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# GOVERNING THE HEALTHCARE SECTOR IN SLOVAKIA

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MARTA KAHANCOVÁ

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# Summary

Being part of the 7th EC Framework Programme project GUSTO (Work Package 6), this report uncovers recent developments in the governance of healthcare sector in Slovakia. In particular, the focus is on the main challenges that public healthcare has been facing since 2001 (healthcare reform, public sector austerity, corporatization and privatization); and changes to interest representation, bargaining procedures and outcomes in the light of the recent heatlthcare reforms. From a substantive point of view, the report provides evidence on the capacity of collective bargaining and collective agreements to govern employment flexibility and security in the healthcare sector.

Public healthcare in Slovakia underwent major reforms after 2001, including substantial decentralization of healthcare providers and differentiation in their organizational forms and financing. This fact had far-reaching consequences and fueled a growing discrepancy between working conditions in larger faculty/university hospitals and smaller public hospitals. Slovakia's entry into the EU, coupled with other national and international developments, opened further challenges for the healthcare sector, including migration of skilled healthcare workers and a domestic shortage of personnel especially in smaller hospitals. With growing demand for health services and a stabilized workforce, the economic crisis helped to even out the healthcare sector. Employment in healthcare is considered stable, without threat of dismissals and the need for particular employment guarantees and employability measures.

Such facts shape the character of governance through collective regulation in the healthcare sector. Initially covered by bargaining in the public service sector, the healthcare sector developed its own bargaining structure from 2006. This structure is a unique combination of bargaining centralization and decentralization. While substantive bargaining happens predominantly at the establishment level, sector-level bargaining plays a prominent role because responding to the diversity of establishment-level agreements. The agenda of collective bargaining did not change substantially and covers predominantly traditional bargaining issues such as wages, working time stipulations and supplementary pension provisions. Governance of these issues via collective agreements remained stable in scope and content in the past decade. A slight broadening in the substantive bargaining agenda is however obvious from 2009, when collective agreements started to include provisions related to flexibility and security. Novel issues include the regulation of performance pay, lifelong learning stipulations, non-discrimination and work-life balance. Despite this trend in the substantive bargaining agenda, sector-level collective regulation of flexibility and security remains distributive in character and increasingly shifts the governance of flexibility and security to the establishment-level.

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# 1. Economic and policy context

## 1.1 ORIGINS AND REFORMS

The healthcare sector, covering both public and private medical services (including services by spas and social care homes), is a relevant sector of the Slovak economy, frequently subject to governmental and societal debates especially since the early 2000s' reforms. Most healthcare services are publicly provided (see Table 4 *Public expenditure on health as a percentage of total expenditure on health*), but the recent trend also shows a growing number of private providers. Private providers specialize in selected medical services (especially one-day surgery, medical services outside the hospital subsector, and care homes for elderly). This selection is market driven and determined by the interplay of supply and demand, capital intensity and access to licences.

The Slovak healthcare sector faces two main challenges. First, there are constant pressures on the state to increase payments to health insurance companies for state-covered individuals (i.e. children, retired, unemployed, public employees). Amounts channelled to health insurance companies from the state are fixed and underwent only minor adjustments despite political debates before each elections and in each incumbent government. At the same time, employees of private firms contribute with a particular % of their salary, which causes a discrepancy in the amounts that health insurance companies receive from the state and from private sector employees. Nevertheless, the public medical service functions on the basis of solidarity and each patient receives the same kind of treatment regardless of his/her contributions. Social partners and professional associations pressure the government to increase contributions, which would channel more funds to healthcare and possibly help contributing to an improved healthcare service and more effective management.

The second major problem, identified especially by trade unions, is the discrimination in working conditions of healthcare personnel in two major type of public establishments. Healthcare reforms brought new roles for larger and better-equipped hospitals with a direct state ownership (providing also education for medical students, therefore faculty/university hospitals[1]); and for smaller public hospitals established by lower administrative units, i.e. regional governments. Large faculty/university hospitals have better access to finances in case of debt creation, while smaller hospitals and specialized public healthcare organizations underwent the process of corporatization in order to avoid their direct dependence on the state budget and debt accumulation. Such differentiation in access to public finances has the following consequences:

- discrepancy in wages of healthcare personnel in faculty/university hospitals and smaller healthcare providers (see Section 2),
- differences in the scope of wage bargaining in the two types of establishments, especially since the public healthcare occupations are no longer subordinated to pay scales in the public sector according to the Act 553/2003 – see below
- migration of nurses and care personnel to better paying employers and abroad,

[1] Prior to 2010, such hospitals were called Faculty hospitals because providing training as part of education to medical students. Since 2010, several large Faculty hospitals undergo transformation to University hospitals, which provide education both for doctors in training and students of other medical professions, i.e., nurses and care workers enrolled in university education.

- shortages of healthcare personnel in providers with larger budgetary constraints.[2]

The current situation in the sector has been significantly affected by a major healthcare reform, starting with the Dzurinda government in 1998. Reforms aimed at introducing market principles into the healthcare sector. First, the government paid the debt of all public healthcare institutions – both faculty hospitals and smaller hospitals – in order to give an equal starting point for each type of establishment on the reformed market. However, this healthcare reform failed to be fully accomplished due to a variety of political pressures and a change of the government from centre-right to social democratic in 2006. Major aspects of this reform are summarized below.

First, from 2003 patient fees were introduced to be paid in cash.[3] For individuals who could not afford these fees, state contributions were introduced. This reform step has brought approximately 1.5 billion SKK into the healthcare system. The number of visits at general practitioners decreased by 10%, at emergency hospital departments by 13%, at specialists by 2%. The number of hospital visits decreased by 2%. In a survey, 1.5% of respondents stated that they stopped going to the doctor, because of the fees (source: FOCUS survey agency). Total expenditures on medications also decreased.

Second, the Ministry introduced a substantive change in its medication policy. From november 2003 fixed surcharges for medications requiring prescription were introduced. In terms of setting financial priorities on medications, the Ministry of Health preferred to cover costly oncological/cardiological medicines to e.g. common antibiotics. In consequence, patients had to start contributing higher surcharges for commonly used medications, which produced some decline in consumption of medications.

Third, the state has bought out the accumulated debts of public hospitals health care establishments through a shareholder company established for this purpose *"Veritel', a.s."*. This step resulted into a decrease in healthcare sector debt by 33 billion SKK.

Fourth, health insurance companies and hospitals were transformed from state-owned facilities to non-profit companies or shareholder companies. This ensured transparency, introduced tough fiscal criteria, allowed for profit creation. Following a market principle, health care companies were expected to compete for patients and profits. Private health insurance companies entered the market and the competition for patients has sharpened. Many patients switched from public health insurance companies to private ones.

Fourth, from 2003 59 small and medium-sized hospitals were selected to be managed by lower public administrative units (i.e., cities or municipalities), while faculty hospitals and specialized medical institutes remained under direct state control. Emergency health care service underwent privatisation. Shortly before the 2006 elections, the reform government stopped the transformation and privatisation of hospitals. After 2010, corporatization of hospitals (transformation from state budgetary organizations onto shareholder companies) has been re-launched, aiming at an effective management under the same conditions that apply to other shareholder companies in the whole economy. This process has been stopped by significant militant action by the medical doctors' trade union targeting the government in late 2011.

Fifth, the Health Care Surveillance Authority, an independent body overlooking the activities of health insurance companies and health care providers, was established. The

[2] Source: Kahancová (2011).

[3] 20 SKK per medical visit and per pharmacy prescription; 50 SKK per person per one day of hospital stay; 2 SKK per kilometre for transportation with an ambulance; 20 SKK and later 60 SKK for medical emergency assistance and medical assistance at hospital emergency department

government also tried to formulate a clearer definition of solidarity in health services, however the findings were never put into practice due to political risks.

After the 2006 elections several further changes were introduced; some of which were counterproductive to the earlier reforms. Fees for medical visits were abolished and the fee for issuing pharmacy recipe was lowered from 20 SKK to 5 SKK. "Recommendation" letters from general practitioners for specialist treatments were introduced, which resulted in increase of visists at general practitioners and their shortage. Transformation of hospitals to shareholder companies or their privatization did not continue. The government prohibited profit creation of private health insurance companies The independence of the Health Care Surveillance Authority became limited. The accumulated debt in healthcare is increasing again (especially in faculty hospitals). There has been an increase in the share of public funding in the healthcare sector.

From 2008 there has been selective contracting between health insurance companies and health care providers. The government approved a minimum network of 34 health care providers – all of them are subordinated to the Ministry of Health. This resulted in discrimination of private health care providers. Since 2010, the preferential treatment of Faculty/University hospitals is less obvious and less supported by the government.

## 1.2 MAIN ACTORS IN THE HEALTCARE SECTOR

The Slovak healthcare sector consists of the following sets of main actors:

**Ministry of Healthcare** (*Ministerstvo zdravotníctva*) – the ministry's main role is strategic decision-making for the healthcare sector and the implementation of reforms, predominantly through legislative tools. The Ministry is also involved in so-called *small tripartism*, where strategic issues at the level of law making are negotiated with social partners from the healthcare sector.[4] This level of social dialogue does not involve collective bargaining over wages and working conditions and does not produce collective agreements. The Ministry does not have competences to directly finance or subsidize hospitals.

**Healthcare Surveillance Authority** (*Úrad pre dohľad nad zdravotnou starostlivosťou*) – one of the key function of this public institution is monitoring the financial behaviour of health insurance companies and the incoming/outgoing amounts for the provision of healthcare services. The Authority also investigates individual disputes over health care services. Politically, the Authority engages in debates over reforms and strategic changes in the healthcare sector and its financing. The Authority also has a normative function in the healthcare system.

**Faculty hospitals, university hospitals** (*Fakultné nemocnice, univerzitné nemocnice*) organized in the Association of Faculty Hospitals of the Slovak Republic (AFN SR) – providers of all hospital services, including specialized medical services for which these hospitals are well equipped. Given the earlier hierarchy of hospitals, which ceased to exist after recent reforms (see above), these hospitals continue to enjoy an important status and state support (i.e. through covering hospital debt or through receiving more funds from the health insurance companies for their services when compared to smaller hospitals). Faculty

[4] Sectoral tripartite dialogue (*small tripartism*) involves SOZZaSS, sectoral employer organisations (AFN SR, ANS, ASL SR, ASK), the Ministry of Healhtcare, secondary medical schools and independent polyclinics.

hospitals are shareholding companies with a 100% ownership of the state. The AFN SR is a major actor in industrial relations at the sector level (see section on IR).

**Smaller hospitals** – the majority of them organized in the Association of Hospitals of Slovakia (ANS) – cover public hospitals established by higher-level administrative units or other public shareholders including the state. Different organizational forms apply to the cluster 'smaller hospitals' (see organizational forms below). Although public, their status does not reach the status of Faculty hospitals and the state fosters their market behaviour without accumulating debt. In terms of specialized hierarchy, in the past these hospitals provided more basic services than Faculty hospitals. Today this distinction no longer applies, but smaller hospitals receive lower payments for the same kind of service when compared to the Faculty hospitals. The ANS is an important player in sector-level industrial relations (see section on IR).

**Professional associations** (i.e. *Slovak Chamber of Medical Doctors – SLK, Slovak Chamber of Dentists – SKZL, Slovak Chamber of Nurses and Midwives – SKSAPA, Slovak Association of Spas – ASK*) – these associations play an important lobby function and at the same time they are key actors in selected aspects of flexibility (mainly lifelong learning, professional requalifications and training, issuing certificates of goodstanding for the purpose of work-related migration). They do not bargain over wages and working conditions, but influence the functioning of the healthcare system by engaging in discussions over norms and standards for particular services and qualifications of healthcare employees.

**National Health Information Centre** (*Národné centrum zdravotníckych informácií*) – the role of the Centre is providing information and statistics on healthcare and health service, standardization of the information system on health service, collection, processing and providing of health-related statistical data and providing librarian services in medical sciences and health services. The Centre operates since 2006 after a merger of two organizations.

**Private health care providers** – operate in selected areas of health care upon licences from the Ministry (i.e. one-day surgery, medical services not requiring hospital treatment). Some of such providers are exclusively private, but the majority negotiated a contract with health insurance companies over a selection of medical services. Other services are covered by the patients. Although private providers are still marginal vis-à-vis the public healthcare sector, the growing demand for healthcare has stimulated the growth of private providers. They are especially demanded by private sector employees but also employers (in the fields where regular checks of employees are necessary for a particular job). A number of individual private physicians is organized in the Private Physicians' Association of the Slovak Republic (ASL SR), with 2,900 members in 2005.

**Health insurance companies** – the market share of public and private health insurance companies is balanced, with one major public (*Všeobecná zdravotná poisťovňa*) and two private insurance companies (*Dôvera, Union*). Patients have a free choice, but health care providers need to have a contract with a selected insurance company in order to treat its patients. Limits of payment for particular services as well as payments to physicians of first contact for maintaining patient databases are subject of negotiation between the insurance company and the service provider. The main problem of health insurance companies was the legal restriction of profit creation and use, approved by Act 581/2004

under the Fico government (2006-2010). Private health insurance companies argue that they are shareholder companies operating according to the law and they have entered the market under profit-making conditions. This case has been addressed in international arbitrary negotiations and investigated by the European Commission until the Constitutional court's decision on the need to change this stipulation and allow health insurance companies to generate/use their profits. The law has to be changed by August 2011. However, some regulation of profit-making will remain in place as health insurance companies handle public funds that each employee contributes through health care premia.

**- organizational forms of public health care providers**

Several organizational forms apply to healthcare providers in the hospital subsector and other specialized healthcare services. Distinction of organizational forms is of crucial importance for financing as well as for industrial relations in public healthcare (character of bargaining procedures, differences in collectively determined wage levels).

- **Faculty/university hospitals (FN):** directly established by and subordinated to the Ministry of Healthcare. These are large hospitals providing the whole range of medical assistance, for which they are compensated by higher contributions per service (possibly subject to revision by the incumbent government). Due to the broad scope of their service, they are also called *hospitals of final contact* where patients are sent from smaller hospitals. As of 30 June 2009, there were 12 Faculty hospitals in Slovakia, employing together 21,151 employees (Laufiková 2009).
- **Hospitals subordinated to higher administrative units (VÚC):** these are public hospitals in smaller cities/towns subordinated to higher regional administrative units and not directly to the Ministry. In 2009, 17 healthcare providers with this organizational form were active, including 13 regional hospitals and 4 health centres (policlinics), employing together 4,942 employees (ibid.).
- **Non-profit organizations providing services in public interest (NO)**: with 12,133 employees in 2009, 42 non-profit organizations were registered (ibid.). In terms of founders of NOs, several types of organizations belong to this cluster:
  - The Ministry of Healthcare directly founded 23 NOs, according to the Act No. 13/2002 (Transformation Act) regulating the transfer of state ownership onto other actors. Following Act No. 416/2001 (transfer of selected governance aspects from the state onto higher and lower administrative units), the Ministry's founding rights were transferred and these NOs are now subordinated to higher administrative units and to municipalities, while keeping ther status as non-profit organizations providing services in public interest.
  - Higher administrative units directly established 19 NOs
- **Shareholder companies:** the Ministry owns 100% of shares in 6 shareholder companies established in 2006. These are specialized health care institutes, including the National Centre for Cardiovascular Diseases and institutes with a similar degree of specializtion, but also 2 hospitals. Next, there are 7 regional hospitals, established directly by Higher administrative units, which then changed their organizational form into a shareholder company.
- **Limited companies:** applies to 5 hospitals in smaller towns, together employing only 831 employees (Laufiková 2009).

The number of employees according to hospitals' organizational form is listed in Table 1.1. Whereas the number of employees of faculty/university hospitals may correspond to

employees covered by the AFN SR, employees in other establishment types do not necessarily correspond to employees covered by ANS. This is because not all hospitals/establishments in Slovakia are organized in a sectoral employer organization.

**Table 1.1 Employees according to healthcare provider type - hospitals (2009)**

| | FN | VÚC | N.O. | Shareholder | Limited |
|---|---|---|---|---|---|
| Number of employees | 21,151 | 4,942 | 12,133 | 7,325 | 831 |

Source: Laufiková (2009)

Notes:

FN – faculty/university hospitals

VÚC – public hospitals founded by regional self-governments

NO – hospitals and providers operating as non-profit organizations in public interest

Shareholder – hospitals and providers operating as shareholder companies with a 100% state ownership

Limited – hospitals and providers operating as Ltd. companies

## 1.3 HEALTH EXPENDITURE AND THE FINANCING OF HEALTHCARE

The only channel of government/state contributions to the healthcare system is through direct premia for health insurance for part of population (*state-insured persons*), including children, students, parents on maternity/parental leave, retired, unemployed, public servants and employees of public organizations (i.e. the Academy of Sciences), military employees and similar groups. The amount of state contributions is not regulated and is subject to political pressures and budgetary constraints. Paradoxically, these groups contribute less to the heatlh insurance budget but receive the largest portion of healthcare services (especially elderly and children), which creates a discrepancy between contributions originating in the private sector and the amount of healthcare services provided to the state-insured persons. At the same time, health insurance companies cover the health services to service providers without discriminating between state-insured persons and those employed in the private sector.

