatization of therapeutic establishments with state and municipal participation
- The People's Health Act (1975) was replaced in 2005 by the Health Act
- Law on the professional organizations of nurses, midwives and medical specialists (2005)
- Ordinance on the access of insured individuals to outpatient and inpatient care (1999, amended 2001)
- Ordinance No. 14 dated 6 April 2001 on the salary levels of the people employed in therapeutic establishments with more than 50 per cent state or municipal participation in 2001
- Internal Regulations of the NHIF, published by the NHIF (1999, amended and supplemented in 2000)
- National Framework Agreement (NFA), which is signed on an annual basis between the NHIF, the Union of Physicians and the Union of Dentists (since 2001)
- National Health-care Strategy, 2001-06

## 2.2. National health system

In the system of outpatient care there were 1,489 therapeutic establishments as of 31 December 2004, including: 828 medical-technical laboratories and medical diagnostic laboratories, 454 medical centres, 107 diagnostic-consulting centres, 56 dental centres and 44 medical dental centres. According to the law on therapeutic establishments, these facilities may open up to ten beds for short-term treatment.

In line with the principles of the health insurance system, the majority of outpatients are under the care of their general practitioner (GP). NHIF data indicate that as of 31 December 2003 there were 5,293 GPs (19.1 per cent of the total number of physicians in the country). In other words, each GP cares for an average of 1,500 people.

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.

At the end of 2003, 28,128 physicians and 6,475 dentists worked in health establishments in the country. The total number of nurses was 29,650, and of midwives was 3,456. The total number of auxiliary medical personnel employed in the health network was 45,731.

The most important sources of health-care financing in Bulgaria are: health insurance contributions; public funding through the Ministry of Health, cash payments from patients:

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user's fees and fees for medical services (regulated and unregulated), and voluntary health insurance.

The analysis of the data on the general public health expenditure shows that they have risen from 980 million leva in 2000 to 1,773 million leva in 2005, i.e. more than double while their portion of GDP has decreased from 4.9 per cent in 2003 to 4.3 per cent in 2005. The comparison with other European countries shows that the share of health in their GDP is considerably higher.<sup>3</sup>

The terms and conditions of funding inpatient health care were contracted under the National Framework Agreement (NFA), concluded on an annual basis since 2001 between the NHIF and the Bulgarian Union of Physicians and the Bulgarian Union of Dentists. The NHIF reimburses 60-70 per cent of hospital treatment costs and the State covers the rest.

### **2.3. The consequences of the health reform**

Five years after the inception of the reform, the evaluations, though not categorical, are largely negative. The analysis of the legislation, practical experience and opinions of both patients and medical personnel surveyed within the framework of different surveys carried out by ISTUR provides a basis to delineate several problem areas that could and should be effectively addressed in dialogue with all concerned.

- The Assembly of Representatives of the NHIF is made up of representatives of the insured, the employers and the State in equal numbers. However, only one-third of the members representing the insured are representatives of the trade unions with the rest involved in administrative matters and not supported by any of the partner institutions popular in society. This means that the Assembly cannot properly execute its functions as a forum for national social dialogue on questions of health insurance. The non-equal status of the representatives means that the Government and employer representatives feel less involved and less responsible. Thus in the practical activity of this body, social dialogue is confined to reviewing and amending documents. As for the other management bodies of the health insurance system – the managing and supervisory boards of the NHIF, which are actually part of the Assembly of Representatives – the legislation does not even mention the principle of equal representation.
- The health reform led to considerable financial pressure on households, especially in view of the declining health status of the population. According to official statistical data<sup>4</sup> the proportion of health expenses in the structure of household expenses shows a clear increase after the start of the reforms. In the period 1995-99 the share of health expenses is within the range of 1.9 per cent to 2.9 per cent of the total household expenditure. In 2000, it rose to 3.6 per cent, in 2004 it reached 4.5 per cent and in March 2005 it rose to 5.5 per cent.

Access to different health services was significantly influenced by the reform. Many services are now highly commercialized in and not accessible for a larger part of the population.<sup>5</sup> Taking into consideration the low average income levels in the country,

<sup>3</sup> “Data Base: Health for All”, WHO, 2001, cited from the National Health Report, 2004.

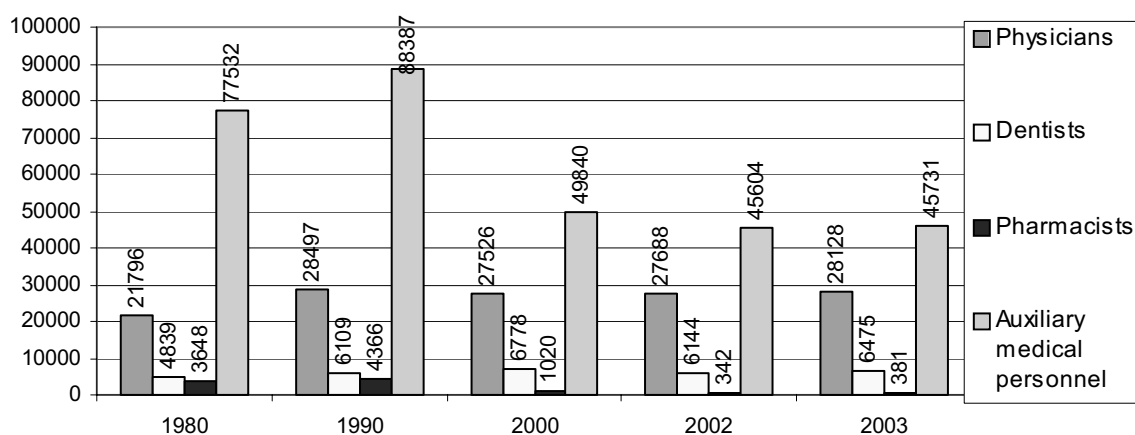
<sup>4</sup> National Statistical Institute. Household Budget Survey, 2004.

<sup>5</sup> Ministry of Health: *National health report at the beginning of the 21st century: Analysis of the reform carried out in the field of health*, 2004.

there is a segment of the population whose health-care service expenses (regulated and unregulated) are very high. According to some experts' estimates, unregulated payments in the form of donations, "appreciation" etc. range between 0.5-1 billion leva<sup>6</sup> and come close to the officially provided money for health care. That is an enormous additional resource paid under duress and at the same time it contains corruption potential that discredits the health reform as such.

- The health reform has had a negative effect on the system of health care as a whole and on the labour market. These issues do not seem to attract the policy-makers' attention as they are seen as "side effects" of reforms which are targeting restructuring and privatization.
- The strong position that was previously held by health-care workers in the labour market was undermined. Job and income security were threatened. The diminished role of the trade unions and trade union rights made their members more vulnerable.
- The restructuring of the health-care sector was accompanied by a drastic decrease of jobs. This was in line with the pressure of the IFIs 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. Nevertheless a large part of the laid-off workers did not find work.
- During the initial stages of the reforms, different professional categories of health-care workers were affected by the outcomes in different ways (chart 2). Over the period 1990-2002, jobs had decreased by more than 47,000 with the most 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.

**Chart 2. Medical personnel (numbers)**



Source: National Statistical Institute Health care, 2004.

<sup>6</sup> Focus group discussion of Health-care Financing, April 2005.

- In the initial stages of the process of restructuring and reforms of the health care system, one could observe salaries dropping in the public and private health sector in comparison with both the average salary for the private and public sector as a whole and with the average salary in the country. The wages were not only low, but the delay in their payment was unprecedented, especially in the health care establishments funded by municipalities. Since 2003 (table 3) the trend shifted and health-care wages started to approach the levels of the average wage for the public sector, and even exceeded the average wage in the country.

**Table 3. Dynamics of the average monthly wage (in BGN) <sup>7</sup>**

Indicators	1999	2000	2001	2002	2003	2004	2005 third quarter
Average monthly wage for the country	201	225	240	258	273	302	320
Average monthly wage in the health	154	190	218	255	297	337	377
Ratio (per cent)	76.6	84.4	90.0	98.8	108.8	111.6	117.8
Average monthly wage for the public sector	229	263	291	323	343	366	399
Average monthly wage in the public health sector	154	194	226	267	314	353	398
Ratio (per cent)	67.2	73.8	77.6	82.6	91.5	96.4	99.7
Average monthly wage for the private sector	168	193	204	218	233	266	282
Average monthly wage in the private health sector	130	104	133	154	178	263	245
Ratio (per cent)	77.3	53.0	65.0	70.6	76.3	98.9	86.9

Source: National Statistical Institute. Statistical reference book, selected years and ISTUR calculations.

- Until 2000, all physicians and auxiliary personnel were paid salaries fixed by national collective agreement. Since then some new payment mechanisms have been introduced which have led to the increased segmentation of the labour market. GPs are paid in accordance with the number of patients on their lists and additional payment for activities related to prevention and national health programmes.
- Specialists in outpatient care were paid based on the number of visits received. The physicians working in the inpatient facilities were salaried. With the introduction of financing by NHIF of the outpatient care there were big differences in the remuneration of the health staff in hospital care and outpatient care, with GPs generating income three to five times higher than the average. After the inclusion of hospitals in the financing schemes of NHIF these differences had been overcome to some extent.
- The data for the private sector showed lower salaries than in the public sector. Two possible explanations exist. Either the employers paid minimal wages to the staff or

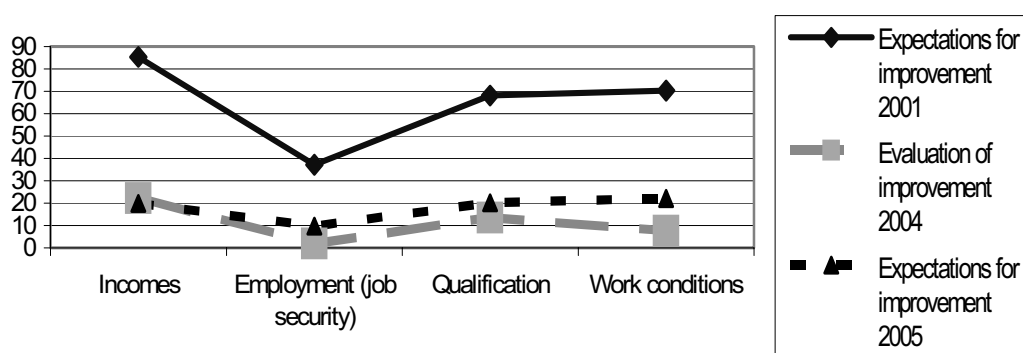
<sup>7</sup> In line with the arrangements of the currency board the exchange rate EUR/BGN is constant EUR1 = BGN1, 95583.

actual salaries received were hidden in order to pay lower social security contributions.

- The mandatory membership in the professional organizations of physicians and dentists and the conclusion of the National Framework Agreement (NFA) only with these organizations enabled them to exert pressure and determine the provisions of the NFA. It guarantees the interests of physicians, dentists and pharmacists rather than the interests of the insured and the other professional groups. The interests of nurses and other medical staff were not sufficiently protected by the NFA. The protection of the rights and interests of all health-care workers involves the enlargement of the group of participants in the process of negotiation and signing of the NFA.

As in other spheres of public life, the health reform was met with many hopes and expectations for the overall improvement of the system of health care and for the quality of life of the people working in it. Health worker expectations were focused primarily on the improvement of health care in the country followed by higher incomes, job security, opportunities for higher professional qualifications and better working conditions in the health establishments. The survey conducted in 2004<sup>8</sup> attempted to determine whether such opportunities had been materialized during the reform process and whether health worker expectations had been justified.

**Chart 3. Expectations and evaluation of the improvement of the main employment parameters in the health establishments in the course of health reform (%)**



Source: *Healthcare Reform: Expectations and Realities*, ISTUR, 2001; *Health-care Reforms and Privatization – Social and Economic Consequences. Case of Bulgaria*. GPN project. ISTUR, 2005.

As the summarized data show (chart 3), the reality was very far from the health workers' expectations at the beginning of the reforms. Restructuring and privatization seemed to have had a predominantly negative impact on health personnel.

<sup>8</sup> *Health-care Reforms and Privatization – Social and Economic Consequences. Case of Bulgaria*. GPN project, 2005.

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## **II. Conditions and elements of social dialogue**

### **1. Historical background**

#### **1.1. Trade unions controlled by the State, 1948-89**

The current state of social dialogue in Bulgaria cannot be properly understood without a brief history of the organizational development of the partners involved.

Before the changes of 1989, union membership, although supposedly voluntary, was compulsory in practice and trade union density was almost 100 per cent. For workers there was only the Central Council of Bulgarian Trade Unions, and genuine employers' organizations did not exist.<sup>9</sup> The role of trade unions was only to "transmit" the interests and objectives of the Communist Party and State to the working population. The protection role of the trade unions was missing and they were directed primarily toward production increases and the establishment of a socialist society. Under this regime, the unions were gradually integrated into the party-state apparatus; they were not allowed to develop the social dialogue and collective bargaining which are characteristic of democratic countries.

#### **1.2. Restoration of pluralism and free trade unionism**

After democratic change began in Central and Eastern Europe in 1989, the trade unions were among the first organizations to transform themselves, and in many countries they were the most powerful motor of change. In Bulgaria, this process was strongly manifested. A few weeks before the changes, the Podkrepa Confederation of Labour (Podkrepa CL) established itself semi-officially as an opposition organization based on the model of the Polish "Solidarity". Initially, Podkrepa CL aimed at protecting the civil rights of workers and particularly of the Turkish minority.

At the end of 1989 the Central Council of Bulgarian Trade Unions started radical restructuring through organizational and political independence, giving priority to protecting the interests of workers. In February 1990, the Extraordinary Congress of Bulgarian Trade Unions turned into a Constituent Congress of the Confederation of Independent Trade Unions in Bulgaria (CITUB). CITUB underwent significant development and was able to transform itself, to gain ground and to maintain itself as the largest trade union organization in the country with a role in civil society.

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.

<sup>9</sup> The directors of factories were appointed by the Communist Party. There was a Bulgarian Chamber of Commerce which represented the employers in international forums, including the ILO.

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Gradually, mainly under pressure from, and with the participation of, trade unions, the old employers' organizations (see footnote 1, Chapter II) were reorganized and new ones were established.

## **2. The development of social dialogue and social partnership**

Social dialogue in Bulgaria grew from nothing and had no traditions or experience. 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.

There are several preconditions, notably the:

- development of market relations and the general economic environment;
- development of a legislative framework and liberalization of labour legislation;
- legitimization of the status of the social partners and institutionalization of their structures;
- attitude of the Government towards social dialogue at national level. This is promoted by trade unions and employers' organizations, as well as by the pre-accession requirements of the EU.<sup>10</sup>

### **2.1. Development of a legislative framework**

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.

The changes to existing legislation were realized with the active participation of trade unions whose proposals were generally accepted. Conditions for the enactment of modern labour legislation in accordance with European legislative standards were created in that context.

A number of fundamental legislative documents concerning the development of social dialogue and collective bargaining defined the:

- partners involved;
- bodies;

<sup>10</sup> Since 1995, Bulgaria has been an associate member of the EU and had submitted a request for full membership. In 1999, the European Council in Helsinki invited Bulgaria to start pre-accession negotiations, which started in 2000. The planned schedule for accession is 2007.

- levels;
- scope;
- procedures;
- other requirements, rules and conditions (box 3).

### **Box 3**

#### **Development of the legislative framework for social dialogue and collective bargaining <sup>1</sup>**

1. In 1990, the General Rules for the Conclusion of Collective Agreements were adopted by the National Committee for Reconciliation of Interests and were signed by CITUB, the Bulgarian Economic Association and the Council of Ministers. At this stage Podkrepa CL was outside these processes although it was included later.
2. Collective Labour Disputes Settlement Act – for the first time legislation set up mechanisms for solving labour disputes, including regulation of the rights and procedures for strike. <sup>2</sup>
3. General Recommendations for Conducting Negotiations, Concluding and Implementing Collective Agreements and Contracts, adopted in 1991 by CITUB, Podkrepa CL, the Government and the National Union of Employers.
4. The adoption of Regulation 129/5, July 1991, of the Council of Ministers regarding wage bargaining, together with other documents, made it possible to negotiate on wages. This became the principal area for collective bargaining.
5. Labour Code <sup>3</sup> – amendments and supplements of 1992 (in force since 1 January 1993) and the related regulations on its enforcement.

For the first time, labour legislation includes and defines:

- “tripartite cooperation” – “The State performs regulation of labour and insurance relations as well as issues related to living standards in cooperation and consultation with the representative organizations of employees and employers”(article 3, paragraph 1);
  - criteria for representativity of the organizations of employees and employers at national level (article 3, paragraphs 3 and 4);
  - actors: conducting collective bargaining for concluding a collective agreement is the sole right of the trade unions <sup>4</sup> and the obligation of the employer (article 52(1)), the employer is also obliged to provide necessary information in this respect to trade unions (article 52(2));
  - the subject areas of collective bargaining (article 50, paragraph 1) – the labour and insurance relations of workers that are not regulated by legal provisions and have to be agreed only upon on the basis of better conditions, as compared to the provisions of the law or minimum norms negotiated at other levels of social dialogue. This provides an opportunity for the trade unions to execute their main protective function (article 50, paragraph 2).
6. The Labour Code Amendments and Supplements Act – in force since 31 March 2001.

The amendments to the law are based on experience of social dialogue at different levels over more than a decade. They also reflect the need to consider the process of harmonization with EU legislation in the course of the pre-accession negotiations. These provisions were elaborated in close cooperation and dialogue with the experts representing the social partners.

The main developments concerning the social dialogue may be summarized as follows:

- The concept of social dialogue is used for the first time:
 

“The State regulates labour relations and the related social security relations as well as the issue of living standards/subsistence level after consultations and in dialogue between employees and employers and their organizations, adhering to the spirit of cooperation and mutual concessions and regard for the interests of each party” (article 2).

The leading role of the State is duly considered in the regulation of the abovementioned relations and the parties involved; mechanisms and procedures are also specified.