Other than through health insurance contributions, the state does not directly subsidize hospitals or other healthcare providers in covering their costs (i.e. facility or medical equipment). An exception relates to the debt of faculty/university hospitals, which are covered according to particular agreements between each hospital and the state. The government formally exerts pressure on faculty/university hospitals towards effective financial management without debt, but according to some key informants from the sector, in reality there is no pressure.

Tables 1.2 – 1.6 below provide more details on the source of finances in the healthcare sector and an international comparison of healthcare expenditures. In comparison with other EU members, Slovakia's expenditures on the healthcare sector remain the lowest (together with the other Visegrad countries). The share of private sources has grown from 2000 till 2007, but the ratio of public and private sources is comparable to other EU countries (source: OECD statistics).

**Table 1.2 Structure of disposable financial resources (in bil. Slovak Koruna)**

| Indicator | 2007 * | 2008* | Difference 2008-2007 | % |
|---|---|---|---|---|
| **A. Sources of public health care insurance together – paid premiums** | 88,3 | 102,5 | 14,2 | 16,1 |
| **By state**[1] | 26,9 | 29,8 | 2,9 | 10,8 |
| **B. Other public sources**[2] | 4,3 | 5,1 | 0,8 | 18,6 |
| **C. Public sources together (A+B)** | 92,6 | 107,6 | 15 | 16,2 |
| **D. Private sources**[3] | 28 | 30,2 | 2,2 | 7,9 |
| **E. Sources together (C+D)** | 120,6 | 137,8 | 17,2 | 14,3 |
| **Share of real sources of financing on GDP** | 6,5 | 6,8 | 0,3 | |

[1] State as in legally defined cases (§11 section. 1 letter. d) of Act No. 580/2004
[2] Payments from Ministry of Internal Affairs (MV SR), Ministry of Transport, Mail and Telecomminications (MDPT SR), Ministry of Defense (MO SR), Ministry of Healthcare (MZ SR), excluding premiums paid by the state and contribution to health insurance companies for state-insured individuals
[3] Population's expenditure on goods and services not covered by public sources (calculation based on development in past years and based on statistical data).
* Data sources of Ministry of Finance (MF SR).
Source: Health Care Surveillance Authority of the Slovak Republic, Vestník 3/2009, pp. 10.

**Table 1.3 International comparison of expenditure on health**

| Country | 1990 | | 2000 | | 2007 | |
|---|---|---|---|---|---|---|
| | **Total expenditure on health as % of GDP** | **Public share of total expenditure on health** | **Total expenditure on health as % of GDP** | **Public share of total expenditure on health** | **Total expenditure on health as % of GDP** | **Public share of total expenditure on health** |
| Denmark | 8,3 | 82,7 | 8,3 | 82,4 | 9,8 | 84,5 |
| France | 8,4 | 76,6 | 10,1 | 79,4 | 11,0 | 79 |
| Germany | 8,3 | 76,2 | 10,3 | 79,7 | 10,4 | 76,9 |
| Hungary | 7,0 | 89,1 | 6,9 | 70,7 | 7,4 | 70,6 |
| Italy | 7,7 | 79,5 | 8,1 | 72,5 | 9* | 76,5 |
| Netherlands | 8,0 | 67,1 | 8,0 | 63,1 | 9,8 | 62,5 |
| Poland | 4,8 | 91,7 | 5,5 | 70 | 7,7 | 66,8 |
| **Slovakia** | **-** | **-** | **5,5** | **89,4** | **7,7** | **66,8** |
| United Kingdom | 5,9 | 83,6 | 7,0 | 79,3 | 8,4 | 81,7 |

*Source*: OECD Statistics 2009; * 2008

**Table 1.4 Total expenditure on health as percentage of GDP**

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|---|
| **Denmark** | 8,6 | 8,8 | 9,3(b) | 9,5 | 9,5 | 9,6 | 9,8 | .. |
| **France** | 10,2 | 10,5 | 10,9 | 11,0 | 11,1 | 11,0 | 11,0 | .. |
| **Hungary** | 7,2 | 7,6 | 8,3(b) | 8,0 | 8,3 | 8,1 | 7,4 | .. |
| **Italy** | 8,2 | 8,3 | 8,3 | 8,7 | 8,9 | 9,0 | 8,7 | 9,0 |
| **Netherlands** | 8,3 | 8,9 | 9,8(b,e) | 10,0(e) | 9,8(e) | 9,7(e) | 9,8(e) | .. |
| **Slovak Republic** | **5,5** | **5,6** | **5,8** | **7,2(b)** | **7,0** | **7,3** | **7,7** | **..** |
| **United Kingdom** | 7,3 | 7,6 | 7,8 | 8,1 | 8,2 | 8,5 | 8,4 | .. |

b – break in series
e – estimate
Source: OECD health data 2009 – selected data: OECD Health Statistics (database); last updated 12 November 2009

**Table 1.5 Public expenditure on health as a percentage of total expenditure on health**

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|---|
| **Denmark** | 82,7 | 82,9 | 83,9(b) | 83,8 | 83,7 | 84,1 | 84,5 | .. |
| **France** | 79,4 | 79,7 | 79,4 | 79,3 | 79,3 | 79,1 | 79,0 | .. |
| **Hungary** | 69,0 | 70,2 | 72,8(b) | 72,4 | 72,3 | 72,6 | 70,6 | .. |
| **Italy** | 74,6 | 74,5 | 74,5 | 76,0 | 76,2 | 76,8 | 76,5 | 77,4 |
| **Netherlands** | 62,8 | 62,5 | .. | .. | .. | .. | .. | .. |
| **Slovak Republic** | **89,3** | **89,1** | **88,3** | **73,8(b)** | **74,4** | **68,3** | **66,8** | **..** |
| **United Kingdom** | 80,0 | 79,9 | 80,1 | 81,6 | 81,9 | 82,0 | 81,7 | .. |

b – break in series
e – estimate
Source: OECD health data 2009 – selected data: OECD Health Statistics (database); last updated 12 November 2009

**Table 1.6 Total expenditure on health per capita at current prices and PPPs (in EUR)**

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|
| **Denmark** | 2378 | 2521 | 2696 | 2832(b) | 3055 | 3152 | 3357 | 3512 |
| **France** | 2542 | 2718 | 2922 | 2985 | 3115 | 3303 | 3423 | 3601 |
| **Hungary** | 852 | 970 | 1114 | 1248(b) | 1305 | 1411 | 1457 | 1388 |
| **Italy** | 2052 | 2214 | 2223 | 2271 | 2399 | 2536 | 2673 | 2686 |
| **Netherlands** | 2337 | 2555 | 2833 | 3099(b,e) | 3310(e) | 3450(e) | 3611(e) | 3837(e) |
| **Slovak Republic** | **603** | **665** | **730** | **792** | **1058(b)** | **1139** | **1322** | **1555** |
| **United Kingdom** | 1833 | 2003 | 2190 | 2324 | 2557 | 2693 | 2885 | 2992 |

b – break in series
e – estimate
Source: OECD health data 2009 – selected data: OECD Health Statistics (database); last updated 12 November 2009

## 1.4 MARKETS AND POLICY IN HEALTHCARE

The scope of the health sector market is national and relatively homogenous across regions. Each region has a centrally defined quota on the number of physicians and healthcare organizations (i.e. hospitals) and the scope of services provided (according to the population size). These quota are defined by the Ministry. Health insurance companies revise these quota at least every 6 months and align it with population changes. Next, each healthcare provider has a negotiated limit for services (a so-called point system, in which a particular number of points for a particular service and a price per point is centrally defined).

An interesting phenomenon is the domestic labour migration, especially from the Eastern part of the country to the Western part, which causes an over-demand for healthcare services in the West and temporary discrepancies between allotted number of doctors and allotted amounts for healthcare services (there are upper limits set for each medical specialization in each region) and the demand for services.

In the second half of 2000s, the following issue was highly debated and produced dissatisfaction of physicians and hospitals. Each healthcare provider has a centrally set upper limit of points per month in the point system, for which these providers were entitled to provide health services. Often these limits were fulfilled during shorter time periods than a calendar month; and the remaining health service has been provided without coverage from the insurance companies, thus raising costs for healthcare providers. For smaller providers, this tendency could lead to bankruptcy if taking place over a longer period of time.

- **internationalisation and migration in the healthcare sector – mobility of goods / capital / labour / services**

Healthcare sector migration constitutes a serious issue in Slovakia, triggering labour shortages in public hospitals (especially in smaller public hospitals) and healthcare provider organizations, as the inflow of third-country qualified professionals is limited and not replacing the emigrants. The scale of healthcare migration is estimated according to the number of issued certificates of good standing, which almost all certified doctors, nurses, and midwives collect from their professional associations prior to their migration abroad. [5] Such certificates declare the professional qualification of the migrant and his/her ability to serve as a healthcare professional abroad. The Slovak Ministry of Healthcare reported a departure of 1700 qualified physicians between 2004 and early 2008.[6] This number roughly corresponds to about 3,5% of overall healthcare personnel in the country (Kaminska and Kahancová 2011).

According to the number of issued certificates of goodstanding for practicing medical doctors aiming at work-related migration abroad, Tables 1.7 – 1.9 below show that the age structure of medical doctors has remained stable between 2006 and 2010, with above 50%

[5] The number of issued certificates as an indication of migration has to be interpreted carefully for the following reasons: the issued certificate is valid for 3 months, therefore the same person can request a certificate of goodstanding several times during a calendar year. The next reason is that once a migrating medical doctor working abroad joins a chamber in his/her country of work and terminates his/her membership in the Slovak chamber, the chamber no longer keeps the records of these specialists (including the number of issued certificates of goodstanding). Source: interviews with SLK president, June 2008 and 11 May 2010; SKSAPA president, 12 May 2010.

[6] Source: Interview SOZZaSS president, 16 June 2008.

of migrants belonging to the group of 30-40 years of age. The character of migrants according to their medical specialization shows that the top specializations sending most migrants include internal medicine (although a steep decline has been recorded since 2008), surgery and anaesthesiology/intensive care. An attractive destination for migrating doctors is the Czech Republic due to the similarity of culture, language and special bilateral country arrangements facilitating labour market mobility between the two countries. At the same time, the number of issued certificates also shows that migration – if indicated by the number of issued certificates - has been declining since 2008, roughly since the economic crisis.

**Table 1.7 Certificates of good standing issued by the Slovak Chamber of Medical Doctors (SLK)**

| **Year** | **Number of issued certificates in total** |
|---|---|
| 2006 | 275 |
| 2007 | 243 |
| 2008** | 143 |
| 2009** | 119 |
| 2010 (between January 1 and May 7 2010)** | 50 |

*Source: SLK (2008), international seminar Migration of labour in the health care sector – the view of the Slovak Chamber of Medical Doctors (June 2008).
** Source: internal statistics SLK (2010).

**Table 1.8 Certificates of good standing according to medical specialization, issued by the Slovak Chamber of Medical Doctors (SLK)***

| **Medical specialization** | **2006** | **2007** | **2008 – 2010 ** (January 1 2008 – May 7 2010)** |
|---|---|---|---|
| Internal specialists | 219 (79,6%) | 161 (66,3%) | 30 (9,6%) |
| Surgeons | 40 (14,5%) | 15 (6,2%) | 34 (10,9%) |
| Anaesthesiologists/ intensive care specialists | 24 (8,7%) | 13 (5,3%) | 19 (6,1%) |

* Source: SLK (2008), international seminar Migration of labour in the health care sector – the view of the Slovak Chamber of Medical Doctors (June 2008).
** Source: internal statistics SLK (2010).

**Table 1.9 Certificates of good standing by age of applicants, issued by the Slovak Chamber of Medical Doctors (SLK)**

| **Age structure of applicants** | **Number of issued certificates** |
|---|---|
| **2006 – 2008*** | |
| Up to 30 | 133 (30,3%) |
| 30 – 40 | 228 (52,4%) |
| Above 40 | 76 (17,3%) |
| **2008 – 2010**** | |
| 20 - 30 | 57 (20%) |
| 31 - 40 | 147 (51,8%) |
| 41 - 50 | 55 (19,4%) |
| 51 - 62 | 25 (8,8%) |

*Source: SLK (2008), international seminar Migration of labour in the health care sector – the view of the Slovak Chamber of Medical Doctors (June 2008).
** Source: internal statistics SLK (2010).

Whereas certificates of goodstanding for doctors are a fair indicator of migration, evaluating the migration of nurses according to issued certificates is less reliable. The Slovak Chamber of Nurses and Midwives (SKSAPA) issues about 55-60 certificates annually, whereas the estimated migration of nurses is much higher. The reason for discrepancy is that nurses tend to migrate also to countries where no certificates are required or necessary for employment (i.e., the Czech Republic, Canada, the USA). The number of issued certificates remained stable over the past 5 years.[7]

- **intensity of market competition between public and private providers, including recent entrants and impact on European producers**

Recent years brought an increase in private health care providers offering above-standard services. Some of these have signed contracts with health insurance companies, others operate purely on a market basis and patients pay for their services. The standard model is a so called club model, where patients pay an annual fee, receive a standard package of health services without extra payment (these are covered by the health insurance company if the provider signed a contract with the particular insurance company) and pay cash for other services (i.e. a fee for no-waiting, or fees for specialized services not covered by the standard health insurance package). Private providers are more motivated to gain customers and therefore more innovative in their systematic management. However, the establishment of private providers follows a principle of "cherry-picking": private health care is limited to particular medical subsectors with highest profit opportunities (i.e., dental medicine, gynaecology, ophthalmology). Subsectors like internal medicine or otorynolaryngology are not attractive due to low limits on points that the provider receives from heatlh insurance companies. State-owned hospitals are obliged to provide all kinds of medical services, including the less attractive and less profitable ones.

Medical tourism to neighbouring countries is not common in Slovakia. In most neighbouring countries where healthcare services are expected to yield higher quality (i.e., Austria or the Czech Republic), costs are higher and the Slovak health insurance company would not cover these costs. There might be some very special cases when patients have their treatments done abroad with the consent of their insurance company – most likely in the Czech Republic. The reason for this can be found in the history of Czechoslovakia where some specialized health care providers were only present in the Czech Republic and others only in Slovakia. This has caused a lack of such providers in national settings after Czechoslovakia's split in 1993.

- **trends in demand**

Within the healthcare reform, a small fee of 20 Slovak Koruna (approx. 66 Eurocent) has been introduced for each medical visit and each pharmacy prescription. The aim was to limit the number of patients with marginal health problems through self-selection (especially elderly people). The fee abolition in 2006 again increased the motivation of

[7] Source: interview with the president of SKSAPA, May 12, 2010.

population to seek medical assistance. General practitioners often send patients for further examinations to specialists, which might not be necessary in all cases. Although no research exists on the reasons of such behaviour of population, it is believed that it is culturally determined; patients are dissatisfied without a thorough medical intervention in (almost) all heatlh issues, including minor illnesses. At the same time, there is shortage of doctors due to migration (see above) and a particular shortage in some medical occupations; thus this situation produces waiting lists and full waiting rooms at doctors' practices.

In the area of care homes services, there is an increase in demand for social service facilities due to population aging. There has been an increase in the number of private providers, however there is great differentiation between them. Although a supply-demand issue, demand is high and the quality of service does not always match the price of the service. Alternatively, some private providers offer the same services as state providers, but customers pay for private services and have to offer various "sponsorship contributions", because of a shortage of beds for elderly/ill/disabled. The third category of care homes consists of those owned/operated by Churches. These were subsidised by the state, but due to crisis-related restrictions subsidies declined. It remains to be seen to what extent can the extra costs be transferred onto the clients (and their families). A further problem relates to wages and working conditions in care homes. In this respect, Slovak care homes as employers face a strong competition from Austria (and partially also Germany) where qualified Slovak social care/service staff migrated for better income. Before July 1 2009 they were working mostly illegally as Austria still required work permits from the new EU Member states. However, given the high demand for such services in Austria and the domestic shortage of care workers, the Austrian state allowed social care/services workers from Slovakia to work as self-employed people from July 2009.

- **predictability of demand (i.e. degree of turbulence)**

Demand for health care services is relative stable and predictable in the current regulatory settings. The future expectation is that a a multi-tiered health insurance and health provision system will be introduced, with a basic coverage and above-standard services. The market is more responsive to the societal needs in this respect, whereas the response of the legislative process is delayed. Currently there is a lack of institutional and legislative conditions to foster such a multi-tiered system.

- **changes to products and processes**

Reforms of early 2000s aimed at greater effectiveness in behaviour of healthcare providers through introducing a market mechanism into the sector and placing all players at the same starting line (the state took over debts, see above). However, after the 2006 elections, the social-democratic government did not continue with earlier reforms and adopted some strategic steps, which together with the previous reform attempts shaped the current mixed system. Their measures included a hidden preferential treatment of public health care providers and their possibility to accommodate debt (although discriminating between faculty/university hospitals and smaller hospitals, see above) and legally prohibited the profit-making of health insurance companies (subject to a court arbitrage). The current government (since 2010) no longer exerts pressure on the public health insurance company to treat Faculty/University hospitals preferentially.

## 1.5 WORKFORCE COMPOSITION AND CHANGES

According to OECD and national statistics (see Tables 1.10 – 1.15 below), the density of practicing physicians per 1000 inhabitants in Slovakia has been slightly decreasing between 2000 and 2006. Initially the density has been comparable to some Western European member states.

Full-time employment positions of medical doctors and dentists have been increasing in all kinds of healthcare provider organizations.

**Table 1.10 Practising physicians (doctors), density per 1000 inhabitants**

| | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** |
|---|---|---|---|---|---|---|---|---|
| Denmark | 2,70 | 2,73 | 2,83 | 2,86 | 2,99 | 3,09 | 3,17 | .. |
| France | 3,32 | 3,34 | 3,36 | 3,38 | 3,39 | 3,40 | 3,39 | 3,37 |
| Hungary | 3,13(e) | 3,16(e) | 3,19 | 3,25 | 3,34 | 2,78(b) | 3,04 | 2,78(b) |
| Italy | 4,14 | 4,34 | 4,40 | 4,12 | 4,19 | 3,82 | 3,69 | 3,65 |
| Netherlands | 3,19(d) | 3,28(d) | 3,38(d) | 3,48(d) | 3,60(d) | 3,71(d) | 3,82(d) | 3,93(d) |
| **Slovak Republic** | **3,14** | **3,14** | **3,11** | **3,06** | **3,06** | **..** | **..** | **..** |
| United Kingdom | 1,94 | 1,99 | 2,07 | 2,16 | 2,30 | 2,38 | 2,44 | 2,48 |

Source: OECD health data 2009 – selected data: OECD Health Statistics (database), last updated 12 November 2009
b – break in series
d – differences in methodology
c – estimate

**Table 1.11 Workforce according to economic activity and gender in thousands, Slovakia only**

| | 2008 | 2009 |
|---|---|---|
| **Men and women together** | | |
| Professional, scientific and technical activities | 76,5 | 82,0 |
| Health case and social assistance | 151,2 | 149,8 |
| **Men** | | |
| Professional, scientific and technical activities | 31,5 | 35,7 |
| Healthcare and social assistance | 27,1 | 24,4 |
| **Women** | | |
| Professional, scientific and technical activities | 45,0 | 46,3 |
| Healthcare and social assistance | 124,1 | 125,4 |

Source: Slovstat

**Table 1.12 Registered employment positions of doctors and dentists, full time equivalents**

| **Work positions in health care facilities** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|
| General practices | 2872,99 | 2962,25 | 3291,67 | 3093,75 |
| Specialised practices | 5067,48 | 5423,29 | 6595,70 | 5890,82 |
| General hospitals | 6533,06 | 6378,71 | 7012,65 | 6749,15 |
| Specialised hospitals | 980,74 | 972,29 | 1089,17 | 1071,90 |
| Therapeutic facilities | 50,34 | 106,42 | 103,62 | 78,84 |
| Natural therapeutic spa facilities | 145,43 | 215,17 | 120,58 | 132,84 |

Source: Slovstat

Slovakia also faces a shortage of nurses, especially in smaller hospitals where wages and working conditions are less favourable than in the Faculty hospitals. This shortage has been more profound in 2005-2010 and is declining since 2010.[8] The strong shortage in the past yeas has not only been caused by migration, but by the a stipulation requiring nurses to obtain university education. For a few years after this stipulation, not enough nurses entered the labour market because continuing in their studies. Since the first groups of university graduates entered the labour market, the shortage of nurses is slightly declining. The age structure of nurses and midwives in 2005 also points to a shortage of young midwives, as most midwives are above 40 and the total number of qualified midwives is low.

**Table 1.13 Number of nurses and midwives in public facilities, according to age in 2005 , Slovakia only**

| | Year 2005 | Percentage |
|---|---|---|
| **Total number of nurses** | 20,521 | |
| Below the age of 40 | 11,237 | 54,2% |
| Above the age of 40 | 9,284 | 45,8% |
| **Total number of midwives** | 1,098 | |
| Below the age of 40 | 211 | 19,2% |
| Above the age of 40 | 887 | 80,8% |

Source: Slovak Chamber of Nurses and Midwives (SKSAPA), Lévyová (2008).

**Table 1.14 Number of nurses and midwives in private facilities, according to age in 2005, Slovakia only**

| | Year 2005 | Percentage |
|---|---|---|
| **Total number of nurses** | 13,486 | |
| Below the age of 40 | 5,937 | 44% |
| Above the age of 40 | 7,549 | 56% |
| **Total number of midwives** | 641 | |
| Below the age of 40 | 217 | 33,8% |
| Above the age of 40 | 424 | 66,2% |

Source: Slovak Chamber of Nurses and Midwives (SKSAPA), Lévyová (2008).

**Table 1.15 Number of school leavers - nurses and midwives per 1000 inhabitants**

| Country | Number of graduates |
|---|---|
| **Other EU states** | **31** |
| **Slovak Republic** | **4** |

Source: Slovak Chamber of Nurses and Midwives (SKSAPA), Lévyová (2008).

## 1.6 CHANGES IN REGULATORY FRAMEWORK AND PUBLIC POLICIES

- **changes in regulatory framework and sector-specific public policies**

The major changes in the regulatory framework directly affecting healthcare derive from the substantive healthcare reform of the Dzurinda government prior to 2006. Remuneration and working conditions in healthcare have followed Act No. 312/2001 on Civil Service and Act No. 313/2001 on Public Service. In 2003, Act No. 553/2003 on the remuneration of selected public service employees has been introduced. These Acts and their relevance for bargaining and wage setting in healthcare are briefly discussed below.

First, **Act 312/2001 on Civil Service** covers selected administrative employees in the healthcare sector (e.g., employed by institutions overlooking the operation of healthcare facilities) and is therefore not overtly important for the project's purposes.

[8] Source: interview ANS president, 8 July 2010.

Second, **Act 313/2001 on Public Service** (incl. education and healthcare) seeked to address the growing differences in employment conditions between the public and private sectors by improving pay and working conditions in the public sector, including education and healthcare. One effect of this legislation was to allow for the first time for collective bargaining over employment conditions at sectoral level for about 400,000 public service employees – 19% of all employees in Slovakia in 2002.[9] This coverage has declined after 2005 when remuneration principles in public healthcare ceased to follow the pay scales applicable to the public sector (see below). Selected issues from the Act on Public Service relevant for collective bargaining include the introduction of two kinds of collective agreements:

- *collective agreements* (=sectoral CAs) concluded between higher-level social partners (sectoral/national unions; and employers explicitly listed in the law and their state-appointed representatives[10]). The substantive agenda of collective agreemens is limited to provisions on working time, holidays, changes in tariff scales (set for public sector by this law), changes in redundancy payments, changes in employer contributions towards employee pensions and contributions towards the establishment's social fund. The government includes employment conditions specified in the sectoral collective agreements for public services (mainly pay increase provisions) in the draft state budget law for the relevant year. Sectoral collective agreements enter into force at the same time as the state budget law takes effect.

- *collective contracts* (=establishment-level CAs) concluded between employers and respective trade union(s) at a specific establishment. At the level of individual public service organisations, it is possible to negotiate better employment conditions than those laid down in sectoral agreements. These collective agreements may regulate remuneration matters and other aspects of the employment relationship, but only to the extent allowed by the Act on Public Service and the sectoral collective agreement. Collective contracts can adjust pay conditions and other conditions, but cannot exceed the scope of the law.

Employee representation in public service, including public healthcare, is – as in civil service – through trade unions or, in their absence, elected personnel councils or shop stewards whose competences are wider than in civil service.

In 2003, **Act 553/2003 on Remuneration of Selected Employees in Public Service** further specified the remuneration conditions in public service areas, including healthcare and education. It defines employers which qualify for being considered as employers who provide work in public interest. The Act also determines qualification criteria for

[9] Source: EIRO articles on Slovakia (2002), in http://www.eurofound.europa.eu/eiro/2002/country/slovakia.htm.

[10] Employers listed in the law include: state administration bodies (except those falling within the civil service) and other organisations relying on the state budget or contributions, the municipalities, state funding bodies, schools and educational institutions (except private schools), other employers stipulated by specific regulations, and a number of stipulated public institutions: the Social Insurance Agency (Sociálna poistovna); the National Labour Office (Národný úrad práce); the General Health Insurance Company (Všeobecná zdravotná poisťovňa); and the Common Health Insurance Company (Spoločná zdravotná poisťovňa). The two latter health insurance companies have merged as of January 1, 2010.

employees working in public interest and specifies the renumeration criteria including salary classes and salary categories, stipulating which employees qualify for which salary class/category. The Act defines the basic tariff salary and all its possible additions, including bonuses. The tariff salary is based on a 14-level scale of salary classes; different tariffs for different types of public services (such as education and healthcare). Employees are placed in a salary class according to the most demanding activity they perform and their qualifications, as laid down in relevant catalogues of working activities issued by means of government decrees. Employers place public service employees in the relevant salary category (12 levels in total), according to the length of their experience. Employees performing some specific duties (such as employees with a university education who perform demanding scientific and research activities in EU projects) can receive an individual salary instead of a tariff salary. Trade unions criticized the fact that although tariff scales for other public areas (i.e., education) increased, scales applicable for healthcare remained on their 2001 levels because of high debts of hospitals and lack of resources of health insurance companies. Unions often highlighted this problem; however, their efforts (including a strike emergency situation in 2005) lead to an exclusion of healthcare workers from tariff remuneration in public service given a revised definition of 'work in public interest'.[11] Since 2005, remuneration of healthcare employees no longer follows the tariff scales of Act No. 553/2003, but the Labour Code. Trade unions see this as a major problem, whereas employers agree with the current decentralized system of sectoral and establishment level bargaining according to the Labour Code. Selected healthcare institutions (i.e. some hospitals) continue to benchmark their salaries and wage bargaining to salary scales of Act 553/2003. Public care homes still fall under regulation by Act 553/2003. However, the standard practice in healthcare is remuneration based on independent sector-level and establishment-level bargaining and wage setting.

- **changes in general regulatory framework relevant for employment conditions and industrial relations**

Besides the particular regulatory changes described above, the general regulatory framework, not exclusive to public sector, serves as the main point of reference for employment conditions and industrial relations in the healthcare sector. This section provides a brief overview of post-2001 legal developments with significant impact on flexibility/security issues, role of industrial relations actors and collective bargaining. The overview below draws on EIRO reports and the respective legal documents. The Constitution of the Slovak Republic - section 5 on economic, social and cultural rights; and within this section Article 36, letter g) guarantees the right for collective bargaining. Other major legal documents stipulating provisions on collective bargaining include the **Act on Collective Bargaining (Act 2/1991),** with 12 amendments between 1991 and 2010. This Act defines and stipulates the scope of collective agreements and defines who can negotiate and conclude a collective agreement on behalf of a contractual party. It further determines validity and terms of collective agreements. Next, the Act specifies procedures in case of collective dispute and defines proceedings in case of an

[11] According to interviewed union representatives, one of the reasons why healthcare no longer falls under remuneration in public services relate to competition between public sub-sectors, namely healthcare and education. Social partners in education did not want to channel the limited public resources to wages in healthcare but into their own subsector. Source: interview SOZZaSS deputy director, 14 April 2010 and 11 May 2010.

Intermediary/Mediator involvement. The last amendment of December 2010 has addressed the extension of sectoral collective agreements and has specified in greater detail the conditions of such extension. Earlier amendments of Act No. 2/1991 did recognize extension, but failed to specify the exact mechanism. The last amendment stipulates that extension is only possible upon a written request signed both by trade unions and the concerned employer. In other words, sectoral agreements cannot be extended without prior consent of the concerned employer.[12]

The most important legal document governing the employment relationship is **Act 311/2001 - the Labour Code**, followed by 8 amendments between 2002-2010.[13] The Labour Code regulates employment conditions of about 1,5 milions of employees in the private sector (and employees in public healthcare), setting ffreedom, democracy and contract-based labour relations for its main principles. The new Labour Code of 2011 abolished previous limits to the scope of collective bargaining: employers and trade union representatives in the business sector can now bargain on any issues of common interest. Labour Code stipulations, relevant for flexibility/security and for industrial relations include the following:[14]

- *employment relationship*: to be established only in the form of a written employment contract; the introduction of the term "domestic employee" to refer to household work; procedures applicable in the case of collective redundancies
- *wages*: main principle for remuneration is that remuneration conditions exclusively follow the contractual principle. In the event that no conditions for remuneration of employees have been agreed upon in the relevant collective agreement, the Labour Code establishes an obligation for the employer to lay down such conditions in the employment contract. The law defines: wages; minimum wages; wages for overtime work; wage compensation for public holidays; and pay premia for night work and for work in a more demanding and harmful environment etc. It also specifies terms and methods for payment of wages, and wage deductions (e.g., income and payroll taxes).
- *working time*: maximum weekly working time is set at 40 hours. Until March 31, 2002, the maximum weekly working time was 42.5 hours. The reduction of 2.5 hours does not mean actual reductions in net working time because the current 40-hours does not include paid breaks for refreshments or meals. Prior to 2002, paid breaks were included in the stipulated maximum weekly working time. According to the Labour Code after 2002, weekly working hours including overtime should not exceed 58 hours, and annual overtime should not exceed 150 hours.
- *agreements for work performed outside a regular employment relationship*: forms of precarious work not considered standard employment relationship, i.e., assignment contracts, temporary contracts for students, and dependent self-employment. In the former two forms, no social security contributions/entitlements apply. In the latter, the employee can subscribe to voluntary social security contributions and upon fulfilling eligibility criteria claim social security/sickness entitlements. These workers do not have a legally stipulated right for paid holidays. These forms of employment are very

[12] Source: http://www.echoz.sk/index.php?option=com_content&view=article&id=95:novelu-zakona-o-kolektivnom-vyjed-navani&catid=49:novely-pracovnopravnych-a-socialnych-zakonov&Itemid=20 [accessed April 7, 2011].
[13] Source: http://hnonline.sk/c1-51364280-novelizacie-zakonnika-prace-od-roku-2001 [accessed March 29, 2011].
[14] See EIRO reports at http://www.eurofound.europa.eu/eiro/2003/01/feature/sk0301102f.htm and http://www.eurofound.europa.eu/eiro/2002/07/feature/sk0207102f.htm [accessed on April 12, 2010].

common to avoid social security contributions applicable in case of a standard employment relationship.

- introducing *home work and telework* (§52): including provisions of non-discrimination of employees working from home or engaged in telework (with employer-provided technologies).
- *labour relations*: a new employee representation structure for the first time in over 15 years. Employees are entitled to collective bargaining, co-decision making and negotiations. They also have a right to information and to monitor activities. In business organisations if no trade unions in workplaces with at least 20 employees, works councils are to be elected. Councils have rights to negotiation, information and monitoring vis-à-vis the employer. In workplaces with 5-20 employees shop stewards are to be elected. Similarly, 'personnel councils' are to be elected in public organisations. The election period of both councils is four years. Moreover, the new Code strengthens the role of unions in determining employment conditions. This provision has caused employer protests and renewed consultations between the government and social partners (EIRO 2002).

Already in late 2002, employers voiced that the adopted Labour Code is not flexible enough to reflect current labour market developments and called for further amendments, arguing that 'at present, [….] it creates obstacles to employers employing more people and to employees working more and thus improving their income'.[15] Similar claims have led to tripartite negotiations and further amendments to the Labour Code between 2002 and 2010. The goal of all Labour Code amendments in Slovakia remained the same – to achieve a higher level of flexibility in employment relations by reducing the extent of regulation and improving the conditions for autonomous collective bargaining. Areas affected by amendments include works council and trade union rights, termination of employment, overtime, paid leave, working time and fixed-term contracts. Labour Code amendments since 2001 also take into consideration requirements of relevant EU Directives, comments from the International Labour Organisation on the previous Labour Code, and issues arising from its implementation. The amended Labour Code stipulates only the basic framework, with actual working and employment conditions to be adjusted at enterprise level, taking into account regional and sectoral circumstances and the employer's situation. The new amendments also eliminate the administrative intervention in labour relations of a number of institutions, thus simplifying Labour Code implementation.[16]

After the government change following parliamentary elections in 2010, further changes to the Labour Code are expected.[17] These follow a single aim – further flexibilization of the Slovak labour market in order to combat high unemployment after the economic crisis. The aim is to give more room to non-standard employment and to liberalize hiring and firing regulation. These changes should result in a new Labour Code currently discussed in the parliament and tripartite council. Upon approval, the effected enforcement date is

[15] Source: EIRO article ID SK0303101N.
[16] Source: http://www.eurofound.europa.eu/eiro/2003/12/feature/sk0312103f.htm [accessed April 22, 2010].
[17] A minor amendment, effective from April 2011, aligns the Slovak regulation with European directives (e.g., on gender equality).

September 2011 or January 2012. Selected issues in ongoing debates relevant for the flexibility and security debate are summarized below:[18]

- *Shared employment*: the new Labour Code introduces the institution of shared employment that shall yield a better work-life balance for employees with children. Shared employment is defined as a job position where concerned employees decide the distribution of working time and work content for the particular job without tertiary intervention.
- *Lenght of notice upon employment contract termination vs. redundancy pay* – employers welcome the new regulation stipulating either redundancy pay or a length of notice period upon employment contract termination. In other words, an employee whose dismissal is planned is either entitled to redundancy pay or to the continuation of his/her employment contract for regular wage for one month (length of notice) before dismissal.[19] The employee is not entitled to both redundancy pay and lenght of notice at the same time. This regulation should contribute to greater labour market flexibility and easier hiring and firing.
- *Paid leave regulation:* the new Labour Code guarantees five weeks of paid leave annually for employees of 33 years of age and older without the need to present any documents to the employer. Until now the employees were entitled to the same length of paid leave, however, only upon presenting written documents, i.e., proofs of their entitlement, to the employer.
- *Variable length of probationary period*: employers welcome the diversified length of probationary period in different types of employment. This provision should increase the flexibility of employment.
- *Temporary employment contracts* – the Ministry's proposal is to increase the number of consecutive temporary contracts with the same employer to three in three years (instead of the current regulation stipulating two consecutive temporary contracts in two years).
- *Labour relations:* the new Labour Code shall grant more room for voluntary agreements and bargaining at the company level and thus supports bargaining decentralization. The Entrepreneur's alliance of Slovakia welcomes such decentralization and argues that it is a win-win situation for employers, employees and job seekers because of lower job creation costs. The new regulation should stimulate new jobs, more intensive wage growth and better employment conditions.