- The issues pertaining to tripartite cooperation are delineated and made richer in meaning: the scope of tripartite cooperation coincides with the issues already indicated in connection with the social dialogue; a mandatory procedure of cooperation and consultation in the adoption of legislation on the abovementioned issues is established; the parties, i.e. the State and the representative employee and employers' organizations are defined, as well as the tripartite bodies at different levels: the NCTC, the sectoral and municipal councils for tripartite cooperation; the mechanisms of implementing tripartite cooperation, i.e. cooperation and consultation and the functions and procedures for meetings and decisions in the partnership bodies.

Therefore, the concepts of social dialogue and tripartite cooperation as already defined suggest "cooperation and consultation" rather than the involvement of representatives of workers' and employers' organizations in the decision-making process. The Government is obliged to listen to them but not to take their positions into account. The obvious assumption is that the spirit of cooperation and mutual concession and regard for the interests of the parties during the discussions and negotiations may facilitate the solutions found "by mutual agreement" to the satisfaction of the three parties involved.

- The representativity criteria for the workers' and employers' organizations are define more precisely.
- The conclusion of collective agreements at a sectoral level is regulated (article 516(1), (2), (3)). That level is assumed but not clearly defined in the previous Labour Code. A procedure typical of European countries is also envisaged, i.e. extension of an agreement or some of its provisions to all enterprises within the sector.
- The level of municipal collective bargaining is also clearly defined (article 51(B)) in the context of the activities financed through the municipal budget, and the collective agreement is signed by representatives of the employees and the employer/municipal authorities.

<sup>1</sup> Because of the limited scope of the research, other legislation directly related to labour regulations and where the principles of tripartite cooperation are set up is not reviewed, i.e. Employment Promotion Act, Health and Safety at Work Act, Mandatory Social Security Code, etc. <sup>2</sup> According to that Act, strikes in the health sector are prohibited. <sup>3</sup> Adopted in 1986.

<sup>4</sup> In Bulgaria, in contrast to other transitional countries, the trade unions are the only channel for interest representation. There are no bodies such as workers' councils, which in some countries are entitled to sign collective agreements.

Due to the economic situation during the initial stages of transition, when there were mass strikes in factories, attention was directed towards tripartite negotiations and towards the elaboration of a framework for collective bargaining. A more recent trend has been towards a different balance between legislation and bargaining, i.e. from broad legislative norms providing very narrow scope for the social partners, to a more liberal and negotiated regulation of working conditions. The Labour Code has kept its role as regulator but contains minimal provisions for labour protection and has set minimal levels of workers' rights and labour conditions, leaving room for the negotiation of better conditions through social dialogue at different levels.

International labour standards are of particular importance for the development of social dialogue. The ILO Conventions and Recommendations which have been ratified by Bulgaria are taken into account when labour legislation is drafted.

The Right to Organise and Collective Bargaining Convention, 1949 (No. 98), and the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87), were ratified by Bulgaria in 1959 and have been included in national law through both the Labour Code and the Constitution. Convention No. 111 was also ratified (1960).

The right of workers and employers to association is part of the citizen's right to association recognized in the Constitution of the Republic of Bulgaria (article 49).

The right to trade union association is confirmed in the Labour Code: "The workers have the right, without prior permission, to freely associate in trade unions of their choice, to voluntarily join or leave these organizations and to follow only their statutes" (article 4, paragraph 1).

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Association in trade unions provides opportunities for the protection of workers' interests in the field of labour, social security and living standards: "The trade union organizations represent and protect worker interests before the state authorities and the employers in the area of labour and social relations, and living standards through collective bargaining, participation in tripartite cooperation, organization of strikes and other actions in compliance with the law" (article 4, paragraph 2).

The Labour Code governs such rights of trade union organizations as: independence; participation in the preparation of regulations at enterprise level; and representation of employees in court (articles 33, 37 and 45).

The Labour Code also regulates the employers' right to association as an internationally established right (article 33, paragraphs 1 and 2).

However, there are several other ILO Conventions concerning social dialogue, including dialogue in the public sector, that have not yet been ratified by Bulgaria (Conventions Nos. 151, 144, 154) despite significant efforts made by the trade unions in that area.

## **2.2. Levels of social dialogue**

In compliance with the legal framework outlined above, the system of social dialogue has been organized as follows:

- At national level, social dialogue is carried out within the National Council for Tripartite Cooperation (NCTC) established in 1993. Permanent commissions dealing with particular issues are set up within the NCTC.
- At sectoral level, a council for tripartite cooperation is established with the participation of the relevant workers' and employers' organizations; and in some sectors, state representatives serve as employer.
- At municipal level, councils for tripartite cooperation are set up. Representatives of trade unions, employers' organizations and the municipal authorities participate in negotiations concerning public sector activities (education, health care, culture and administration).
- At enterprise level, the existing trade union organization/organizations and employers take part in negotiations.

All tripartite bodies have equal representation of the State, the trade union and the employers' organization, with two members representing each party.

## **2.3. Main actors in social dialogue at national level**

### **The Government**

The Government participates in all tripartite bodies through the Council of Ministers, different ministries and ministers, municipal and regional governors, mayors and their representatives.

The role of the Government is in the capacity of regulator and employer. Within the bodies for tripartite cooperation it both discusses the issues and has the final say.

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## Representative worker organizations

As already pointed out, the Labour Code defines the criteria for trade union representativeness:

Worker organizations recognized as representative on national level are only those organizations that have:

1. At least 50,000 members;
2. At least 50 organizations with at least 5 members in more than half the sectors according to the National Sector Classification;
3. Local authorities in more than half the municipalities in the country and a national governing body;
4. The quality of a legal entity acquired in compliance with article 49 (article 34).

Currently three trade union confederations – the CITUB, Podkrepa CL and United Trade Unions Association Promiana (Promiana) are officially recognized as representative organizations.<sup>11</sup> When the Government recognized Promiana in November 2004 as being representative, the two representative confederations expressed strong objections against the procedure used for establishing its membership, and the perceived lack of a precise definition of sectors. The recognition of a new nationally representative trade union organization has strained relations between the Government and the two main confederations and they ceased their participation in NCTC. The fact that the Government made this decision a week after a large-scale nationwide protest against its economic and social policy, organized jointly by CITUB and CL Podkrepa, was not viewed as accidental. Now under pressure from the two larger confederations, the present Government was in the process of checking the basis on which Promiana was granted its representative status.

CITUB has about 400,000 members within more than 7,000 organizations united in 35 sectoral federations. Regional coordinating councils and municipal coordinating councils are set up. Podkrepa CL has about 110,000 members united in 24 federations. There are regional organizations in 34 regions in the country.

## Representative employer organizations

The representativity criteria for employers' organizations are also defined in the Labour Code (article 35):

1. At least 500 members with no less than 20 workers each;
2. Organizations with no less than 10 members, in more than one-fifth of the sectors defined in accordance with the National Sector Classification;
3. Local bodies in more than one-fifth of the municipalities and a national governing body;
4. The status of legal entity in compliance with Art. 49.

<sup>11</sup> According to the trade union census performed in 1998 by the Ministry of Labour and Social Policy, CITUB has 607,883 members; Podkrepa CL, 154,894; Promjana Trade Union, 7,802; Union of Trade Unions in Bulgaria, 4,011; Association of Democratic Trade Unions, 2,098; General Centre of Branch Trade Unions in Bulgaria, 357; Independent Trade Union, 118; Edinstvo National Trade Union, 113. On the ground of resolution No. 17 of the Council of Ministers of 18 January 1999, CITUB and Podkrepa CL are the only organizations recognized as representative on a national level. At the end of 2003, a new census was carried out to determine the membership of workers' and employers' organizations in order to define their representative status. CITUB reported 393,843 members, CL Podkrepa 106,309 and Promiana 58,613.

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There are six recognized representative employer organizations at national level:

- the Bulgarian Industrial Association (BIA), with 56 sectoral organizations representing all sectors of the economy;
- the Bulgarian Chamber of Commerce and Industry (BCCI) with 70 sectoral organizations;
- the Union of Private Entrepreneurs in Bulgaria “Vuzrazhdane” (UPEB);
- the Union for Economic Initiative (UEI), with about 50 regional and sectoral organizations;
- the Employers’ Association of Bulgaria (EABG) with membership of the major Bulgarian private companies which had more than 100 employees;
- the Bulgarian Industrial Capital Association (BICA) with a well-developed network of regional structures, covering more than 50 municipalities.

The last two organizations were recognized as nationally representative in 2004.

Under the Labour Code, all subdivisions of organizations recognized as representative at national level are also recognized as representative (article 36, paragraph 4).

There is thus an apparent trend towards the fragmentation of social partner organizations. Over a period of less than a year during 2005, the number of representative organizations had increased from six (two trade unions and four employers’ organizations) to nine (three trade unions and six employers’ organizations). The new representative organizations included in the tripartite cooperation process will undoubtedly complicate the work of the dozens of national, industrial and territorial social dialogue structures. The process of consolidating the positions of the employers’ and workers’ organizations in the social dialogue bodies on significant issues will now become especially complex.

Tripartite cooperation at national level has been expanding in recent years. New mechanisms have been introduced such as: the participation of the social partners in government activities through an advisory council under the Parliamentary Commission for Labour and Social Policy; the establishment of special working groups to draft new labour and social legislation; the involvement of the social partners in working groups for EU pre-accession activities. A joint non-governmental body for social cooperation has been established – the Joint Consultative Committee, European Union-Bulgaria. The social partners are included in tripartite management and supervisory bodies set up in the field of employment, social and health insurance, vocational education and training.