Trade unions are very critical of the suggested changes. The main point of critique is that the proposed Labour Code attempts to significantly increase labour market flexibility and at the same time seriously cut down security provisions. Trade union's interpretation of suggested changes is the following:[20]

- extended probationary period to 6 months with the possibility to dismiss the employee anytime
- employment insecurity because of more temporary contracts and their extensions

[18] Source: http://ekonomika.sme.sk/c/5806791/rodicov-cakaju-v-praci-nove-vyhody.html#ixzz1HLIQFPnQ [accessed March 22, 2011].
[19] The current Labour Code stipulates a length of notice of at least two months and for employees having worked for the same employer for more than five years three months. Source: The Labour Code, § 62. Employers' representatives propose that the new Labour Code stipulates only a one-month length of notice, or a redundancy pay of a monthly wage. Source: SOZZaSS Newsletter 2/2011 in www.sozzass.sk [accessed March 22, 2011].
[20] Source: SOZZaSS Newsletter 2/2011 in www.sozzass.sk [accessed March 22, 2011].

- the law shall guarantee only the statutory minimum wage of EUR 317 instead of the current six levels of minimum wage depending on the character of work. Trade unions criticize that wages can remain as low as the minimum wage in workplaces without a collective agreement
- shorter length of notice upon dismissal, less complications in dismissals (i.e., dismissal without a specified reason)
- dismissal of a handicapped workers will no longer require an approval by the relevant Labour Market Authority
- role of trade unions and Labour Market Authority shall be more limited in hiring and firing
- trade unions' codetermination in issues of working time, overtime, work norms and other workplace regulation
- in case of lockouts due to lack of production inputs on the employers' side employees are entitled only to half of their regular wage
- lower dismissal protection of selected groups of employees (pregnant women, parents taking care of young children or disabled family members
- introduction of *flexikonto* (working time annualization) at the workplace even without a prior approval of the trade union
- overtime payment no longer guaranteed by law but depending on agreement between employer and employee

Finally, in 2007 Slovakia adopted the **Act No. 103/2007 on tripartite consultations** at the national level. The purpose of this Act is supporting effective social dialogue at the national level as democratic means toward resolving current economic and social challenges, development of employment and securing of social peace. In practice, there are different views of social partners on the real functioning of tripartism: some social partners see a great value added, whereas others remain critical and claim tripartism is dominated by the government seeking to approve its policies by (weak) social partners.

# 2. Comparative wage developments in the healthcare sector (1989 – 2008)

This section reviews the major wage-related developments in the healthcare sector. Statistical evidence has been provided by the National Centre of Healthcare Information (NCZI) and processed by Laufiková (2009). Further sources of evidence include the Slovak Statistical Office (Slovstat). As for defining the healthcare sector, NCZI covers data on wages only in selected healthcare organizations. [21]

[21] These include organizations directly established by and subordinated to the state (Faculty Hospitals); organizations established by regional administrative units (i.e., smaller hospitals and other public healthcare providers), non-profit healthcare organizations that operate according to the Act No. 553/2003 on Remuneration of Selected Employees in the Public Service, healthcare providers that are shareholder companies and healthcare providers that are Limited companies. Statistical evidence excludes the wage developments of employees of Spas that were privatized in the first privatization wave and currently operate as private providers. Next, there is no official evidence on the pay of doctors and nurses of first contact (general practitioners) that operate as privatized non-state actors, or newly established fully private healthcare providers.

**- comparative wage developments: healthcare sector vs. national economy**

Table 2.1 and Graph 2.1 document the development of average montly gross wage (in current prices) in the economy in general and in the healthcare sector in particular between 1991-2008. The average wage in healthcare closely oscillates around the average in the economy, but remained below the average over 15 years between 1993-2007.

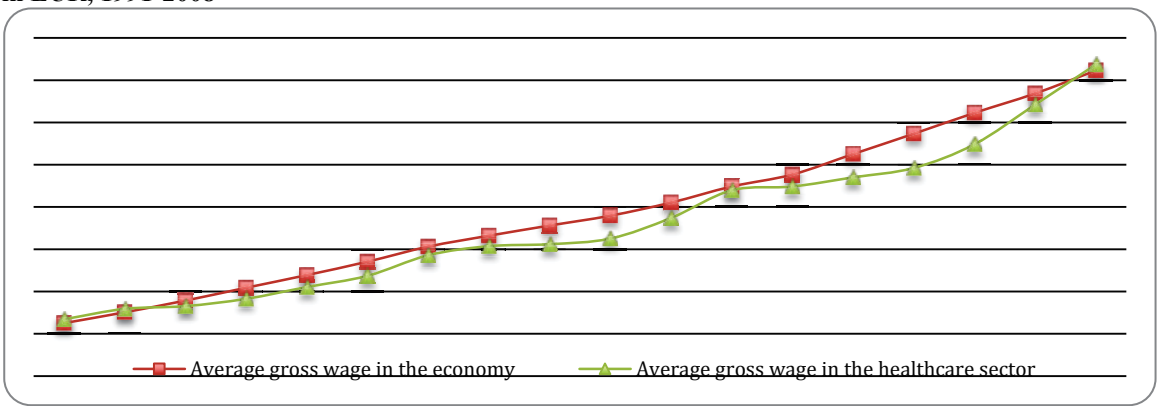
**Table 2.1 Average wage developments in the Slovak economy and the Slovak healthcare sector, in EUR, 1991-2008***

| Year | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Average gross wage in the economy | 125 | 151 | 179 | 209 | 239 | 271 | 306 | 332 | 356 | 379 | 410 | 448 | 477 | 525 | 573 | 623 | 669 | 723 |
| Average gross wage in the healthcare sector | 134 | 159 | 165 | 183 | 211 | 237 | 286 | 307 | 312 | 325 | 374 | 440 | 448 | 470 | 492 | 548 | 642 | 737 |
| % | 107 | 105 | 93 | 87 | 88 | 88 | 93 | 93 | 88 | 86 | 91 | 98 | 94 | 89 | 86 | 88 | 96 | 102 |

* Gross wages in current prices; conversion from Slovak Koruna (SKK) into Euros using the officially fixed exchange rate as of July 1, 2008 upon Slovakia's entry into the European Monetary Union. 1EUR = 30,126 SKK

Source: the author following Laufiková (2009) for 1991-2008; SOZZaSS and NCZI for 2009-2010.

**Graph 2.1 Wage developments in the Slovak economy and the Slovak healthcare sector, in EUR, 1991-2008***




* Gross average wages in current prices; conversion from Slovak Koruna (SKK) into Euros using the officially fixed exchange rate as of July 1, 2008 upon Slovakia's entry into the European Monetary Union. 1EUR = 30,126 SKK

Source: the author following Laufiková (2009)

Taking a closer look at wage developments of doctors and nurses in comparison with averages in the healthcare sector and the national economy (Table 2.2 and Graph 2.2 below), we can observe that wages of doctors have been growing from about 150% of the national economy's average, reaching the double of national average in 2008. At the same time, wages of nurses remained slightly but consistently below the national economy's average, exceeding the national economy's average only in 1991 by 4 percent and in 1992 by 1 percent. Wages of nurses remained over the whole period systematically close but below sectoral averages in the healthcare sector, except for 2001-2003 when the nurses' wages equalled the average wage in the sector.

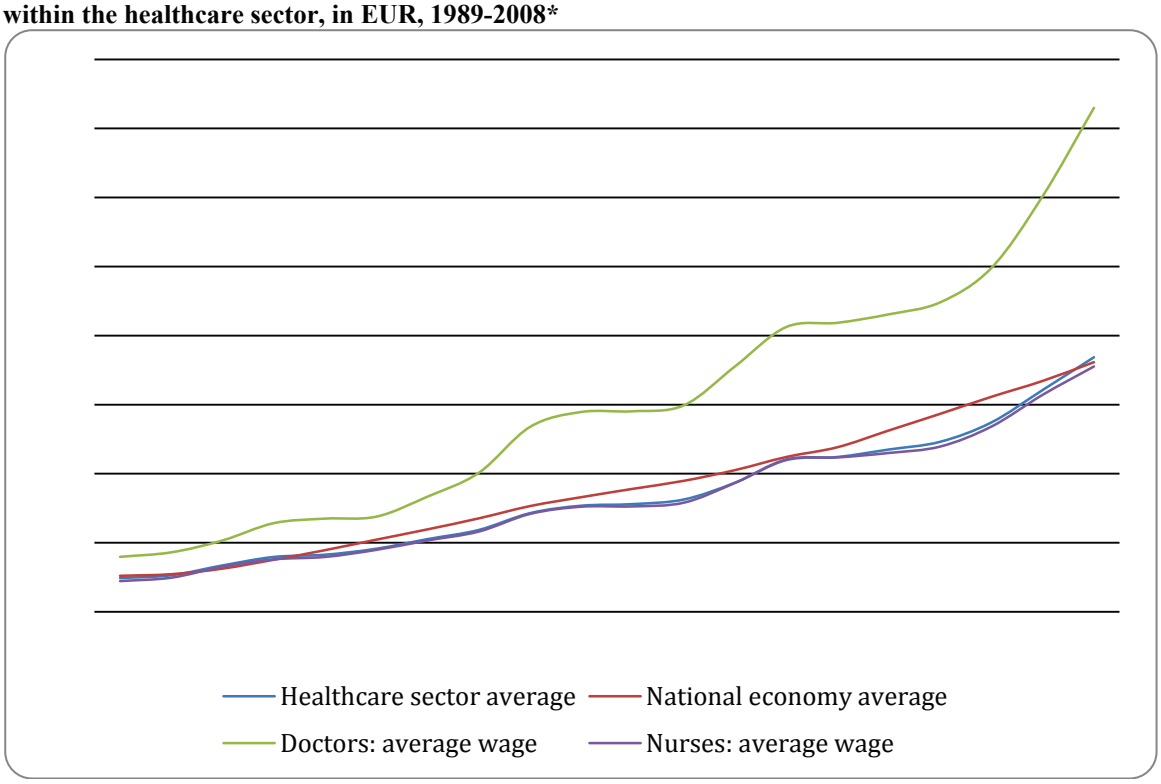
**Table 2.2 Comparison of average wages in the national economy, healthcare sector, and among doctors and nurses within the healthcare sector, in EUR, 1989-2008**

| Year | Doctors: average wage (in EUR) | Doctors' wages compared to national economy average (in %) | Doctors' wages compared to sectoral average (in %) | Nurses: average wage (in EUR) | Nurses' wages compared to national economy average (in %) | Nurses' wages compared to sectoral average (in %) |
|---|---|---|---|---|---|---|
| 1989 | 159 | 153 | 163 | 89 | 85 | 91 |
| 1990 | 172 | 158 | 163 | 99 | 91 | 93 |
| 1991 | 207 | 165 | 154 | 131 | 104 | 97 |
| 1992 | 257 | 170 | 162 | 152 | 101 | 96 |
| 1993 | 270 | 151 | 163 | 159 | 89 | 96 |
| 1994 | 276 | 132 | 151 | 179 | 86 | 98 |
| 1995 | 334 | 140 | 159 | 207 | 87 | 98 |
| 1996 | 403 | 149 | 170 | 232 | 86 | 98 |
| 1997 | 536 | 175 | 187 | 284 | 93 | 99 |
| 1998 | 579 | 174 | 188 | 304 | 92 | 99 |
| 1999 | 581 | 163 | 186 | 305 | 86 | 98 |
| 2000 | 598 | 158 | 184 | 316 | 83 | 97 |
| 2001 | 711 | 173 | 190 | 373 | 91 | 100 |
| 2002 | 825 | 184 | 188 | 441 | 98 | 100 |
| 2003 | 837 | 176 | 187 | 447 | 94 | 100 |
| 2004 | 862 | 164 | 183 | 460 | 88 | 98 |
| 2005 | 896 | 156 | 182 | 479 | 83 | 97 |
| 2006 | 996 | 160 | 182 | 537 | 86 | 98 |
| 2007 | 1204 | 180 | 187 | 629 | 94 | 98 |
| 2008 | 1460 | 202 | 198 | 711 | 98 | 96 |

* Gross wages in current prices; conversion from Slovak Koruna (SKK) to Euros using the oficial fixed exchange rate as of July 1, 2008 upon Slovakia's entry into the European Monetary Union. 1EUR = 30,126 SKK

Source: author's adaptation of Laufiková (2009)

**Graph 2.2 Wage developments in national economy, healthcare sector, and among doctors and nurses within the healthcare sector, in EUR, 1989-2008***




* Average gross wages in current prices; conversion from Slovak Koruna (SKK) to Euros using the oficial fixed exchange rate as of July 1, 2008 upon Slovakia's entry into the European Monetary Union. 1EUR = 30,126 SKK

Source: the author following Laufiková (2009)

**- wage composition in the healthcare sector (doctors and nurses)**

Wages of doctors and nurses consist of the base wage (established in an employment contract between the employer and employee; or subject to collective agreement regulation at the establishment level and sector level), and several surcharges. The Slovak Labour Code, which regulates remuneration in the healthcare sector since 1.1.2005 for all organizational forms of healthcare providers, distinguishes between several wage supplements, including:

- wage supplement for work in the night, Saturdays and Sundays, work on a public holiday, work in shifts, personal bonus, bonus for a management position, wage compensation for difficult working conditions
- additional wage
- bonuses
- compensation for overtime work
- wage supplement for on-call promptitude
- wage compensation (in case of sickness leave, holidays, etc.)

The average composition of doctors' and nurses' monthly gross wage (see Table 2.3) documens that the base wage is a more important wage component for nurses than for doctors. However, wage supplements specified above are a more important part of the gross wage for nurses than for doctors. Finally, for doctors, the overtime compensation and on-call promptitude together account for 24% of the gross wage (for nurses this is only 4.3%). In sum, nurses are more dependent on a fixed base wage, which justifies the efforts of trade unions to regulate base wages collectively. At the same time, doctors' salaries consist of a higher share of variable pay, especially overtime, which leaves more room for doctors to improve their monthly wages other than through collective bargaining. It is indeed the case that in the trade off between a collective base wage growth versus more room for overtime work the trade union representing doctors (LOZ) opted for the latter (see Kaminska and Kahancová 2011).

**Table 2.3 Average composition of monthly gross wages of doctors and nurses in Slovakia**

| Wage component | Doctors | Nurses |
|---|---|---|
| Agreed base wage | 51.2% | 64% |
| Wage supplement | 11.9% | 17.7% |
| Additional wage | 0.8% | 0.6% |
| Bonuses | 3.1% | 1.9% |
| Overtime compensation | 10.7% | 3.2% |
| Supplement for on-call promptitude | 13.3% | 1.4% |
| Wage compensation | 7.2% | 9.6% |

Source: Laufiková (2009)

**- wages of healthcare personnel according to the organizational form of healthcare providers**

Table 2.4 below presents average gross wages of different types of personnel according to different organizational forms of health care providers. Graph 2.3 documents the wage gap applicable to the same type of occupational groups (e.g., doctors, nurses etc.) but working in different types of organizations. In general, highest wages are paid in state-owned faculty hospitals (FN), although base wages of doctors and pharmaceutical employees are highest in specialized shareholder establishments. These findings have to be interpreted with caution, because doctors earn significant surcharges through overtime work especially in hospitals (see above), which accounts for the fact that doctors' actual montly wages in

hospitals, particularly faculty hospitals, are higher than shown in the below table and graph. For other types of healthcare staff, including nurses and midwives, highest wages are paid in faculty hospitals. This is consistent with the structure of healthcare financing and with existing tensions between faculty hospitals and other types of hospitals related to their financing and budget constraints (see other sections of this report).

**Table 2.4 Average gross wage according to occupation and organizational form of the employer in 2008 in EUR***

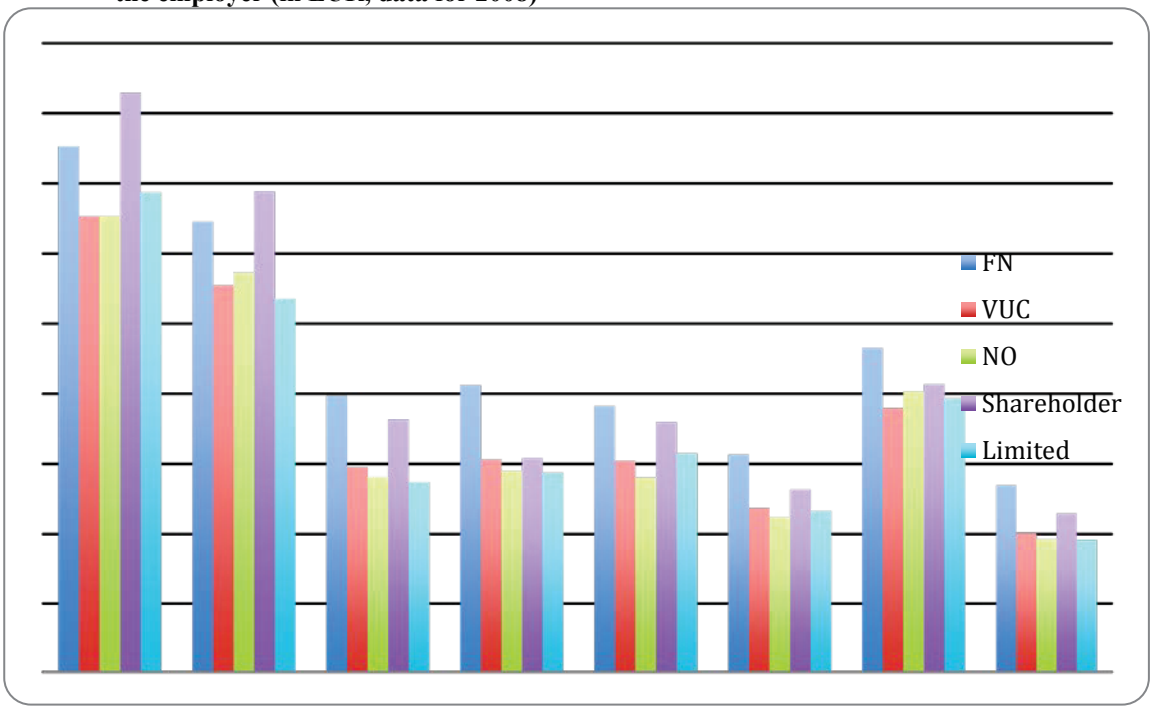
| | FN ** | VÚC ** | NO** | Shareholder** | Limited** |
|---|---|---|---|---|---|
| **Healthcare staff** | 909 | 733 | 725 | 864 | 729 |
| Doctors | 1506 | 1306 | 1307 | 1659 | 1375 |
| Pharmaceutical employees | 1291 | 1110 | 1146 | 1377 | 1071 |
| Nurses | 795 | 590 | 563 | 727 | 548 |
| Midwives | 825 | 613 | 580 | 616 | 575 |
| Laboratory employees | 765 | 609 | 562 | 719 | 630 |
| Assistants | 626 | 474 | 448 | 527 | 466 |
| Other qualified healthcare staff | 931 | 760 | 806 | 827 | 787 |
| Medical orderly | 539 | 402 | 385 | 458 | 383 |
| **Non-healthcare staff** | 1252 | 927 | 1021 | 1133 | 940 |
| Administrative and technical employees | 730 | 572 | 667 | 760 | 589 |
| Administrative and technical employees with a university degree | 1009 | 845 | 1070 | 1180 | 840 |
| Operators and service employees | 522 | 355 | 355 | 373 | 350 |

* Average gross wages in current prices; conversion from Slovak Koruna (SKK) into Euros using the officially fixed exchange rate as of July 1, 2008 upon Slovakia's entry into the European Monetary Union. 1EUR = 30,126 SKK

** FN – Faculty hospitals
VÚC – hospitals subordinated to higher administrative units
NO – healthcare providers operating as non-profit organizations providing services in public interest
Shareholder – healthcare providers operating as shareholder companies with 100% state ownership
Limited – healthcare providers operating as Ltd. Companies

Source: author's adaptation from Laufiková (2009)

**Graph 2.3 Average gross wage of selected healthcare occupations according to organizational form of the employer (in EUR, data for 2008)***



* Average gross wages in current prices; conversion from Slovak Koruna (SKK) into Euros using the officially fixed exchange rate as of July 1, 2008 upon Slovakia's entry into the European Monetary Union. 1EUR = 30,126 SKK
Source: the author using data from Laufiková (2009)

# 3. Industrial relations actors and institutions

This section highlights the major characteristics of industrial relations in the Slovak healthcare sector.

## 3.1 INDUSTRIAL RELATIONS ACTORS IN THE HEALTHCARE SECTOR

- **Trade union organization and membership density; recent changes**

The Slovak healthcare sector is relatively well organized, with an estimated trade union density in the hospital subsector reaching 51%, making healthcare one of the best organized sectors in the Slovak economy. Table 3.1 summarizes industrial relations characteristics in the sector. These largely resemble broader developments in the public healthcare sector as the majority of hospitals are public despite a diversity of their organizational forms (see section 1 of this report).

**Table 3.1 Industrial relations in public healthcare***

| | |
|---|---|
| Number of sector-level unions | 2<br>(SOZZaSS, LOZ) |
| Estimated trade union density in the hospital subsector | 51% |
| Trade union density with regard to the sector** | SOZZaSS: 46.5%<br>LOZ: 4.2% |
| Number of sector-level employers' associations | 4<br>(AFN, ANS SR, ASL SR, ASK) |
| Dominant bargaining level for collective agreements | Sectoral, multi-employer level<br>Wage agreements mostly at establishment level |
| Sectoral bargaining characteristics | Sectoral bipartism with collective agreements;<br>Sectoral tripartism (*small tripartism*) without collective agreements |
| Sectoral bargaining coverage*** | 95% |

* Data for 2006. Source: Czíria (2009) and author's interviews with sectoral social partners.
** Estimated density of particular unions within the healthcare sector.
*** Percentage of employees in the sector covered by a sector-level collective agreement

Two trade unions are active in the sector:

**SOZZaSS (Slovenský odborový zväz zdravotníctva a sociálnych služieb; Slovak trade union federation of healthcare and social services)** – is the largest sectoral trade union, representing all kinds of healthcare personnel. In September 2009, SOZZaSS reported 26,450 members. Most members work in hospitals (69%) and in the field of social care (20%). 79% of members are women, 10% are retired and 12.6% are people younger than 35. The occupational membership structure is listed in Table 3.2 below.

**Table 3.2 Trade union membership structure, SOZZaSS (2009)**

| Occupation | % membership of total |
|---|---|
| Nurses | 41% |
| Manual workers in healthcare and social care | 20% |
| Technical and administrative workers in healthcare | 7.4% |
| Health assistants | 7.3% |
| Laboratory workers | 4.6% |
| Physicians | 4.6% |
| Midwives | 1.5% |
| Pedagogical workers | 2% |
| Other healthcare workers | 11% |

Source: Laufiková (2009)

SOZZaSS is the only trade union in the healthcare sector that is member of the peak-level confederation of trade unions (KOZ SR) engaged in tripartite social dialogue. SOZZaSS therefore has close ties to the national-level tripartite forum (HSR). Given the public character of the healthcare sector, healthcare policies – mostly referring to legal changes and state healthcare strategies – are negotiated within the tripartite committee serving as an advisory board to the government. Other than through KOZ SR, SOZZaSS also has direct access to HSR, because the SOZZaSS leader is one of the members of the tripartite committee on behalf of trade unions (unions have all together 7 seats in the tripartite council), which accounts for a timely information flow between the sector-level and tripartite-level organizations. No collective bargaining takes place at tripartite level, which is exclusively concerned by above-mentioned legislative and strategic developments.

Collective bargaining happens only at the sector and establishment levels. At the sector level, SOZZaSS bargains with three employers' associations (AFN, ANS SR and ASL SR – see below). SOZZaSS associated 305 establishment-level trade union organisations in 2009. These organizations (*základné organizácie*) bargain at the establishment level, often with direct advise and involvement of SOZZaSS (i.e. in cases where establishment-level bargaining needs to address problematic issues).

**LOZ (Lekárske odborové združenie; Trade union federation of medical doctors),** is the second trade union in the healthcare sector. As the union only organizes members from among doctors that have an employee status, its membership is marginal: in 2008, LOZ reported its membership to slightly exceed 2000 individual members. Estimated density of LOZ within the healthcare sector stood at 4.2% in 2006 – see Table 3.1. The majority of members are hospital employees, as after the 1990s reforms other doctors became independent from the state and many of them became employers of a nurse.

In general, LOZ views itself as a more potent trade union (compared to SOZZaSS), with critical views and a high capacity to mobilize for particular action (i.e., negotiation or public protests). Other social partners (including SOZZaSS and employers' associations) perceive LOZ as a union that only acts upon special occassions (i.e. the 2006 strikes or current 2011 pressures addressed to the prime minister). LOZ is not affiliated to the peak organization KOZ SR and does not have an intention to join this confederation. LOZ emerged by splitting from SOZZaSS after the impression that SOZZaSS did not sufficiently represent interests of doctors. The current relationship between LOZ and SOZZaSS is rather competitive and cooperation is difficult. LOZ criticizes SOZZaSS for

being too benevolent in accepting employer offers (especially at the establishment level). It has been the case on few occassions in the past 10 years that a sectoral collective agreement has been signed between employers' federations in the sector and SOZZaSS (a separate agreement with each employer federation), but not between employers' federation and LOZ. If SOZZaSS signs a collective agreement but LOZ does not, the agreement covers also doctors due to valid extension mechanisms at the establishment level. LOZ retrospectively joined some sectoral agreements concluded by SOZZaSS and employers' associations through an amendment to sectoral collective agreements.

Kaminska and Kahancová (2011) present a case study of SOZZaSS and LOZ responses to migration of doctors and the problem of the working time directive and point out the difference between the approach of these two unions, which yielded different results in terms of wage increases (SOZZaSS successful in bargaining a wage increase, LOZ unsuccessful due to a trade off between higher wages and flexible working hours and overtime work in hospitals). At the same time, LOZ claims that the reduction in continuous working time of doctors from 32 hours to 24 hours (then followed by a day off) has been achieved thanks to LOZ's bargaining ability.[22]

As for LOZ's engagement in collective bargaining, the structure is similar to SOZZaSS. LOZ has base organizations in hospitals, which bargain at the establishment level. LOZ bargains at the sector level with relevant employers' associations, sometimes joining forces with SOZZaSS (signing one collective agreement), on other occassions bargaining on its own behalf without coordination with SOZZaSS. LOZ does not have a formal connection to the tripartite council. However, in the past years, LOZ often voiced its claims vis-à-vis the governmental policy through public action targeting the ministry. There is also cooperation between trade unions and SLK (Slovak chamber of medical doctors), but the distinction of bargaining and lobbying competences of these two organizations is clear and respected.

Main problems that both unions have been facing is a declining membership, cleavages among SOZZaSS and LOZ, and underfinancing of the healthcare sector. Moreover, both unions see reforms in healthcare to have created a divergence within public healthcare providers (those directly subordinated to the state, and those subordinated to other public organizations, i.e. municipalities and regional entities) as highly problematic and causing discrimination in working conditions for healthcare employees (considerably higher salaries in state-owned healthcare providers and hospitals than in other public healthcare entities, especially smaller hospitals). The implication of this distinction for collective bargaining, especially on wage agreements, is that AFN (associating faculty/university hospitals) are more eager to raise wages and indeed do raise them as a result of bargaining, whereas ANS (associating smaller public hospitals) faces more budgetary constraints leading to tougher bargaining procedures and a growing wage gap between larger and smaller hospitals.

[22] Source: interview LOZ director, 6 May 2010.

**Industrial action organized by healthcare trade unions:**

The last strikes in the sector occurred in April 2006 upon LOZ's initiative. These strikes took place before parliamentary elections. Targeting the incumbent government, their aim was to demonstrate healthcare workers' discontent with working conditions and wages. Actual wage increases that took place in 2006 did not directly result from these strikes, but from single-employer and multi-employer bargaining. Direct outcomes of 2006 strikes include: a greater attention of the Ministry to urgent problems in the healthcare sector (i.e. the effects of reforms), and a discussion on healthcare workers' right to strike in contrast to their duty to provide healthcare services.

Since 2007, several incidences of strike alert and protest actions deriving from trade unions' demands on wage increases occurred, including:

- the 2010 SOZZaSS protest demanding higher transfers from health insurance companies to ANS members that should produce wage increases in public healthcare. This action produced renewed discussions with the Ministry of Healthcare and insurance companies. The ANS itself appreciates the SOZZaSS's effort in lobbying for higher transfers, claiming that without union action improvement would not have been possible. Exact outcomes in terms of transfers are negotiated individually between ANS members and insurance companies.
- the 2009-2010 strike alert of SOZZaSS announced in public hospitals in Levice and Topoľčany due to an ownership change causing delays in wage payments and changes in workers' contracts. Negotiations with the new owner are still in progress.
- the 2011 April protest organized by SOZZASS, LOZ and professional associations in healthcare, addressing the Ministry of Healthcare with the following requirements:
  - immediate financial stabilization of the heatlhcare sector, namely, adjusting the point system to reflect real costs already in 2011 contracts between healthcare providers and health insurance companies
  - open-ended contracts between healthcare providers and health insurance companies, with a 3-months period of notice in case of serious breach (no need to renegotiate contracts on a regular basis)
  - stopping the process of hospital transformation onto shareholder companies, stop the sales of smaller hospitals to so-called 'strategic investors'
  - stabilizing the number of healthcare employees by creating standard working conditions and remuneration rules reflecting the required skills, experience, job content and particular need of lifelong learning
  - creating legal possibilities for wage rises in healthcare in 2011
  - increasing the state contributions to health insurance premia of state-covered persons (see Section 1 of this report) to 5,5% of base of assess from 2012

  Trade unions suggest that additional funds for the healthcare sector could be secured upon the government's willingess to revise the state budget's financing priorities.

- the 2011 April protests organized by LOZ, targeting the government with the following claims: respecting the Labour Code in healthcare organizations, reasonable financial flows to healthcare organizations, a stop to transformation of hospitals onto shareholder companies, and wage increases from 2013 equaling to 1,5 – 3 times the average wage in the Slovak economy. LOZ seeks negotiation with the prime minister, otherwise the

union threatened with action similar to the recent Czech experience – a massive departure of medical doctors from their employment relationships.[23]

Another important protest action, especially from the perspective of flexicurity, is the 2011 petition by the Slovak Association of Nurses and Midwives (SKSAPA) with strong support of both trade unions, domestic professional associations, and Nurses' associations from other EU countries.[24] The petition formulates several substantive areas, in which nurses aim for improvement in the regulatory framework. Nurses' requests include:

- a minimum hourly wage for nurses and midwives under the principle equal pay for equal work
- a guaranteed retirement age of 58 years regardless of future changes in relevant legislation
- stricter implementation of workplace norms, including the ratio between patients and nurses
- broadening the definition of healthcare service to cover also social homes (i.e., for elderly), personal care and outpatient care; the aim being non-discrimination of nurses working in such services due to the fact that they fall under different regulation than the one applicable to healthcare services
- support for lifelong learning of nurses and midwives by stipulating at least 5 days of paid leave for training/learning participation; and stipulating financial contributions to individuals with active participation in seminars, conferences and similar events in lifelong learning.

**Table 3.3 Strikes and lockouts in Slovakia according to economic activity: health and social work (ILO classification)**

| | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|
| Number of strikes and lockouts | 0 | 4 | 0 | 0 |
| Number of workers involved* | 0 | 1,333 | 0 | 0 |
| Number of working days lost** | 0 | 14 | 0 | 0 |

Source: ILO Laborsta (2010).

* The number of workers involved in strikes and lockouts usually includes those involved indirectly as well as those involved directly.

** The number of days not worked is usually measured in terms of the sum of the actual working days during which work would normally have been carried out by each worker.

- **Employers' organizations and membership density; recent changes**

There are four sector-level healthcare employer organisations with clearly delineated fields of operation. This structure has been at place since 2006. Self-reported membership data, together with the relevance of particular associations as social partners, demonstrate that AFN SR and ANS, operating in the hospital subsectors, are the most important players.

**Association of Faculty Hospitals of the Slovak Republic** (*Asociácia fakultných nemocníc SR, AFN SR*) – associated 15 healthcare provider organizations in 2008,

[23] Source: SME, 13 April 2011 *Lekári dali premiérke ultimátum na rokovanie*, in http://www.sme.sk/c/5849223/lekari-dali-premierke-ultimatum-na-rokovanie.html [access date 13 April, 2011].

[24] Source: SKSAPA website, http://www.sksapa.sk/Pet%C3%ADcia/peticia.html [access date 14 April, 2011].

including 12 faculty/university hospitals and three highly specialized healthcare providers operating as state-owned shareholder companies. The number of AFN SR members has grown to 19 in 2010. As of 30 June 2009, 21,151 employees worked at faculty/university hospitals affiliated to AFN SR.[25] AFN SR reports about 28,500 employees in its member organizations in 2010.

AFN SR engages in collective bargaining with SOZZaSS and LOZ at the sector level. The organization was founded in 2006 by splitting from the previous employer organization. The split and creation of AFN SR and ANS grew out of the large healthcare reform and new roles for – on the one hand – larger and better equipped faculty hospitals; and on the other hand for smaller public hospitals with a variety of organizational/ownership forms. As discussed above, because the possibility of debt accumulation in faculty/university hospitals,[26] AFN is more open towards wage increases and concessions in collective bargaining (e.g., covering some costs for lifelong learning of doctors/nurses, following legal stipulations regarding overtime payments, etc.).