The establishment of some structures typical of European social dialogue is delayed, despite relevant legislation passed in 2001. The Economic and Social Council (ESC) and the National Conciliation and Arbitration Institute started work only in 2003. The role of the ESC is to express the views of the social partners and other representatives of civil society on Bulgaria’s main economic and social problems, drawing up statements on draft laws, national programmes and plans for economic and social development on the initiative of the President of Bulgaria, the Chairperson of Parliament, the Government or the ESC itself.

### III. Social dialogue in health sector

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.

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## 1. Sectoral/branch level

Social dialogue at sectoral/branch level is developing slowly and with some difficulty, largely because of the undeveloped employer structures at that level. In contrast to the other candidate countries, however, dialogue at sectoral level in Bulgaria, especially in the health sector, has a role in the protection of workers' rights and interests.

### 1.1. Sectoral social dialogue bodies

After a long interruption in the work of the former Sectoral Council for Social Partnership, a Sectoral Council for Tripartite Cooperation in Health (SCTCH) was set up in 1997 as a body for consultation and cooperation in the area of labour relations and social security, living standards and the adoption of health legislation.

A Sectoral Council on Working Conditions based on the principles of social dialogue was also created in 2002 but is still not functioning effectively despite pressure from the trade unions.

### 1.2. Main actors

Two representatives each from the Ministry of Health, the trade union organizations<sup>12</sup> and the employers' association are members of SCTCH. Before 2001, only representatives of Government and the two health sector trade unions participated in the Council due to the absence of any employers' structure.

#### The Ministry of Health

The Government is represented by two Ministry of Health officials. One of them is the Deputy Minister of Health and usually she/he is elected to chair SCTCH by the Council members on the nomination of the Ministry.

#### Representative trade union organizations

##### *Federation of Trade Unions in Health (FTUH)-CITUB*

**Foundation:** March 1990 at the Extraordinary Congress of the former Health Workers' Union.

**Union membership:** As at October 2003, FTUH has 17,800 members, who belong to 370 trade union organizations. About 75 per cent of the members are women. There is a trend towards a significant decline in membership, as compared to 1999 when there were 32,285 members. The 46 per cent decline is a result of the restructuring of health-care establishments, the introduction of new principles in outpatient health care and drastic staff cuts caused by public sector reform. Some stabilization of membership was observed after 2002 and new members have been recruited. For the period 2004-05, membership increased by 4.1 per cent (769 new members). 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 the private health establishment and practices, organizing is difficult.

<sup>12</sup> Until the status of Promiana is clarified, the two representative medical federations declined to accept the participation of representatives of the medical federation of Promiana in SCTCH.

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**Associate members of the Federation:** These include the Union of Kinematics and Rehabilitation Therapists, the Association of Private Dental Technicians, the Union of Nurses<sup>13</sup> and Union of Pharmacists. They participate in the governing bodies and have the right to a deliberative vote.

**Governing bodies:** The Federal Council was set up on an occupational and territorial principle with 51 members and an Executive Council with 17 members.

A total of 28 regional and municipal coordination councils have also been formed.

FTUH is a member of Public Servants International (PSI) and the European Public Servants Union (EPSU).

#### *Medical federation Podkrepa (MF Podkrepa)*

**Foundation:** 1989.

**Union membership:** MF Podkrepa has about 6,800 members who belong to 210 sections throughout the country (2002). The 2003 census showed a serious decline of the membership and a disorganization of the regional unions.

**Governing bodies:** Federal Council, Executive Council.

Some 25 regional medical trade unions (RMTU) and district trade union organizations based on the sectoral principle have been formed.

Members of the Federation are RMTU and sections of the Medical University-Sofia and the Rehabilitation Centre.

MF Podkrepa is a member of PSI and ESPU.

#### Employers

##### *National Association of Employers in Health (NAEH)*

**Foundation:** 2001.

**Membership:** The membership of NAEH consists of 35 health-care establishments – mostly large medical establishments in Sofia, centres in other large cities, university hospitals and municipal hospitals.

The Association works on the sectoral principle.

**Governing bodies:** Managing Board and Supervisory Board.

NAEH is a member of the BIA, which is recognized as a representative employers' organization at national level.

<sup>13</sup> With the adoption of the law on the professional organizations of nurses, midwives and medical specialists (2005) which made obligatory membership in these organizations mandatory, the Union of Nurses discontinued its associated membership. Nevertheless individual membership in the medical trade union federations is preserved.

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### **1.3. Formal procedures**

The activities of the SCTCH are organized in compliance with the Labour Code and the Rules on the Organization and Activities of the Councils for Tripartite Cooperation adopted by the NCTC in May 2001. The Council sessions are convened by the Chair, who proposes the agenda. Sessions may also be called at the request of the workers or employers, who then propose the agenda. Resolutions are passed by general consensus of the permanent members of the Council. The records of the session are submitted to the Minister and the social partners, together with the written positions of the parties involved.

Standing and ad hoc working groups are set up at SCTCH as necessary to deal with issues which have been discussed but not resolved. The working groups draft the preliminary positions and proposed resolutions for discussion by the Council.

Experts from the Ministry of Health, the trade unions and employers' organization may also participate in the work of the Council, although they have no voting rights. Representatives of other trade unions not recognized as representative and of professional organizations may be invited to attend the discussion of issues which particularly concern them.

## **2. Social dialogue at municipal level**

### **2.1. Institutionalization**

A number of cities have set up a Municipal Council for Tripartite Cooperation (MCTC). These Councils are made up of representatives of the workers' and employers' organizations, nationally recognized as representative, and of the local authorities, participating on a parity basis. The Council is usually chaired by the Mayor of the municipality. Depending on the nature of the issues discussed, experts of all represented parties may also attend the Council meetings.<sup>14</sup> The regional structures of the NAEH have not yet been established, so that the NAEH does not participate fully in the social dialogue at that level.

### **2.2. Scope**

Informant interviews held with members of the MCTC in Smolyan, Sofia and Stara Zagora show that the trade unions are the most frequent initiators of discussions at the Council. The MCTC discusses a broad range of issues:

- progress of the health reform and its impact on the workers' incomes, employment and jobs;
- structural elements of the reform: restructuring, privatization, closure of health establishments;
- conciliation whenever labour disputes arise in individual units of the health system; a number of problems find a solution through dialogue. The causes of social tension and labour conflicts are usually related to low pay, violations of the Labour Code and collective agreements;

<sup>14</sup> With a right to discuss, but without a role.

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- funding of outpatient health care.

Conducting negotiations and concluding a municipal collective agreement are among the most important functions of social dialogue.

The social partners at municipal level play a decisive role in collective bargaining and the conclusion of collective agreements in health and medical establishments. They also review problems in implementing agreements already concluded. The trade unions press the municipal authorities to help get negotiations started in the individual establishments and especially at the diagnostic-consultative centres.

### **3. Social dialogue at establishment level**

One of the primary goals of social dialogue at the level of the health establishment is the conclusion of collective agreements. The trade union organization/organizations and the respective employer set up a bargaining group. This is a bipartite body.

At that level, there are no requirements for trade union representativity. The union elaborates the draft agreement; if there are two or more organizations affiliated to different confederations they present a joint draft. If they cannot agree, the employer concludes a collective agreement with the organization whose draft received the majority vote of the members of the general workers' assembly.

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## **IV. The implementation of social dialogue in the health sector**

### **1. Sectoral level**

The health sector constitutes a specific industrial relations environment which determines the content of the strategic and everyday work issues to be negotiated and agreed by the social partners.

The SCTCH was formed in response to union pressure in view of the pending reform in the health sector and the need to solve its specific problems. Since the Council was set up in 1997, it has held over 50 sessions and discussed over 150 topics.

SCTCH sits almost every month, sometimes several times in a month depending on the issues to be discussed and the urgency of their solution. However, its work is sometimes interrupted because of political instability, i.e. changes of governments and ministers.

The SCTCH sessions and agenda are usually initiated by the trade unions and primarily by the representatives of FTUH-CITUB since they are most closely related to workers in the health sector and are thus informed on problems as they arise. It should be noted that the Ministry of Health has recently adopted a more proactive approach.

#### **1.1. Scope of the social dialogue**

Social dialogue at SCTCH is not confined to negotiating collective agreements. It covers a broad range of issues and takes various forms: information exchange, consultations, informal meetings, exchange of documents, conflict resolution procedures, monitoring mechanisms for the resolutions and decisions adopted, participation in discussions and meetings on the problems of the sector,<sup>15</sup> etc. These regular activities help sustain social dialogue.

Almost all health-related issues have been placed on the agenda of SCTCH. The most important problems discussed are as follows:

- sectoral agreements, sectoral collective agreements (SCAs) and annexes to them;
- financial problems:
  - draft budget and execution of the health budget;
  - hospital debts;
- remuneration – salaries and additional remunerations;
- employment, redundancies and job vacancies;

<sup>15</sup> In the last few years, through the initiative of CITUB and/or both medial federations, a number of tripartite conferences and workshops have been carried out, e.g.: The Health Reform, 2002; The Crisis in the Health Care, 2003; The legislation in the Health Care, 2004; The Policy Concerning Drugs and the Rights of Insured, 2004; Health Care in Bulgaria – Problems and Challenges, 2004; Financing of the Health Care, 2005; Health Policy – Financing and Managing Design, 2005.