**Association of Hospitals of Slovakia** (*Asociácia nemocníc Slovenska, ANS*) – the second major employers' association in the sector; in 2010 organizing 55 smaller hospitals of various organizational forms (see also Section 1). ANS engages in bargaining at the sector-level with SOZZaSS and LOZ. Given the limited budgets of hospitals associated in ANS, bargaining between unions and ANS brings less wage increases and concessions when compared to bargaining between the unions and AFN SR. The development of ANS's member organizations and their employees is listed in Table 3.4 below. In 2006, AFN split from ANS, which partly explains the declining trend in membership and employees. Other reasons for decline are privatization, changes in organizational forms of hospitals and the lack of interest of some providers to continue their membership in ANS.

**Table 3.4 ANS members and their employees 2001-2010***

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| **ANS members** | 104 | 104 | 105 | 91 | 85 | 73 | 66 | 58 | 58 | 55 |
| **Employees in establishments that are ANS members**** | 69,301 | 69,535 | 65,278 | 61,023 | 55,399 | 50,101 | 20,441 | 19,970 | 19,955 | 19,282 |

* Data of January 1of the respective year
** Number of registered employees
Source: internal statistics of ANS

**Private Physicians' Association of the Slovak Republic** (*Asociácia súkromných lekárov Slovenskej republiky, ASL SR*) – represents individual physicians operating as private entrepreneurs providing their services upon contracts individually negotiated with health insurance companies. ASL SR associated 2,900 members in 2005. Members are private physicians providing services in market conditions where the majority of physicians (except medical doctors that are hospital employees) operate as private entrepreneurs.

ASL SR negotiates and concludes collective agreements with trade unions at the sector level. The general importance of ASL SR for industrial relations and bargaining does not reach the importance of AFN SR and ANS as employer's organization, because

[25] Source: Laufiková (2009).
[26] This does not mean that all such hospitals have debts, there are hospitals with a balanced structure of income and costs.

employment in establishments organized in ASL SR is marginal (only a small number of nurses employed by private physicians). ASL SR operates outside the hospital sub-sector.

**Association of Slovak Spas** *(Asociácia slovenských kúpeľov, ASK)* organizes healthcare providers in balneology and health spas and engages in the regulation of healthcare provision in spas. ASK has 26 members, the majority of them being privatized health spas. No information on the number of employees working in affiliated organisations available. ASK does not engage in sector-level bargaining, but its affiliated members bargain with trade unions individually at the establishment level.

In sum, three employer organisations (AFN SR, ANS and ASL SR) are individually involved in multi-employer bargaining with trade unions. Members of these employer organisations also engage in single-employer bargaining with establishment-level trade unions affiliated to SOZZaSS and/or LOZ. ASK engages only in single-employer bargaining with establishment-level trade unions. AFN SR, ANS and ASL SR are involved in sector-level bipartite and tripartite social dialogue. Through their membership in the Federation of Employer Associations (*Asociácia zamestnávateľských zväzov a združení, AZZZ*), all four employers organisations in the health care sector are represented in national-level tripartism.[27] AZZZ is one of two peak employers' federations engaged in tripartite concertation. Tripartism's focus is predominantly on law making and regulation in the healthcare sector; thus not collective bargaining. Currently no higher-level collective agreements at the national level exist in Slovakia, the practice of concluding general framework agreements in the tripartite forum ceased to exist in early 2000s.

## 3.2 INDUSTRIAL RELATIONS INSTITUTIONS IN THE HEALTHCARE SECTOR

Since the healthcare sector is no longer subordinated to the Act No. 553/2003 on remuneration in the public sector, bargaining in the sector (mostly concerning wage bargaining) can be characterized by a peculiar combination of centralization and decentralization. While sector-level bargaining is still playing a prominent role, it lacks coordination with the establishment-level (SEB) and only sets minimum standards.

**- Multi- or single-employer bargaining arrangements;**

- **amongst MEB, sector and/or inter-sector;**

Both MEB and SEB arrangements are important and common in Slovakia's healthcare sector. MEB applies to sector-level bargaining, leading to sector-level collective agreements (so called higher-level collective agreements, *kolektívne zmluvy vyššieho stupňa*). As for inter-sector agreements, the only relevant type of agreements applicable to the healthcare sector until 2005 were higher-grade agreements concluded for the public sector as a whole. Since 2005, the relevance of these agreements for the sector significantly declined, due to the fact that healthcare employees are no longer covered by the Act No. 553/2003 on remuneration in public service (see above). Current MEB and

[27] The other peak employer organization – the Republic's union of employers (*Republiková únia zamestnávateľov SR, RUZ SR*) – does not have member organizations from the healthcare sector.

SEB follows Labour Code provisions; some establishments continue to use the wage scales in Act No. 553 as benchmark in SEB.

- **amongst SEB, relative incidence of multi-site organisations of site-based or company-wide CB arrangements**

Coordination of SEB is not applicable even to cases of multi-site organizations. Although some hospital organizations do operate as multi-site organizations (i.e., the University hospital of Bratislava covers in fact several hospitals; or the company Agel operates several hospitals throughout the country), each establishment has its own base trade union organization which bargains with the management of the respective hospital. In case of smaller hospitals that are founded by the same subject (i.e., the same self-governing region) but located in geographically distinct areas, 'company-wide' arrangements do not exist.

- **Collective bargaining coverage, and recent changes**

Trade unions conclude sector-level collective agreements individually with each employers' organization (except ASK). These agreements cover all members of the particular employer association and their employees. Thus, the coverage of MEB agreements is 100% among employers' organization members and about 95% in the public healthcare sector. There are no recent changes applicable to the coverage rates.

- **Existence and use of extension arrangements**

Extension arrangements are not common at sector level; concluded agreements cover all employees in member organizations of particular employers' associations. However, extension arrangements do exist in two forms:

- sector level: if SOZZaSS signs a collective agreement with one of the employers' associations but LOZ does not, this agreement also covers medical doctors working in hospitals and possibly organized in LOZ.
- establishment level: collective agreements apply to all employees in a particular establishment.

In June 2010, the Ministry of Work, Social Affairs and Family approved a binding flat extension mechanism to entire sectors, covering also employers that are not members of sectoral associations. This new extension mechanism did however not apply to the healthcare sector and has been revoked by the new government taking office in July 2010. Extension mechanisms now apply only to employers (non-members of employers' organization), which request/agree with an extension.

- **Procedural provisions for articulation between levels (under MEB) and the incidence of second-tier (company) bargaining under two (multi) tier arrangements**

Since 2005, both sector-level and establishment-level play a role but lack mutual coordination. Although wage bargaining happens at both levels, sectoral social partners lack a detailed overview of wage bargaining developments at establishment level and on variation in wages across particular establishments. Sector-level bargaining *responds* to the diversity of establishment-level collective agreements by negotiating a certain flat % of

wage increases applicable to all establishments that are members of one of the concerned employers' associations (AFN SR, ANS, ASL SR). However, even if sectoral bargaining does play an important role, sectoral social partners are not aware of the impact of the negotiated % increase on the actual wages across hospitals and other providers. Sectoral social partners are neither aware of wage changes of particular groups of employees in these establihsments.

- **Coordination of bargaining across sectors (formal / informal means)**

Cross-sector bargaining coordination has been more prominent before 2005 when healthcare followed remuneration pay scales for the public sector and higher-level collective agreements for the public sector applied. Within all-public-sector bargaining, pay scales have been negotiated separately for healthcare, education and other sub-sectors of the public sector. The growing gap between payscales in these sub-sectors have led to an exclusion of healthcare from public sector bargaining and remuneration scales.

Coordination of bargaining in post-2005 settings is only indirectly relevant and applicable to the following three domains: healthcare sector, public care homes (in which some healthcare workers work), and higher-level public sector bargaining covering a small part of healthcare employees. Coordination across these three domains does not directly apply to the bargaining process itself, but to the fact that the same trade union (SOZZaSS) engages in bargaining in all three domains. It is in the union's interest to reach more coordinated and regulated payscales for healthcare workers in the whole economy. Therefore, although bargaining in all three domains is independent, we can assume that the union draws on resources across all three domains when engaging in bargaining in a particular domain.

- **Coordination of bargaining within sectors (under company-based arrangements)**

Not applicable due to the existence of sector-level bargaining and establishment-level bargaining, which are not extensively coordinated with each other.

- **Workplace representation, including crucial distinction between single- and dual-channel arrangements**

At workplaces, employees are represented through trade union base organizations (*základné organizácie*). As of September 2009, SOZZaSS reported 305 base organizations in Slovakia, of which 104 (34%) are established in hospitals.[28] LOZ reports about 35 base organizations, the majority of which are based in faculty/university hospitals.[29]

# 4. Procedural dimension to collective bargaining

## 4.1 DECENTRALIZATION/CENTRALIZATION

- **Relationship between levels (articulation and relative weight) under two (multi) tier bargaining arrangements, recent changes therein and rationale(s) for these**

[28] Source: internal materials of SOZZaSS.
[29] Source: interview LOZ director, 6 May 2010.

Decentralization of wage setting in healthcare after 2005 has significantly increased the role of establishment-level bargaining (SEB). Wage increases are exclusively bargained at the establishment level (in particular hospitals). At the same time, sectoral bargaining sets the general percentage of wage increases, which individual employers/hospitals (members of sectoral employers' federations) have to follow.

SEB is thus complementary to sectoral bargaining despite lacking close coordination between two tier arrangements. Sectoral social partners, especially trade unions, attempt to set sector-wide standars. For this aim, social partners need to be informed of establishment-level wage increases, which is a difficult task. Lacking coordination between the sectoral and company level arrangements stems from the imperfect information flow on bargained provisions from the establishment level to the sector level. Information on how exactly individual SEB tops up sectoral arrangements is not available to sectoral social partners. This issue most obviously concerns wage bargaining.

- **Recent changes which have a decentralising effect under two (multi) tier arrangements? Rationale for changes?**

Healthcare reforms taking place before 2006 brought a decentralization of healthcare providers and of wage setting (public sector collective agreements and the tarrif wages for public sector no longer apply to healthcare providers). Decentralization has significantly increased the role of SEB, while the role of sector-level bargaining arrangements also continues to play an important role.

- **Recent changes which have a (re)centralising effect under two (multi) tier arrangements? Rationale for changes?**

SOZZaSS strives to return to a coordinated wage setting in healthcare, arguing that equal pay should be paid for equal work regardless of the ownership/organization form of hospitals. Such coordinated wage setting would in fact resemble the situation prior to 2005 when wage bargaining in healthcare followed the tariff scales specified for the public sector (and further detailed for particular sub-sectors including healthcare) in Act 553/2003. However, in the current situation when reforms have brought significant decentralization of organizational forms in healthcare providers, return to a coordinated wage setting is unlikely. Sector-level bargaining arrangements remain therefore the strongest centralizing element, which bring stability into the two-tier bargaining procedure.

## 4.2 NATURE OF COLLECTIVE REGULATION

- **Nature of sector/inter-sector agreements, recent changes therein and rationale(s) for these**

    - **Legally binding or not**

Collective agreements are legally binding if signed by both parties. In the 2008-2010 bargaining round between SOZZaSS and ANS (sector-level bargaining), ANS disputed the validity of the sectoral agreement given the economic crisis and the tightening of hospital

budgets. In consequence, provisions of this agreement have not been implemented until April 1, 2010, when hospitals affiliated to the ANS finally accepted the stipulated wage increase of 2,5%. Given the legally binding status of collective agreements in Slovakia, during the period of dispute solving (through an appointed mediator and an amended agreement between the unions and ANS), stipulations of the previous collective agreement remained valid until the dispute has been solved.

- **Establishing minimum or universal standards**

Sector-level stipulations in collective agreement cannot be strictly considered as establishing minimum standards. Some provisions replicate the Labour Code, whereas others are elaborated according to particular needs of the healthcare sector, hospital sub-sector, or even specifically the type of hospitals to which sectoral agreements apply (depending on whether the agreement concerns AFN SR or ANS). Establishment-level agreements in member organizations of AFN SR and ANS cannot undercut sectoral provisions, the two levels are complementary in setting standards in particular stipulations. If concerete provisions are set at sector level, employers can build on them and provide better conditions, or include company-specific stipulations in establishment-level agreements that are not addressed in sector-level agreements. In this respect, the two bargaining levels are complementary and sector-level agreements do in fact establish minimum standards, which are however sector-specific. In other issues, i.e. provisions concerning lifelong learning and health and safety at workplace, sector-level agreements establish universal standards in the healthcare sector (and hospital subsector).

- **Framework or detailed provisions**

The extent of details depends on the particular issue; i.e. in wages – general % of wage increases are set, but this % applies to different starting points across different hospitals (faculty vs. smaller hospitals of various organizational forms) and occupational groups (e.g. doctors, nurses, medical orderlys, etc.). In lifelong learning and health and safety at work, concrete provisions (such as a monthly contribution of employer to learning) are specified in sector-level agreements. See Section 5 for more information on the substantive agenda of collective agreements.

- **Derogations possible? Under what circumstances?**

No formal derogation practices and opt-out rules apply.

- **Complete or incomplete (i.e. leaving aspects open) regulation of an issue**

Some aspects are specified in detail in sector-level agreements, others are open for company-level bargaining. See Section 5 for more information on the substantive agenda of collective agreements.

- **Nature of company agreements under two (multi) tier bargaining arrangements: authorised or unauthorised? Recent trends, and reasons for them?**

Not applicable to Slovakia

- **Has regulation via collective agreements at inter-sector/sector levels become 'harder' / 'softer' / remain unchanged in character? Rationale for changes?**

See above for more information on the character of sector-level agreement in the two-tier bargaining system. In general, regulation via sectoral agreements has remained unchanged in character after 2005. This is given the strong institutionalization of two-tier bargaining and the role of sector-level industrial relations in Slovakia in general. Although decentralization of healthcare providers and of wage bargaining did weaken sectoral bargaining to some extent, sector-level bargaining continues to play an equally important role as SEB. Sector 5 discusses particular content of sectoral agreements (without major changes in issues addressed over the past decade) referring to substantive issues in flexibility and security.

## 4.3 COVERAGE OF COLLECTIVE AGREEMENS

Collective agreements (sector-level and establishment-level) cover about 95% of employees in public healthcare. Coverage is lower in private healthcare due to a low unionization rate and lacking extension mechanisms for collective agreements.[30]

Establishment-level agreements apply to all employees at the respective employer.

- **Opting-out of sector CB arrangements? Reasons for this?**

Sectoral collective agreements apply to all employees working in establishments associated to one of the above sector-level employer organisations engaged in sector-level bargaining. All employers that are covered respect these agreements and the practice of opting out is not common. It is also unlikely that such practice is possible, given the status of the sector-level agreements. However, in the bargaining round of February 2008, SOZZaSS and AFN SR, and SOZZaSS and ANS, did not agree on wage increases due to the economic crisis. The disputed terminated after an appointed mediator decided in the case and stipulated a wage increase of 2.5% from November 2009 and 2.5% from April 2010 in faculty hospitals affiliated to the AFN SR.

SOZZaSS and ANS signed the last collective agreement in 2006 and failed to conclude agreements in the following years. In August 2009, a mediator's decision stipulated two waves of wage increases (3-4% from September 2009 and 3-4% from March 2010), financial compensation for uneven working hours in case of shiftwork, overtime and shiftwork premiums beyond the law. ANS further protested against these stipulations. An agreement has finally been reached in 2010. Before the final agreement, employers followed the previous sectoral collective agreement, thus did not opt out of sector-level arrangements.

- **Switching between sector agreements? Reasons for this (e.g. cost, flexibility)?**

[30] Private physicians often employ just one person, i.e., a nurse. Nurses working in private healthcare are likely to have lower wages than in public hospitals where collective agreements apply. Such nurses are less unionized, which complicates trade union access to private healthcare workplaces. Earlier trade union initiatives in cooperation with SKSAPA to establish a country-wide union for nurses in private healthcare failed due to lack of nurses' interest. Source: interview SOZZaSS deputy director, April 14, 2010.

Given the structure of Slovak healthcare providers and a clear delineation of particular employers and their membership in particular employers' association, it is not possible to switch between sectoral agreements. For example, a faculty/university hospital cannot choose to switch from a sectoral agreement applicable to AFN SR members and follow instead the collective agreement applicable to smaller hospitals (ANS members).

- **Under company-based bargaining arrangements, instances of de-recognition? Non-recognition at new sites? So-called 'double breasting' (recognition continues at existing sites but no recognition at new sites)?**

Establishment-level agreements in healthcare apply to a single workplace (i.e. a particular hospital even if the founding institution of the hospital manages several hospitals). For this reason, agreements are negotiated always between a particular hospital's management and the trade union base organization, without extension to other workplaces. The issue of 'double breasting' or non-recognition at new sites is therefore not applicable.

## 4.4 ASSESSMENT AND PROSPECTS

- **What advantages have recent procedural changes brought for employers / trade unions?**

Long-term developments in procedural changes show a clear trend of decentralization in collective bargaining. At the same time, sector-level bargaining is strongly institutionalized and serves as an important reference point in a number of sectors, including public healthcare. A new Labour Code, to be effective from late 2011 or 2012, should support further decentralization. Employers welcome decentralization because of greater flexibility of employment conditions and their determination at the establishment level.

- **What problems / difficulties have they caused?**

Trade unions do not welcome the decentralization trend and argue that too much flexibility shall lead to an erosion of working standards and guaranteed wages. Unions strive for equal pay for equal work in healthcare, which requires governance similar to the pre-2005 period (legally determined pay scales). Related to this effort is the unions' argument that the regulation of working conditions in healthcare should be governed by a higher-level institution than establishment-level collective agreements.

- **Looking to the future, what further developments might be on the horizon? What proposals are employers' advancing? What proposals are trade unions advancing?**

The currently negotiated major Labour Code change shall stipulate further decentralization of bargaining and grant more freedom to company and establishment-level social partners. Employers do welcome this trend as part of a package of measures stimulating greater labour market flexibility. Trade unions push for more security, especially in times of higher unemployment due to the recent economic crisis.

Proposals advanced by employers in the area of procedural bargaining issues include limiting the codetermination rights of trade unions in working time, overtime, work plan and similar workplace issues; and limiting trade union involvement and the involvement of the Labour Market Authority (*Úrady práce*) in dismissal procedures. These changes are currently under discussion in the Slovak parliament and the tripartite council; at the same time they are subject to protests by unions (LOZ), a petition for better working conditions of nurses (SKSAPA, with support of trade unions, professional associations and international support by professional associations in other EU member states) and open dissatisfaction (SOZZaSS).[31]

# 5. Substantive agenda and outcomes of collective bargaining

This section monitors the changing agenda and outcomes of collective bargaining between 2003 and 2010, focusing on questions of flexibility and employment security. The selection of this time period results from particular national developments, where collective bargaining in the healthcare sector was legally enabled for the first time by Act 313/2001 (entered force in April 2002). The first collective agreement for public service, covering also healthcare employees, was signed in August 2002 and entered force in April 2003. Given the already described legal developments and changes in public policy (see Section 1.6), Slovakia experienced a major shift in the governance of employment conditions in healthcare:

- between 2003 and 2005, healthcare has been covered by a higher-level collective agreement for public service, signed at the national inter-sectoral level by nationa-level social partners.
- since 2006, sectoral trade unions in healthcare negotiate individual sector-level collective agreements with respective employers' organizations (AFN SR, ANS and ASL SR). Higher-level collective agreements for public service continue to exist, but their relevance for public healthcare (and especially hospitals) is marginal.

The analysis of substantive agenda of collective agreements reflects the above shift. Table 5.1 provides and overview of collective agreements relevant for public hospitals in 2003-2010. The analysis in next sections builds exclusively on the substantive agenda of agreements listed in Table 5.1. In 2011, new bargaining is in progress between trade unions and each employers' federation (AFN SR, ANS). Until a new agreement is signed, the 2009 agreements (see Table 5.1) remain in force.

**Table 5.1 Collective agreements governing the public healthcare sector (in particular hospitals), 2003-2011***

| Year | Agreement kind | Signatory parties | Level | Coverage |
|---|---|---|---|---|
| **2003** (signed 2002) | Higher-level collective | National-level social partners** | Inter-sector | Entire public sector including all public |

[31] Source: SME, 13 April 2011, in: http://www.sme.sk/c/5849223/lekari-dali-premierke-ultimatum-na-rokovanie.html [accessed April 13, 2011]; SOZZaSS Newsletter 1/2011, 2/2011, 3/2011, in www.sozzass.sk; and SKSAPA Petition in http://www.sksapa.sk/Pet%C3%ADcia/peticia.html [accessed April 14, 2011].

| | | | | |
|---|---|---|---|---|
| | agreement for public service | | | healthcare establishments |
| **2004** (signed 2003) | Higher-level collective agreement for public service | National-level social partners** | Inter-sector | Entire public sector including all public healthcare establishments |
| **2005** (signed 2004) | Higher-level collective agreement for public service | National-level social partners** | Inter-sector | Entire public sector including all public healthcare establishments |
| **2006** (signed 2005) | Higher-level collective agreement for public service | National-level social partners** | Inter-sector | Entire public sector including all public healthcare establishments; healthcare establishments governed by this agreement only until sector-level collective agreements signed in Spring 2006 |
| **2006** (signed 19.4.2006) | Higher-level collective agreement between SOZZaSS and AFN SR | Sector-level social partners (SOZZaSS and AFN SR) | Multi-employer, sector-wide | All healthcare establishments that are members of AFN SR |
| **2006** (signed 9.5.2006) | Higher-level collective agreement between SOZZaSS and ANS | Sector-level social partners (SOZZaSS ANS) | Multi-employer, sector-wide | All healthcare establishments that are members of ANS |
| **2007** (signed 1.6.2007) | Amendment to the 2006 higher-level collective agreement between SOZZaSS and AFN SR | Sector-level social partners (SOZZaSS and AFN SR) | Multi-employer, sector-wide | All healthcare establishments that are members of AFN SR |
| **2008** (signed 15.1.2008) | Amendment to the 2006 higher-level collective agreement between SOZZaSS and ANS | Sector-level social partners (SOZZaSS, LOZ and ANS) | Multi-employer, sector-wide | All healthcare establishments that are members of ANS |
| **2008** (signed 17.1.2008) | Amendment to the 2006 higher-level collective agreement between SOZZaSS and AFN SR | Sector-level social partners (SOZZaSS, LOZ and AFN SR) | Multi-employer, sector-wide | All healthcare establishments that are members of AFN SR |
| **2008** (signed 15.2.2008) | Amendment to the 2006 higher-level collective agreement between SOZZaSS and AFN SR | Sector-level social partners (SOZZaSS and AFN SR) | Multi-employer, sector-wide | All healthcare establishments that are members of AFN SR |
| **2008** (signed 10.6.2008) | Mediator-stipulated amendment to the 2006 higher-level collective | Appointed mediator | Multi-employer, sector-wide | All healthcare establishments that are members of ANS |

| | | | | |
|---|---|---|---|---|
| | agreement between SOZZaSS and ANS | | | |
| **2009** (signed 20.8.2009) | Mediator-stipulated higher-level collective agreement for ANS members in the dispute between SOZZaSS, LOZ and ANS | Appointed mediator | Multi-employer, sector-wide | All healthcare establishments that are members of ANS |
| **2009** (signed 6.10.2009) | Higher-level collective agreement between SOZZaSS, LOZ and AFN SR | Sector-level social partners (SOZZaSS, LOZ and AFN SR) upon stipulations by appointed mediator as of 29.9.2009 | Multi-employer, sector-wide | All healthcare establishments that are members of AFN SR |

* Higher-level collective agreements for public service continue to exist after 2006; however, they no longer govern the public hospital sub-sector and are therefore excluded from analysis.

** the government, Association of Towns and Communities of Slovakia (ZMOS), self-governing regions, KOZ SR, Independent Christian Trade Unions of Slovakia (NKOS) and the General Free Trade Union Federation (VSOZ).

## 5.1 SUBSTANTIVE ISSUES IN COLLECTIVE AGREEMENTS IN 2003-2011

- **Jobs and contracts**

The governance of jobs and contracts is in majority outside the scope of collective bargaining. The specificity of labour market in healthcare, including recent shortages of workers, together with the traditional substance of collective agreements, is responsible for the fact that jobs and contracts are beyond the bargaining agenda. Most employment in healthcare is standard full-time employment through open-ended employment contracts. Employment conditions applicable to this form of employment is governed by the Labour Code. The only issue that is subject to bargaining at inter-sector and sector-level is the redundancy pay (see below).

- **Dismissal protection**

No dismissal protection measures apply through collective agreements at inter-sector and sector-level. Direct dismissal protection is not a relevant bargaining issue given the shortages of healthcare personnel. However, some form of dismissal protection does occur through legal and collective stipulations on the amount of redundancy pay (*odstupné*) and the discharge benefit (*odchodné*). The Labour Code stipulates redundancy pay to those employees whose employment relationship is terminated on the grounds of redundancy or if the employer or part thereof is closed or relocated (and to those doing work in relation to the employer's liquidation in such circumstances). Discharge benefit is provided to employees upon the first termination of their employment; upon entitlement to an old age or invalidity pension; or upon entitlement to pension on grounds of length of employment.
In 2003-2005, redundancy pay governance occurred through inter-sector collective agreements in the public sector. The 2003 agreement stipulated a redundancy pay equal to

three months' pay, thus exceeding the Labour Code provision stipulating a two months' pay. Employees who are at least 45 years old and have been working in public services for more than 15 years may have received supplementary redundancy compensation of up to another three months' pay (bringing the maximum to six months' pay). The discharge benefit has been increased from one month's to two month's pay in the public sector, thus exceeding the Labour Code stipulations.[32] The amount of redundancy pay and discharge benefit further increased in the 2004 inter-sector collective agreement for public service employees.[33] The break with previous trend came in the 2005 collective agreement, which brought a reduction in the level of redundancy pay to one month's pay regardless of the employee's length of service. The stipulation on discharge benefit exceeded the Labour Code in stating that the benefit may be increased by at least one month's pay above the Labour Code provisions.[34] Since 2006, when individual multi-employer bargaining was established in the healthcare sector, stipulations on redundancy pay and discharge benefit have been adopted from the 2005 inter-sector collective agreement. All consequent collective agreements, their amendments and mediator-stipulated decisions re-state the earlier stipulations.

- **Employment guarantees**

Given the recent shortages of healthcare personnel, employement guarantees are not a central issue of concern and are not subject to collective bargaining. Rather than employers guaranteeing employment, they attempt to attract and maintain healthcare workers. Measures to improve the recruitment and retention of healthcare workers occurs mostly through wage increases, partially also through negotiated employer contributions to pension funds beyond legal requirements, higher redundancy pay upon layoffs than legally stipulated. Another example is the single contribution of 5000 EUR upon starting a job as a nurse in the Children's hospital, which was the management's reaction on shortages of nurses.[35]

- **Re-employment assistance in case of dismissal**

This issue is not relevant in the healthcare sector given the shortages of qualified healthcare staff. In other cases of dismissals, i.e., non-health workers, re-employment assistance is not common.

- **Promotion of mobility within enterprise, within sector, outside sector**

Promotion is not subject to bargaining; it is governed at the enterprise level via management decisions without trade union codetermination.

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[32] Source: EIRO report, http://www.eurofound.europa.eu/eiro/2002/09/inbrief/sk0209101n.htm, accessed 15 April, 2011.

[33] Redundancy payment amounts to at least three month's pay if the employee has been working for the employer for up to five years and termination of the employment relationship is based on an agreement; and at least four month's pay if the employee has been working for the employer for more than five years and termination of the employment relationship is based on an agreement. 'Discharge benefit' has been increased by one month's pay (over and above the provisions laid down in the Labour Code). Source: EIRO report, in http://www.eurofound.europa.eu/eiro/2004/01/inbrief/sk0401109n.htm [accessed 15 April, 2011].

[34] Source: EIRO report http://www.eurofound.europa.eu/eiro/2005/02/inbrief/sk0502101n.htm [accessed April 15, 2011].

[35] Source: interview SOZZaSS deputy director, 11 May 2010.

- **Use fixed-term, part-time contracts, agency workers, foreign labour**

The use of precarious forms of employment in healthcare is marginal. This is due to existing shortages and competition in terms of wages and working conditions between large and small hospitals. In a small number of cases, especially small hospitals with high financial constraints, trade unions report fixed-term contracts and dismissals of these workers. Given this is a marginal form of work in healthcare, and most likely covers lower-grade healthcare personnel or non-health care workers in hospitals, such forms of contracts are not subject to collective bargaining at sector-level or establishment-level. Governance of precarious work, if applicable, happens through the Labour Code and individual employment contracts with particular workers.

- **Working time (flexibility)**

Working time is a crucial bargaining issue, which is regulated by inter-sector and sector-level agreements next to the Labour Code. The most important stipulations regarding working time include working time reductions and overtime regulation, especially overtime pay. Although not subject to bargaining, the most serious issue is the amount of overtime, where a mismatch between regulation and practice applies. Since overtime work is a source of extra income, many qualified healthcare workers are willing to take on overtime, night work, shift work and work during public holidays. Employers, trade unions and the Ministry of Healthcare together faced a challenge of implementing the EU Working time directive in healthcare, as limiting the extra income from high overtime hours was inacceptable for the social partners. The current practice in many hospitals is a high number of overtime (partially also due to labour shortages), additional pay, but at the same time dual time sheets with real hours worked and with those hours that follow the legal limits on overtime.[36] Working time annualization, working time accounts, and other related issues do not apply.
Part-time work in Slovakia is marginal, therefore not subject to collective bargaining or other explicit forms of regulation besides the Labour Code.

- **Flexible working time schedules**

The 2003-2005 collective agreements did not include stipulations on flexible working time. The first stipulation occurs in the 2006 multi-employer agreement between SOZZaSS and AFN SR and stipulates the following: employers, whose operation allows for that, shall implement flexible working time. In practice, this stipulation is too general for governing specific working time flexibility at the workplace. Hospitals operating in a 3-shift mode determine the working time schedules of their employees at the establishment level without union codetermination. Unions monitor working time practices and act upon breach of law or collective agreements.

- **Reduced working time**

Working time reductions do apply in healthcare when compared to general Labour Code stipulations. These are subject to bargaining and have been stipulated in each collective

[36] Source: interview SOZZaSS deputy director, 11 May, 2010.

agreement since 2003. The initial working time reduction from 40 hours to 37,5 hours a week (in a two-shift operation to 36,25 hours, and in a three-shift or non-stop operation to a maximum of 35 hours)[37] has been introduced in the 2003 inter-sector agreement for public service employees. The 2004 agreement re-stated the above stipulation and introduced an additional possibility of working time reduction to 33,5 hours per week for employees who deal with high-level X-ray radiation and ionisation devices. The 2005 agreement re-states the earlier stipulation. The 2006 multi-employer agreements between trade unions and AFN SR and ANS stipulate that work-life balance arrangements at multi-employer level refer to working time adjustments in shift work stipulated in earlier collective agreements. In fact, this re-states the earlier working time stipulation. The 2009 agreements also did not bring any changes in stipulations on working time reduction. Although working time has been a point of dispute during bargaining, the mediator's decision re-states the earlier stipulation.

- **Holidays**

Holiday regulation for public service including healthcare workers does bear specificities when compared to general Labour Code provisions. Holiday provisions are subject to bargaining at the sector level and are part of the substantive agenda of each collective agreement. The 2003 agreement stipulated that public service employees will receive one more week of paid annual leave than the current Labour Code stipulates.[38] The 2004, 2005 and 2006 agreements re-stated the above holiday stipulation. Holiday regulation has been a point of dispute in the 2009 multi-employer bargaining round between AFN SR and SOZZaSS and LOZ. The draft agreement aimed at directly guaranteeing an extra week of holidays beyond the Labour Code provisions. This point of dispute has been solved by an appointed mediator, who re-stated the earlier regulation that extra holidays *can* be agreed in establishment-level collective agreements. The argument behind this decision has been that as holiday regulation is closely coupled with working time regulation, stipulated working time reduction together with holiday extensions can lead to an ineffective workplace management and shortages of skilled employees at all times. A similar situation occurred in bargaining between SOZZaSS and LOZ and ANS. The appointed mediator in the collective dispute decided in line with the Labour Code, which already allows for additional paid leave for healthcare employees. This stipulation is a trade off between holidays and a shorter working week for healthcare employees.

- **Leaves (parental, study, etc.)**

Other forms of leaves are not subject to collective bargaining at sector and inter-sector level. The fundamental governance refers to the Labour Code and related Acts (i.e., concerning parental leave). Additional leaves, i.e., for study purposes, may be agreed individually between the employer and employee.

- **Education and training**

[37] Source: EIRO report, http://www.eurofound.europa.eu/eiro/2002/09/inbrief/sk0209101n.htm, accessed April 15, 2011.
[38] Source: EIRO report, http://www.eurofound.europa.eu/eiro/2002/09/inbrief/sk0209101n.htm and http://www.eurofound.europa.eu/eiro/2002/07/feature/sk0207102f.htm, accessed April 15, 2011.

Education and training has not been subject to collective bargaining prior to 2009. Only the 2009 and latter agreeements, tailored at healthcare personnel, recognize the relevance of on-the-job training. This shift is among others related to the change in legal regulation concerning the qualification of nurses (see below). At the same time, a divergence in stipulations in AFN SR and ANS agreements becomes obvious, because AFN members (large hospitals) have more funds available for supporting education and training. ANS members are on the one hand pushed to support the training of nurses, but do not have the financial means for such measures, which creates disputes with trade unions while bargaining.

- **Rights to training and who decides**

The 2009 agreement between SOZZaSS, LOZ and AFN SR for the first time stipulates employees' education and learning. This relates to the legal change in Slovakia according to which nurses need to extend their education and obtain a university degree. The collective agreement stipulates employer support for lifelong learning and, in particular, support for nurses' education that aims at reaching a university degree in line with legal stipulations. Furthermore, the agreement stipulates the possibility of tax reductions given the costs incurred to an employee for education. This applies only to employees practicing a profession of doctor, nurse, and midwife.

- **Types of training (company-specific skills, broader skills)**

The 2009 agreement applicable to AFN SR members include provisions on education, learning and training. In particular, the agreement stipulates employer support for further education with the aim to acquire *broader skills*. Collective agreements at sector-level do not refer to *establishment-specific skills*. Specific skills are less relevant in healthcare than in other sectors of the economy.