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- working conditions;
  - working hours, rest and paid leave;
  - restructuring of medical establishments;
  - draft laws related to health;
  - social dialogue in health and medical establishments;
  - problems of individual health establishments.

In 2004-05 two new issues were included into the discussions in the SCTCH: the negotiations on minimal obligatory social security thresholds to be set up each year and the restructuring of the centres for emergency medical aid (CEMA).

Conflicts often arise over the appointment or replacement of directors, pay, employment and working conditions, non-fulfilment of the collective agreements or refusal to negotiate, rest and working hours.

## **1.2. Relations between the social partners**

All interviewed members of the SCTCH agree that relations between the three parties are relations between colleagues; all representatives are ready to hear the opinion of others, to make concessions and compromises and to respect the interests of the other parties. The general aim is to reach a consensus. A sharper tone is rarely heard. On occasions when no consensus is reached the parties sign the minutes, but make a disclaimer noting their particular opinion.

When it proves impossible to reach a common position, the issues are resolved through consultation between the parties; informal meetings take place and an agreement is usually reached.

## **1.3. Competence, information and ability to conduct social dialogue**

The capacity of the social partners at all levels is a vital prerequisite for the development of social dialogue as an effective instrument to influence health reform. The tensions and conflicts connected with the reform call for adequate decision-making abilities. The government representatives greatly appreciate the competence and expertise of the trade unions, especially of FTUH-CITUB, whose experts are well-informed on a broad range of issues. The employers have a similar opinion.

According to the trade unions, government representatives on the Sectoral Council and the working groups are not always sufficiently familiar with the legislation on social dialogue. To a large extent that is due to the constant replacement of governments, ministers and even experts from the Ministry. The employer representatives are much better prepared.

## **1.4. Compromises**

No serious compromises have been made, according to the government representatives. Employers believe that they have made a compromise on paid leave by accepting a proposal for unjustifiably long additional leave in the 2002 SCA. In the new

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2004 SCA they once again made concessions on additional paid leave including for the trade union activists. The trade union made concessions on some additional payments.

The three parties have not yet reached consensus on the right to strike for health workers, or on the debts owed by many health establishments. The trade unions brought the case of the ban on the right to strike in some sectors before the Strasbourg Court. The health federations hope that the new Government will amend the legislation providing for the right to strike in health care.

## **2. Establishment level**

This analysis of the social dialogue at establishment level is based on data from sociological surveys carried out by the ISTUR in 2002<sup>16</sup> and 2003. The collective bargaining 2003 survey was carried out in 50 health and medical establishments in three municipalities (Smolyan, Sofia and Stara Zagora). The establishments are noted for good practice in the field of social dialogue and the survey was made especially for this report. Both surveys follow the same methodology and use the same questionnaires, which were distributed to the trade union leader in each establishment.

The surveys cover several problem-specific areas: the first analyses the parties to social dialogue, the second relates to the bargaining process and the third focuses on effectiveness.

### **2.1. Trade union organizations**

More than half of the health establishments surveyed in 2002 and 2003 have only one trade union organization – FTUH-CITUB. Almost all the other establishments have FTUH-CITUB and MF Podkrepa. There are very few establishments where other trade unions are represented.

Both surveys found that trade union pluralism is not a barrier to successful negotiations and the conclusion of collective agreements. The prevailing values are good partner relations, where constructive competition means achieving consensus between the trade unions. No confrontational relations between the two major trade unions have been witnessed.

**Table 5. Relations between the trade union organizations** (percentage of respondents)

	<b>2002 survey</b>	<b>2003 survey</b>
Partners	87.1	82.4
Constructive competition	12.9	17.6
Total	100.0	100.0

### **2.2. Relations between the social partners**

The success of social dialogue to a large extent depends on good relations between the social partners. The data from both surveys indicate that cooperation and partnership

<sup>16</sup> “Collective bargaining 2002: Characteristics and new trends” covering 772 enterprises throughout the country, including 56 health establishments.

are paramount in the relations between trade unions and employers. Compromise and consensus are the basis for a constructive approach to contentious issues. Very few establishments have witnessed an open confrontation between the partners.

**Table 6. Relations between the social partners (percentage of respondents)**

	2002 survey	2003 survey
Cooperation and partnership	51.8	68.3
Constructive opposition	14.3	12.2
Both partnership and opposition	28.6	17.1
Open confrontation	3.6	0.0
No answer	1.7	2.4
Total	100.0	100.0

### 2.3. Negotiation

#### Preparation

In establishments with more than one trade union, union representatives agree on their positions in advance. FTUH-CITUB and MF Podkrepa developed a joint draft collective agreement in 67.7 per cent of the cases studied, and FTUH-CITUB had its own draft in 32.3 per cent of cases.

Information is a motivating factor in retaining trade union members and attracting new members, thus increasing the bargaining power of the trade unions. Bringing union activities closer to the interests of members in the conclusion of collective agreements is a process that can be observed in a large number of the health establishments studied.

**Table 7. Did you inform/consult the trade union members? (percentage of respondents, 2003 survey)**

	Yes	No	Total
Before negotiations/concerning demands	95.2	4.8	100.0
During negotiations/on concessions	90.6	9.4	100.0
Concerning the parameters agreed in the collective agreements	90.6	9.4	100.0
Concerning amended clauses in collective agreements?	87.5	12.5	100.0

#### Compromise

Against the background of the unfavourable economic and financial situation in the health establishments both sides have made concessions in the conduct of negotiations. However, the survey found that one in ten employers refused to change their position compared to one-third of unions.

**Table 8. Compromises made by the social partners** (percentage of respondents, 2003 survey)

	<b>Employers</b>	<b>Trade unions</b>
Working hours, rest and leave	55.6	32.0
Training and retraining	30.6	16.0
Additional remuneration	27.8	20.0
Conditions for trade union activities	22.2	8.0
Social and daily life problems	19.4	8.0
Higher wages	13.9	40.0
No compromise	9.8	32.4

### Range of agreements reached

The collective agreements cover all aspects of labour relations, but the parameters on some of them are higher than those concluded in previous years. Thus in 2003, as compared to 2002, better conditions concerning working hours, rest and leave were agreed in 75 per cent of establishments; concerning staff employment, training and retraining, in 50 per cent; social benefits, in 40.4 per cent; health and safety at work, in 44.2 per cent; conditions for trade union activity, in 42.3 per cent.

### Social dialogue effectiveness

The opinion of the trade union leaders surveyed is that social dialogue is an effective way of solving the problems of health personnel. The conclusion of a collective agreement is regarded as a significant advance in the development of industrial relations in itself. The conclusion of the first collective agreement ever has been registered in a number of the establishments surveyed.

## 3. Results and achievements

### 3.1. *At sectoral level*

Members of the SCTCH consider the regular conclusion of a SCA every two years, the first in line with the amendments in the LC<sup>17</sup> concluded in March 2002 as their highest achievement in recent years. The 2004 agreement provides for better working conditions, longer paid leave and higher remuneration.

Another achievement is the agreement concerning centres for medical emergency aid (CEMA), signed in 2003 after continuous strike action, confrontations between the two trade union centres and a conflict with the Ministry of Health. According to the agreement on 1 July 2003 the salaries of CEMA doctors and paramedics were increased by 10 per cent (compared with a 3.5 per cent increase for other health-sector workers). The aim is to reduce the wage gap between CEMA employees and staff in health establishments financed by the NHIF. The practice of concluding agreements on remuneration in CEMA as annexed to the SCA continues in 2004 as well.

<sup>17</sup> In 2000, the first Agreement was concluded after one year of difficult negotiations with very narrow scope.

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One of the very important successes of the social dialogue process was the inclusion of the issues of violence and stress in the 2004 Branch collective agreement in the section “Health and safety at work”. The SCA provided for undertaking joint measures of the employer and trade unions to prevent all forms of discrimination, physical and psychological violence at the workplace. The procedure to manage the cases of violence was also introduced. The Health and Safety Committees/Health and Safety Groups established in all health establishments have to collect information and investigate all cases of violence at the workplace and take decisions on them. The Agreement is mandatory at national level and applies to all health institutions. This provides the necessary legislative framework for addressing workplace violence at institutional level and enforcing action to be taken. This is result of the support and follow-up activities in the framework of the ILO, ICN, WHO and PSI Joint Programme on Workplace Violence in the Health Sector.<sup>18</sup>

### **3.2. At municipal level**

The main achievements of social dialogue at municipal level are as follows:

- cooperation between the social partners in the search for joint solutions to improve the working conditions of health workers in the context of reform;
- agreements on maintaining the scope of the work of health establishments in the process of restructuring;
- solutions to a number of common problems, including problems in the health establishments.

The understanding on the part of the social partners of the need for collective bargaining is considered as an important achievement of social dialogue. The constructive nature of the dialogue and the willingness of the social partners to make concessions make it easier to reach agreements through consensus. As a result, the first municipal collective agreements have been signed for some individual types of health-care establishment: childcare complexes, health units and school health. In 2002-03 between 60 and 70 per cent of all municipalities in the country had signed collective agreements, while in the period 2004-05 about 80 per cent of the municipalities had collective agreements for the medical staff in the child-care complexes.

The municipal collective agreement on childcare establishments in Sofia City has increased the influence of trade union organizations in these establishments and is a strong motivating factor for union membership.

<sup>18</sup> Bulgaria has been selected as one of the countries to complete an exemplary project cycle at national level within the Joint Programme on Workplace Violence in the Health Sector. Since 2001 the Institute of Social and Trade Union Research (ISTUR), together with the Federation of Health Trade Unions (CITUB) and the Medical Federation Podkrepa, participated in the Joint Programme activities. Two tripartite workshops were organized in 2003 and 2005; a follow-up survey in 2004 was conducted, action plans for 2003 and 2005 have been adopted. The Bulgarian case study and Framework Guidelines have been published in Bulgarian.

**Box 4**  
**Municipal collective agreement in child health-care establishments  
and child health care – Sofia municipality**

A national agreement reached at the SCTCH enabled the trade unions to initiate collective bargaining at municipal level. Under the Health Act these establishments are not part of the health system because they are funded by the municipalities and are subordinated to the Ministry of Labour and Social Policy.

The first municipal collective agreement was concluded in Sofia in January 2002. Parties to the agreement were the Territorial Coordination Council at FTUH-CITUB, the Regional Medical Trade Union at MF Podkrepa and Sofia City.

The collective agreement regulates labour and social security relations at child health-care establishments and the school health system. Its purpose is to promote the professional self-esteem and satisfaction of the employees in that sector involving them and giving them a sense of responsibility in mutually acceptable decision-making. The parties to the agreement are obliged to ensure the normal operation of these establishments.

The agreements reached are in conformity with the SCA, the Constitution of the Republic of Bulgaria, the Labour Code and the legal framework regulating the activities of these establishments.

The section on employment regulates the role of the trade unions as parties to the agreement in case of impending lay-offs and structural changes and lays down the principles and criteria for action in that field. Where such measures are necessary the employer shall inform the trade unions in writing and discuss with them the need for staff changes. The period of notice for any termination of employment due to lay-offs, which according to the Labour Code is one month, has been increased to three months.

The section on salaries provides possibilities for increasing the initial levels of salaries and additional remuneration in the amount established in the sectoral agreement through negotiations between the parties to the municipal collective agreement; indexation of the individual salaries where funds are available in the Salary Fund; voluntary insurance of the employees against occupational hazards.

The provisions agreed in the section on working time, rest and leave are better than those envisaged in the Labour Code and nurses and trainers are allowed to use one hour of their eight-hour working day for self-preparation.

In the section on training the employer is obliged to draft a staff training plan and to agree it with the trade unions. The employer is obliged to provide ten days of official leave to the employees in child health care and school health units for training purposes.

The section on health and safety at work envisages the creation of a working conditions group.

In the section on terms and conditions for trade union activities the employer has committed to provide paid leave to unsalaried leaders for the performance of their trade union duties, as well as material and other conditions necessary for the fulfilment of trade union functions.

Apart from the agreements already mentioned the most important achievements of the municipal collective agreement are as follows:

1. It marks the first time that employees in such establishments are covered by collective bargaining.
2. With the help of the trade unions this agreement is extended to other municipalities in the country and has a multiplier effect.
3. The collective agreement is a strong motivating factor for increasing FTUH-CITUB membership in these establishments in Sofia City. Since the agreement was signed, the number of members has risen from 40 to 640.

### **3.3. At establishment level**

The very signing of a collective agreement at establishment level is a success for trade unions in the health sector for a number of reasons:

- After the start of the health reform trade union density declined significantly due to the reductions in medical staff. This had an adverse effect on the bargaining power of the unions.

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- Due to the termination of all collective agreements concluded before 1 March 2001, the trade union organizations found themselves in a new situation defined by the health reform which was already under way: change of ownership and status of a number of health workers.

Collective agreements have been concluded by over 90 per cent of the trade union organizations in health establishments and this is a considerable achievement, the more so as many employers are not members of the nationally represented employer structures – parties to the SCA. Nonetheless they have recognized their social partners and acknowledged their right to negotiate and sign collective agreements.

Despite the grave financial and economic situation in health establishments generally, the trade union organizations and employers have reached agreement on all aspects of labour and social standards concerning health workers. In most cases they have confirmed provisions in the SCA which are higher than the minimum standards provided in the Labour Code. On pay-related issues the social partners have agreed the same terms as those for the whole sector. Some higher standards have been established concerning rest and additional paid leave, social benefits, conditions for trade union activities and the procedure for other workers, who are not members of the trade union organizations, to join the agreement.

In addition to collective bargaining the social partners have held joint discussions on a number of issues. These include jobs and employment, higher salaries for medical workers with secondary/college education, and training and retraining programmes for medical workers. In the context of the Labour Code<sup>19</sup> the trade union organizations have participated in drafting rules and regulations governing labour relations. In some establishments trade unions have also participated in the discussion of financial questions concerning the allocation of the additional funds collected from paid medical services and used as additional incentives.

In a number of health establishments union representatives are members of the Medical Board, and thus participate in decision-making. In other cases they are invited to participate in the work of these bodies on issues concerning labour relations.

The main conclusion from the surveys carried out is that social dialogue, collective bargaining and the conclusion of collective agreements at health establishments are becoming established as a social practice contributing to the development of effective industrial relations.

<sup>19</sup> “The bodies of any trade union organizations at enterprise level shall be entitled to participate in the preparation of all draft interior rules and regulations referring to labour relations and the employer shall be obliged to invite them to do so”, Labour Code, article 37, 2001.

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## V. Analysis of the process

An analysis of the information reported in the first four chapters of this report makes it possible to identify the factors contributing to the development of social dialogue and the factors hindering it. This lays the basis for looking at ways to improve effectiveness.

### 1. Contributing factors

#### *At sectoral level*

The development of the legislative framework for social dialogue has made it possible to clearly identify the parties involved, and the procedures, mechanisms and instruments to be used.

The work of the SCTCH helps reconcile the various interests and positions. The Council promotes a consensual culture of dialogue and enhances the capacity of the actors to engage in partnership between Government, trade unions and employers' organizations.

In the years of transition trade unions grew up as strong independent social partners capable of participating effectively in social dialogue. It can be said that the development and consolidation of dialogue in the health sector is largely due to their potential, persistence and pressure.

The gradual structuring and formation of the employer side in social dialogue provides opportunities for the future development of autonomous bipartite dialogue.

#### *At municipal level*

All participants interviewed at the municipal level believe that cooperation between the social partners and the spirit of genuine dialogue that reigns in the discussions contribute to the achievement of consensus.

Despite the severe constraints resulting from the financial situation of municipalities the social partners are always willing to discuss the broad range of issues which arise as a result of the health reform. Such talks help to solve problems whenever social tensions and labour conflicts occur and also to maintain social peace in health establishments.

The initiative of the workers' representatives (trade unions) contributes to the effective functioning of the MCTC. Problems with the decision-making competence of the MCTC are identified in the interactions between the municipal and local level.

The bargaining power of the trade unions related to their competence, expertise and professionalism, as well as their ability to exert pressure on the social partners for problem solution, enhance the effectiveness of social dialogue.

MCTC control over the implementation of collective agreements in health establishments also helps strengthen social dialogue.

The SCA is a major factor contributing to effective cooperation at municipal level. The standards, rules and principles of interaction laid down between the social partners in health are a good basis for starting negotiations and concluding a municipal collective agreement.

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## ***At establishment level***

The civilized relations of cooperation and partnership established between the representatives of trade union organizations and employers helps to promote a dialogue between them and quite frequently contribute to reaching a consensus on the issues discussed. The maturity of the social partners is demonstrated by the fact that both parties have made concessions during negotiations and sought to bring their positions closer together by following a constructive approach rather than confrontation. The use of collective bargaining as a mechanism to regulate labour relations is confirmed by the survey findings.

Trade union pluralism is not an obstacle to successful social dialogue. The trade union organizations of FTUH-CITUB and MF Podkrepa have negotiated successfully on the basis of cooperation and partnership in the name of the common goal – promotion of the rights and interests of their members.

The permanent contact maintained between trade union leaders and members throughout the bargaining process makes it possible to consider their interests and exert control from the bottom up.

The bargaining power of the trade unions based on their competence, skills and commitment is a factor in the successful development of social dialogue in health establishments.

## **2. Hindering factors**

### ***At sectoral level***

The state of the economy and the constraints imposed by the budgetary policy and the operation of a Currency Board limit the capacities of the social partners in the public sector and restrict the opportunities for promoting of decent working conditions and adequate payment.

This is aggravated by the frequent change of governments, ministers and experts at the Ministry of Health. Lack of capacity on the part of government representatives has an adverse effect both on the process of dialogue and its results.

Although the employers' organizations have achieved some growth, there is still no employers' organization that is clearly structured and sufficiently representative at all levels of the health system to act as a partner, especially in the private sector. This further complicates bipartite dialogue at the sectoral level.

Additional complications led to the fragmentation of the social partners with the recognition in 2004 of three new partners as representative, potentially threatening the effectiveness of the dialogue at all levels.

The involvement of the social partners in the discussion of a number of changes and important decisions related to the health reform is neglected.

Government representatives in SCTCH report the following difficulties in the process of social dialogue:

- sometimes the unions raise insignificant problems experienced by individual health establishments and a lot of council time is lost in discussing them;

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- problems concerning municipal health establishments are sometimes raised, although they cannot be solved at that level;
  - in some cases the trade unions make unrealistic demands;
  - there are difficulties in implementing the SCA due to the different forms of ownership in the health sector and the different conditions of work in the health establishments;
  - trade union and government representatives have some conflicting interests: the former want to preserve the status quo and oppose the closure of individual hospitals, while the latter are obliged to follow the government policy of restructuring.

According to the employers:

- difficulties in social dialogue proceed from the great powers of the trade union organizations in health establishments;
- a confrontational style and the protection of occupational or personal interests is typical of enterprises: where the trade unions are strong, the employer is obliged to respond to their demands.

According to the trade unions:

- there are still cases of formal dialogue when the social partners are confronted with a fait accompli; unilateral decisions are made that affect the interests of health workers and deprive dialogue of any value;
- certain procedural and technical difficulties exist: late submission of documents or a failure to prepare the necessary paperwork cause delay in the discussion;
- in many cases the representatives of the Government are not ready to compromise;
- the obligatory membership in the professional organizations of physicians, dentists, nurses and midwives has impacted the role and influence of the trade unions and has led to decreasing membership.

### ***At municipal level***

The main barrier to conducting an effective social dialogue is the financial status of the municipalities. The lack of real decentralization and the low budget provided by the Government and its restrictive policies on health, together with the inability of the municipalities to support themselves financially, make it impossible to negotiate higher labour and social standards for health workers under the umbrella of the municipality. The most contentious issues at the MCTC involve higher wages and income determination. In all three municipalities studied for this report, both the municipal and the employer representatives refused to discuss pay and salary updating mechanisms during collective agreement negotiations.

All interviewed representatives of the MCTC reported that contradictions in the legal framework and frequent amendments to the law were a major problem in its work. More often than not, due to the unstable legal framework, some resolutions already made lose their meaning and the social partners have to review them and try to reach another consensus on the issues concerned.

Another inhibiting factor is the ownership of some medical establishments registered under the Trade Act, notably diagnostic consulting centres (DCCs). Although DCCs are

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essentially private establishments, the employer is appointed by the municipality. Confusion over the employer's status affects the relations between the parties to social dialogue. Whenever problems arise, the dual role of the employer who does not actually represent the owners tends to hinder the execution of the decisions made.

The rhythm of social dialogue is disrupted by the irregular meetings of the councils for tripartite cooperation. This slows the negotiation process and delays the conclusion of a municipal collective agreement (in Sofia and Smolyan the negotiations lasted six months and in Stara Zagora – five months).

The high number of employers' organizations that have been recognized as representative (six) and the absence of any clear identification of the employers at municipal level makes the efficiency of the decisions and their applicability in the health establishments rather difficult. For that reason the dialogue is frequently conducted by the municipality and the trade unions. Many employers are not members of the representative employer structures at national level.

The representatives of the municipality at the MCTC are often replaced, which affects the quality of the expert resources of this social partner. Coordination between these experts and the municipal authorities represented by the Mayor is not always optimal.

In the last few years the scope of social dialogue at the municipal level became narrower. Trade unions were excluded from discussions on health issues in the regions.

In the capital, Sofia, where the majority of hospitals and Diagnostic Consultative Centres are located, the establishment of a holding of hospitals and DCC hindered social dialogue as separate negotiations had to be conducted both with the holding and with the hospitals and with the DCC. The trade unions have considered this structure inefficient and unnecessary.

### ***At establishment level***

The main barriers to the effective development of a social dialogue relate to the financial and economic problems of the health and medical establishments. As of November 2005 the indebtedness of the hospitals in the country was about 191 million leva due mainly for medicines, electricity and heating and poor management.

The trade union leaders believe that issues in the field of labour relations cannot be resolved easily regardless of the will of the social partners. This explains why no agreement has been reached on incomes in a number of health establishments.

In some establishments the position of the employer and the insufficient capacity of the union organizations to conduct negotiations and conclude collective agreements are barriers to effective dialogue.

The bargaining process is hindered by the employers when they fail to provide sufficient information in good time or refuse to provide it on the pretext of a company secret. Employers often dragged out the negotiations but it was only in three establishments that they were unwilling to reach a consensus.

The development of the bargaining process in DCCs is hindered by the delayed signing of a municipal agreement on the diagnostic-consulting centres. The employers in these establishments often refuse to negotiate and sign collective agreements. In other cases after signing the collective agreements they deliberately sign individual employment contracts with non-union members envisaging higher parameters than those agreed with the trade unions.

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### **3. Areas of improvement of social dialogue**

#### ***At sectoral level***

Social dialogue should be further developed so as to serve as an effective instrument in providing decent working conditions for health workers and in enhancing the quality of health services. To this end it is necessary to:

- develop further the structures of dialogue in the health system;
- strengthen the structures of trade unions and employers' organizations;
- enhance the capacity of the social partners through training;
- start the activity of the Branch council on health and safety because of the serious problems in health establishments.

#### ***At municipal level***

Social dialogue at municipal level is not yet well developed. It is necessary to:

- establish employer structures at municipal level;
- extend the scope of municipal bargaining by holding negotiations and concluding collective agreements covering all kinds of health establishments;
- expand the scope of the collective agreements;
- widening the subject field of the municipal social dialogue including the health-care issues in the municipalities.

#### ***At establishment level***

The achievements of social dialogue at establishment level could be improved through:

- institutionalizing cooperation and dialogue through the establishment of standing social cooperation bodies of employer and trade union representatives;
- enriching the forms and mechanism of dialogue;
- widening of the opportunities for trade union organizations to participate in decision-making related to labour issues;
- enhancing the capacity and bargaining power of trade union organizations through recruiting campaigns;
- training trade union leaders in social dialogue, economics, strategies and tactics of collective bargaining.

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## **VI. Impact of the social dialogue**

### **1. Social dialogue and working conditions**

The efforts of the trade unions are largely focused on achieving enterprise agreements and SCAs mainly on salaries, additional benefits, working hours and paid leave.

The trade union strategy presupposes coordinated action at national, sectoral and establishment level. Thus, some minimal generally applicable standards are provided whose parameters may be improved at the lower levels depending on the specific possibilities and characteristics of the establishments concerned.

In the sphere of payment the main framework is established by the state budget. In the course of discussion and presentation of expert positions, the representative unions at national level have the opportunity to fight for health appropriations.

The procedure of discussing the state budget with the social partners is exceptionally important since it is the point of departure for the annual round of collective bargaining in the budget-funded sector, including health. At the same time, however, we have to admit that it is here that the Government is most unbending. Its arguments always stress the need to implement a restrictive policy, whether the Government is left or right wing. On the one hand, the restrictive policy is dictated by the Currency Board and, on the other, the adoption of the state budget is preceded by its agreement with IMF representatives whose most important advice in recent years has been to achieve a zero budget deficit. That condition is largely observed by the Government: it has achieved an unprecedented low deficit level of 0.7 per cent.

The effects of the restrictive policy are evident: on the one hand, inflated state expenditure and sprawling administration with the argument that new structures need to be introduced in the process of European integration and, at the other extreme, maintaining a low level of national expenditure with limited salary growth in key budget-funded sectors, such as health and education. At an average annual inflation rate of 5 to 6 per cent, salaries in these sectors were raised by only 3.5 to 5 per cent annually in the last few years, which meant a decline in real income.

The trade unions demand a consistent incomes policy providing for 20 per cent nominal growth up to 2007, yet, for the time being at least, this proposal is categorically refused by the Government. CITUB's insistence on updating the lowest levels of additional compensation provided under the Labour Code and a special Ordinance on additional compensations for hazardous or specific conditions at work, for qualifications and night work does not meet with any sympathy on the part of the Government or the employers' organizations, although they have not been increased since 1999. Low incomes have a demotivating effect on the workers, particularly in the health sector, where qualified people work at night and often in hazardous conditions.

Experience of social dialogue at the next (sectoral) level indicates that some breakthroughs may occur in negotiating remuneration at a level above the average for the budget-funded sector, but as a rule these successes are partial and sporadic and come as a result of long and painful negotiations. As already mentioned, success was achieved in 2003 and in 2004 with the priority growth of the salaries of senior staff or the employees at the CEMAs. Some higher levels of payment are also negotiated in a number of health establishments within the funds provided from the state budget – in some cases for specific staff categories and in others through streamlined employment or improved work

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organization. At that level some good opportunities are available for negotiating higher levels of additional compensation to the basic salary.

Certain achievements can also be cited in working hours and leave. Under the provisions of the Labour Code the paid annual leave of at least 20 working days allows negotiation of more favourable conditions at sectoral and establishment level. An indisputable success of the activities of the trade unions is the already mentioned sectoral agreement between FTUH, the Ministry of Health and MF Podkrepa signed in March 2000 after 11 months of difficult negotiations. The agreement helped protect the interests of trade union members and it served as a basis for collective agreements at medical and health establishments. Some individual health establishments managed to win even more beneficial parameters in that area, such as the psychiatric dispensary in Sofia City where an additional 18 days of annual leave for specific conditions of work were negotiated. The additional paid annual leave for specific working conditions – at CEMAs, Pirogov Emergency Hospital, psychiatric dispensaries etc. in the 2004 SCA is in the margins of six to 22 working days for the different staff categories. In 2002 and 2004, collective agreements at the branch level with higher additional paid leave for the implementation of trade union duties by trade union activists had been negotiated. Fifteen working days were negotiated for members of the sectoral leadership, ten working days for the members of territorial leadership, and no less than eight days for the leaders of trade union organizations within health establishments.

Social dialogue in health may be defined as relatively successful considering the fact that the results achieved in a number of sectors, such as manufacturing, are weaker and that collective bargaining in some other sectors is either slipping or in complete stagnation.

## **2. Social dialogue and monitoring of health services**

In their present form the functions of the supervision carried out by the Ministry of Health are obscure as they duplicate those of other institutions: the NHIF, professional organizations and the State Insurance Supervision Agency. Ministry supervision will probably be transformed so as to establish a uniform authority monitoring the quality of medical services. The supervisory functions of the Ministry should cover, not only mandatory and voluntary health insurance, but it should monitor the entire range of health care, regardless of who pays for services.

The object of supervision should be:

- the quality of medical services, regardless of who pays for them;
- the proper observance of the rules of good medical practice as an objective criterion of best quality;
- the qualifications of the providers of medical services;
- the settlement (arbitration) of disputes concerning the quality of medical services.

In the context of funding provided through health insurance the following groups of institutions protecting different interests have a role in patient-physician relationships:

- the patients (insured), patient associations, patient-related non-governmental organizations (NGOs);
- the NHIF and private health insurance companies;

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- funding bodies: municipalities, central Government, NGOs, trade unions, employers' organizations;
  - health-care providers (GPs, health and medical establishments), professional associations.

The need to harmonize divergent interests calls for representation or at least consultation within the framework of a broad social dialogue, irrespective of the authority supervising the quality of health services. In that context the trade union organizations at different levels should be involved in certain problematic areas, such as the:

- procedures and functioning of voluntary arbitration before any disputes are referred to court;
- development and observance of exact rules for good medical practices;
- development of licensing rules for specialized medical activities;
- development of rules, criteria, registration and control of ongoing training for medical staff;
- rules governing the acquisition of specialized medical qualifications, the registration of new qualifications, and the register of medical specialists.

Until now, the monitoring of the quality of medical services carried out by the NHIF, the Boards of Ethics of the Bulgarian Union of Physicians and the Bulgarian Union of Dentists has not been very successful. That conclusion reflects both their functional efficiency and the opportunities for social dialogue.

### **3. Social dialogue and health reforms**

As already pointed out in section one, the reform of the health sector and the health insurance model which was introduced were in a large measure unilaterally imposed by the Government. This was the case despite extensive discussions by experts and within the existing health system. The discussions created the illusion of a social consensus concerning the pace, direction and parameters of the reform. This was important because the reform was overdue and pressure from the world financial institutions for immediate change seemed irresistible against the background of fast privatization and restructuring in other economic sectors.

In this situation the trade unions were forced to perform two main functions:

- as a corrective factor, sending clear warnings of negative processes that were either impending or already taking place;
- as an initiator of programmes to alleviate the social effects of the reforms.

With regard to the first function, different instruments of social dialogue and mechanisms of influence were used:

- participating as experts on the Parliamentary Health Commission in the discussion on draft legislation or regulatory amendments;
- consulting and collective bargaining within the framework of the SCTCH;

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- participating in the hospital accreditation procedures to prevent the closure of health establishments and to protect jobs in the health sector;
  - exerting union pressure and organizing protest actions in health establishments;
  - holding conferences and workshops related to the health reform, its effects and challenges;
  - publicizing the results of a number of research projects.

With regard to the second function, the trade unions have tried to introduce some stimulating social projects and compensation programmes beyond the general measures applied by the Government. However, it has not been possible to implement them in full, mostly due to lack of funds.

Overall, the potential for influencing health reform through social dialogue is significant, but the opportunities have not been used to the full. The reasons lie in government attempts to confine the role of the social partners to the industrial relations sphere, neglecting the need for broad public support for a reform that is vitally important but extremely unpopular.

Social dialogue would increase its influence if the range of questions were extended. Trade unions in the health sector are insisting that they should take part in the work of the highest advisory body of the Ministry of Health – the Higher Medical Board, where professional associations and higher medical schools are represented. The issues considered at the Board are of great importance, as they cover the:

- main trends in the national health policy;
- draft legislation and annual health budgets;
- development of facilities and medical technologies;
- criteria for evaluating of the quality of prophylactic and diagnostic activities and medical qualifications.

Participation in the work of the Higher Medical Board would expand the scope of trade union influence beyond its traditional confines. That would be especially useful at a time when the health reform begins to affect the country's population at large.

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## **VII. Conclusions and recommendations**

### **1. Lessons learned**

Practical experience in Bulgaria confirms the important role of social dialogue in protecting the rights of health workers and improving the quality of health services.

The social, economic and political situation has a strong impact on the development of social dialogue. It is important not only to build up the necessary legislative and institutional framework, but also to ensure the readiness and political will of all parties, and especially the Government, to engage in dialogue. No simple transfer of experience and good practice is possible without considering the context and environment where social dialogue is developing.

The implementation of the reform without the genuine involvement of the social partners has led to failure and discontent among health workers and the general population.

Building the institutional framework for social dialogue is no more important than building the capacity, mutual trust and respect of the partners and involving them in decision-making. The social dialogue can be effective, sustainable and influential only if it incorporates information, consultation and informal meetings. It needs to deal with a broad range of problems in the health system, rather than being limited to negotiations leading to formal collective agreements.

### **2. Success factors**

One of the most important achievements of democratic development and transition to a market economy is undoubtedly the adoption of the principles of modern social dialogue at national and sectoral level and in individual enterprises.

The building up of the relevant institutions and the legitimization and recognition of the partners at all levels ensure the sustainability of social dialogue at all levels. Regardless of the divergence in their interests, representatives of the three parties acknowledge the role of dialogue in the regulation of labour relations and in the avoidance of serious conflicts in the separate units of the system.

It is impossible to overestimate the importance of the training, seminars, consultations and other initiatives realized with support from the International Labour Organization, PSI<sup>20</sup> and many national trade union centres in the European countries and the United States in raising the capacity of the Bulgarian trade unions in the field of health. This support should continue to develop.

<sup>20</sup> PSI is an international trade union federation which represents 20 million public sector trade unionists around the world. It has 603 affiliates in 147 countries. PSI is an autonomous body, which works in association with federations covering other sectors of the workforce and with the International Confederation of Free Trade Unions (ICFTU). Both Bulgarian health federations are members of PSI.

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### **3. The way ahead: Recommendations for strengthening social dialogue**

Reforms and privatization in such sensitive areas such as health care must be introduced very carefully, with the participation of all concerned. The principles of the development of the health-care system should be adopted by national consensus of all interested parties and not just by one political force or another. The establishment of a meaningful consultation process and dialogue with the unions and civil society organizations, mainly patient organizations is very important for the reforms to continue successfully.

The Government should encourage social dialogue by establishing the framework envisaged in the Labour Code.

To strengthen social dialogue in health it is necessary to use new mechanisms and extend the scope of discussions, mainly by involving the social partners in making decisions on reform and defining national health priorities.

The Government should create a stimulating environment and provide capacity-building opportunities to the social partners, especially for their experts. Training opportunities are needed in the area of legislation, the conduct of social dialogue, the experience of other countries, communications and conflict-resolution techniques.

The trade unions should work on further promotion of labour and trade union rights based on the ILO core labour standards at all levels of the health system and continue to urge the ratification of important ILO instruments, such as Conventions Nos. 151, 144 and 154.

The trade unions should be conscious of the fragmentation of the workforce in the health sector, the changing employment model and the need to extend their social base in the private sector so as to ensure that they are sufficiently representative.

The employers should continue to strengthen their organizational structures, to identify their interests and positions clearly and to develop their representative potential in the private sector.

Trade unions and employers should strengthen their capacity and prepare to engage in autonomous bipartite dialogue without government participation.

The good practices of social dialogue at different levels should be carefully identified and disseminated.

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6. Dr. Kerana Mileva – TCC – Sofia.
7. Dr. Julia Kissmova – TCC – Smolyan.
8. Deniza Penkova TCC – Stara Zagora.
9. Dr. Svetlinka Koleva – Psycho-dispensaria, Sofia.
10. Dr. Amalia Georgieva – Fifth MPHAT.

### **Employers**

Dr. Gelev – Vice-President, NAEH.

### **Government – Ministry of Health**

Dr. Stoyan Aleksandrov.

### **Municipal authorities**

Dr. Lyubka Badeva – Municipality of Smolyan

Dr. Roumiana Raeva – Municipality of Sofia



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