- **Amounts of training**

Trade unions, together with professional associations (SLK and in particular SKSAPA), lobby for more training and education for healthcare workers and employer contributions towards education and training. The reality shows that upon individual decision (not collectively stipulated at the establishment level), particular employers with less financial constraints (mostly faculty/university hospitals) contribute small amounts to nurses' additional education, conference attendance and other forms of lifelong learning. The standard however is that nurses and other personnel cover their expenses for lifelong learning themselves.[39]

Education and training, with its specificities applicable to healthcare, is also subject to collective bargaining at sector and establishment level. The amount of training and the related question of who covers training costs continues to be a point of dispute between employers and trade unions. A mediator's decision following the failure of unions and ANS to conclude a collective agreement after 2006 stipulates a contribution of 30

[39] Source: interview SKSAPA president, 12 May 2010.

Euro/month to lifelong learning for all healthcare personnel. A similar provision also applies to university hospitals affiliated to AFN SR. In the bargaining round leading to the conclusion of the 2009 agreement between SOZZaSS, LOZ and ANS, the mediator's decision stipulates a contribution of at least 30 Euro/month to lifelong learning for healthcare employees that need to be in continuous training/education according to the Law in order to be able to exercise a healthcare profession.

- **Employability programmes**

The healthcare sector does not face the challenge of dismissals or insecurity of employment. Instead, the sector faces the challenge of shortages of qualified personnel, willing to work for the current wage levels and under existing working conditions. Given the relatively stable overall employment,[40] which has been stabilized also during the years of the economic crisis, employability programmes are not relevant for the healthcare sector and are not subject to collective bargaining or other form of regulation. Employability of individual employees is secured through their qualification, experience, and the legally stipulated lifelong learning and additional education, such as the recently implemented university education requirement for nurses.

- **Work organization**

Work organization as such is not subject to collective bargaining at sector and inter-sector levels. Workplace rules refer to the Labour Code and are adjusted to to particular workplaces. Trade unions have a monitoring role and report cases of abuse. The experience shows that unions do not see work organization as a central point of dispute with the employer or an issue on which more bargaining should take place.

- **Polivalency, multi-skilling**

Although not subject to collective bargaining and not part of the substance of sector-level collective agreements, trade unions pointed to the (marginal) informal practice in some hospitals that shifts from one workplace to another workplace, often in different town, have occurred without consent of concerned employees. Employers argue that this is a very rare issue, in fact governed by an individual's employment contract, and is therefore negligible as a substantive agenda for collective bargaining at sector-level. According to the Labour Code, an employment contract needs to stipulate a particular workplace for the employed person.

- **Other issues**

Addressing risk factors at work, including health risks, violence and harassment is subject to regular collective bargaining at multi-employer level. Sector-level multi-employer stipulations between SOZZaSS and ANS, valid from 2006, oblige employers to pay a compensation of 30 Euro/month in case an employee is exposed to health risk factors at

[40] Fluctuations apply to selected professions, i.e., medical orderlys and other lower-grade healthcare personnel because of low wages and to doctors and nurses due to migration.

work, i.e. infection danger. Specific provisions are agreed in single-employer agreements according to particular workplace types.

Next, the 2009 agreement between SOZZaSS, LOZ and AFN SR stipulates, following a mediator's decision, a joint monitoring of safety and health protection measures at workplace. Employers are obliged to elaborate and regularly update rules for health and safety provisions at the workplace and inform trade unions at least once in six months. Trade unions shall monitor and control the implementation of these health and safety provisions.

- **Wages**

Wages are the core of each bargaining at each level and the fundamental provision in each collective agreement. Interviews with social partners suggest that bargaining actually always centres on traditional issues, wages being the most important of them. Disagreement over proposed wage increases has been the most frequent reason for failures to conclude collective agreeements and the need for a mediator in collective disputes since the origins of sectoral bargaining in healthcare. Disputes stem from a disagreement over the % of wage rise, but also from the definition of the base salary, to which rises are negotiated. Whereas employers propose wage rises to the minimum wage entitlements from the Labour Code, trade unions push for wage rises of the standard wage applicable to healthcare personnel.[41]
Since 2005, wages of healthcare personnel no longer follow the Act 553/2003 and are regulated via the Labour Code (see earlier sections of this report) and via multi-employer and establishment-level collective agreements. The peculiar characteristic of wage bargaining in Slovak healthcare is the relevance of both bargaining levels without their closer coordination. Sector-level agreements stipulate a general % of wage rises without referring to particular wage levels of particular employee groups, which are subject to establishment-level bargaining. The large variety of establishment-level agreements and their wage stipulations is not responsive to the sectoral stipulation; instead; often the sectoral stipulations respond to establishment-level regulation without detailed information on the variety of bargaining outcomes at the establishment-level. Some establishment-level agreements stipulate wages according to the Labour Code, others follow wage scales derived from the Act 553/2003 on remuneration of public service employees. Trade unions fight for an equal pay for equal work, but lack knowledge on the wages across the high number and variety of hospitals and other employers in healthcare.

  - **Wage scales**

While covered by public service collective agreements, wages in healthcare followed detailed wage scales, over which bargaining occurred at the inter-sector level. A general and a specific table of wage scales applied, and increases in each have been bargained separately. The trend shows a slowdown in wage growth in the public sector, with the same trend continuing also after 2006 when wages in healthcare were subject to multi-employer bargaining in the sector, in line with Labour Code provisions.

[41] Source: interview SOZZaSS deputy director, 11 May 2010; SOZZaSS Newsletters; relevant collective agreements.

The 2003 agreement stipulated an 8% increase in the basic scale (the so-called 'general table' applicable to all public service employees). Some groups, namely pedagogical employees, also received an increase in their specific scale of salary tariffs. Healthcare workers did not receive an increase in their specific scales.[42] The 2004 agreement stipulates a 7% increase in the general table and 7% in the specific table for some employees, but not healthcare workers.[43] The 2005 agreement stipulates that pay rates (tariffs) for public service employees will increase by 5%, applicable to both the basic scale table and the specific table of pay tariffs. The increase in the specific table also applied to healthcare workers who were not covered by increases in the specific table in earlier years. The 2005 public service collective agreement also includes a 'supplementary memorandum' expressing the social partners' willingness to reach preliminary agreement on pay tariff increases of 6% from 1 July 2006 and 5% from 1 July 2007. For the first time, such a forward-looking approach has been taken in sectoral collective bargaining in the public sector, possibly indicating increasing trust between the partners.[44] The 2006 agreement for public service did stipulate the above 6% increase in both the base tariff scales and the specific tariff scales. However, this increase no longer applies to the majority of public healthcare employees, as they no longer follow remuneration in public service. according to 553/2003. In Spring 2006, new sector-level agreements were signed between unions and respective employers' organizations (ANS and AFN SR), which take over the governance of wages in healthcare through multi-employer and establishment-level collective agreements.

Sector-level bargaining between trade unions and AFN SR after 2006 stipulated the following wage increases in university hospitals (applies both to base wage increases and increases in the individual performance component of wage):

- 10% from May 2006
- 10% from December 2006
- 10% from June 2007 (stipulated in the 2007 amendment)
- 10% from February 2008 (stipulated in the 2008 amendment)

Due to the economic crisis, social partners did not agree on wage increases after February 2008. A mediator's decision stipulated a wage increase in base tariff wages of 2.5% from November 2009 and 2.5% from April 2010.

The 2006 collective agreement between trade unions and ANS, applicable to smaller public hospitals, stipulates a 5% wage increase in each tariff scale (base and motivation component). At the same time, the average wage of an employee in 2006 shall exceed the 2005 level by at least 8%. Employees whose average wage did not reach the stipulated 8%

[42] Source: EIRO report, http://www.eurofound.europa.eu/eiro/2002/09/inbrief/sk0209101n.htm, accessed April 14, 2011.
[43] Source: EIRO report http://www.eurofound.europa.eu/eiro/2004/01/inbrief/sk0401109n.htm and KOZ SR archive http://www.kozsr.sk/?page=./archiv/a23 [accessed 15 April, 2011].
[44] Source: EIRO report, http://www.eurofound.europa.eu/eiro/2005/02/inbrief/sk0502101n.htm [accessed 15 April, 2011].

increase are entitled to a compensation. SOZZaSS and ANS failed to conclude an agreement after 2006, wage disputes being the most important reason. In June 2008, a mediator's decision stipulated an amendment to the 2006 agreement. The only substantive agenda of this amendment is an increase in base wages by 7% from 1 June 2008. Increase in individual performance-related wage component shall be regulated through establishment-level collective agreements. In the subsequent bargaining rounds between trade unions and ANS, the employers' association claimed the invalidity of the existing agreement, while failing to conclude a new collective agreement. Trade unions argue that the reason has been the ANS members' aim to shift the date of wage increases, which is a significant burden on their budgets in the period of crisis. Following almost two years of unsuccessful bargaining, in August 2009 a dispute mediator stipulated two waves of wage increases for healthcare personnel in ANS establishments (4% from September 2009 and 4% from March 2010), financial compensation for uneven working hours in case of shiftwork, overtime and shiftwork premiums beyond the law.

In 2010, a new bargaining round started between trade unions and each employers' association, the main point of dispute again being wage increases. Trade unions request at least an increase reflecting inflation and the growing costs of life, whereas employers aim at freezing wage levels or even some temporary decline in wages (applicable to ANS members) due to the difficult financial situation of smaller hospitals. This proposal is not acceptable for the unions. Therefore, bargaining is still in progress even in 2011 without a clear prospect for signing a new multi-employer agreement soon.

- **Minimum wages**

Minimum wage is governed by Act 663/2007 on the Minimum Wage and its later amendments. A statutory montly minimum wage is 317 EUR for a full-time employment. However, the Appendix to the Labour Code stipulates six levels of occupations according to the job content's difficulty. Minimum wages in each level are calculated through appointed coefficients. This means that in fact Slovakia has six minimum wages, which cannot be lower than the statutory 317 EUR.
Prior to 2011, the legally stipulated minimum wage is not subject to collective bargaining at sector level. Social partners negotiate over legal increases in minimum wage in the tripartite council. However, the proposed new Labour Code, which is currently under revision, aims at abolishing the six occupational levels, thus stipulating a single minimum wage. The Minister of Work, Social Affairs and Family aims at giving more scope to sector-level social partners to negotiate particular minimum wages in respective sectors.[45]

- **Variable pay systems**

The 2006 agreement between SOZZaSS and AFN SR for the first time regulates the wage composition and performance-related pay increases at multi-employer level. In particular, the above-described wage increases applicable to AFN SR employees do not in full refer to base wage increases, but also to increases in variable components of wages. 70% of the

[45] Source: Pravda, article *Minimálna mzda závisí od náročnosti práce* [Minimum wage depends on how demanding the job is], 17 April 2011, in http://profesia.pravda.sk/minimalna-mzda-zavisi-od-narocnosti-prace-fgv-/sk-przam.asp?c=A110417_092311_sk-przam_p01 [accessed 26 April 2011].

stipulated wage increase from May 2006 referred to base tariff wages and 30% to individual performance-related pay. From December 2006, the individual performance-related pay component has further been strengthened via multi-employer collective regulation: it shall comprise max. 40% of the wage and the tariff wage shall be reduced to min. 60% of an employee's wage. To avoid an excessive growth of the performance component only, the 2007 and 2008 amendments to the 2006 collective agreement explicitly guarantee that wage increases do not only apply to the individual performance component of wages, but to the base tariff wages.
The 2009 agreement between SOZZaSS, LOZ and AFN SR stipulates that establishment-level social partner should negotiate and jointly evaluate the possibility to pay benefits and premia to employees. A similar provision is part of the 2009 mediator-stipulated agreement with ANS; however, in this case it is specified in the following detail: employers will negotiate with trade unions over the financial results in year 2009 and jointly evaluate whether extra bonuses can be paid to employees in the month of December 2009. Such bonuses should be 50% of current base wage of each employee.

Next, multi-employer collective agreements explicitly regulate also other types of variable pay. The 2006 agreement between SOZZaSS and AFN SR stipulates overtime payments and extra payments for night work, shift work, work during public holidays and work in difficult or dangerous conditions (i.e. potential danger for the employee's health). In contrast, the 2006 agreement between SOZZaSS and ANS only stipulates extra payments for work during public holidays. The agreement does detail wage supplements for overtime, night work, shift work, etc.; however, these stipulations are not binding at the multi-employer level. Instead, the agreement encourages overtime payment stipulations to be addressed in establishment-level collective agreement. This provision has been changed in the 2009 agreement, where overtime payments, payments for shiftwork, work during weekends and during nights is stipulated in detail upon the mediator's decision.

- **Opening or hardship clauses allowing for reduced payments in situations of economic difficulties**

Existing collective agreements at the sector-level do not include opening or hardship clauses. All provisions are binding either upon an agreement of social partners or upon the mediator's decision. In the ongoing 2010-2011 bargaining round, employers (ANS) request reduced payments due to economic difficulties, which can be seen as a hardship clause proposal. However, trade unions do not agree with this proposal and bargaining is still in progress.

- **Scope for employee choice between current income (wages) / deferred income (pensions) / time (more holiday)**

A trade off between wages, pensions and holidays has not been subject to collective bargaining or direct regulation by law or collective agreements at the sector level. The 2009 agreement between SOZZaSS, LOZ and AFN SR for the first time includes a provision that employers, under the support of trade unions, grant conditions for work-life balance of employees. Particular details should be subject to regulation in establishment-level collective agreements.

SOZZaSS did report a few cases of establishment-level bargaining, in which employees preferred wage increases to deferred income (pension contributions by employer).

- **Retirement**

Next to wages and working time, retirement-related provisions belong to the most important substantive bargaining agenda in Slovakia. Obligatory pension contributions, stipulated by law, are in greater detail governed via sector-level collective agreements.

- **Retirement age**

The retirement age is part of a complex legal regulation of retirement age, pension insurance schemes and related entitlement. It is not subject to collective bargaining.

- **Pre-pension arrangements**

From among the analyzed collective agreements, only the 2006 inter-sector collective agreement for public service (applicable to healthcare workers only until specific sector-level agreements have been signed in May/June 2006) includes a stipulation on pre-pension arrangements. The agreement stipulates that upon the first termination of an employment contract after being entitled to old age pension, reaching the pre-pension age or being entitled to invalidity pension, the employer shall provide the discharge benefit of at least one month's pay above the general Labour Code stipulation.
The 2006 sector-level agreement between SOZZaSS and AFN SR takes over this provision from the public sector.

- **Pension provisions – supplementary pension schemes**

By law, employers are obliged to contribute to their employees' pension provision. Particular details of these contributions, especially employer contributions to supplementary pension schemes, are an important part of collective bargaining. The law stipulates obligatory contributions to supplementary pensions for employees practicing occupations clustered in particular risk groups; however, healthcare unions strive to achieve the same contributions also for employees not classified in these risk groups. The developments in collective regulation of pension contributions are summarized below.
The 2003 collective agreement for public service laid down the supplementary pension insurance contribution to be at least 2% of wage of public servants, including healthcare workers. This stipulation has been explicitly re-stated in the 2004, 2005 and 2006 collective agreements for public servants.[46] The agreements also explicitly states hthat contributions to supplementary pension of employees in high-risk groups are at least 2% of these employees' wages. Between 2003-2006, employees covered and the conditions for

[46] Source: EIRO reports http://www.eurofound.europa.eu/eiro/2002/09/inbrief/sk0209101n.htm, http://www.eurofound.europa.eu/eiro/2004/01/inbrief/sk0401109n.htm and http://www.eurofound.europa.eu/eiro/2005/02/inbrief/sk0502101n.htm [accessed 16 April, 2011].

making contributions remained unchanged. Elaboration of contributions to supplementary pension insurance has been subject to establishment-level collective bargaining.

The 2006 sectoral agreement between SOZZaSS and AFN SR stipulates that particular employers (AFN SR members) shall sign a contract with a selected pension insurance provider. Stipulations about particular employers' contributions to employees' pensions shall be subject to agreement in establishment-level collective agreements. In the 2009 agreement, stipulations on supplementary pensions have been a point of dispute, leading to the following mediator's decision: employers employing workers in the high-risk groups are obliged to sign a contract with a supplementary pension provider if not yet bound by such a contract. The amount of contributions shall be 2% of these workers' wages, but a higher amount may be agreed in establishment-level collective agreements. Through this stipulation, the mediator re-confirmed the earlier stipulation applicable to public servants, which means that although healthcare is no longer covered by public service inter-sectoral agreeements, these continue to be an important benchmark for particular provisions in healthcare-specific collective agreements.

The 2009 collective agreement between trade unions and ANS stipulates a 2% contributions for workers in the risk groups 3 and 4 (same as stipulations applicable to AFN SR members and public service) and a 1% contribution of workers in the risk groups 1 and 2. The employer is not obliged to pay these contributions if the employee refuses to sign a contract with a supplementary pension provider. In fact, trade unions do report a few cases where employers preferred wage increases to supplementary pension contributions. This has been the case in smaller hospitals that are ANS members, with generally lower wage levels.

- **Others, i.e., greening the workplace, gender equality**

Such issues are not subject to bargaining or other explicit form of regulation. The interviewed trade union representative claimed that Slovakia is lagging behind Western European countries in the governance of similar issues, including ecological workplaces and gender equality.

## 5.2 HORIZONTAL ISSUES IN BARGAINING OUTCOMES

- **Explicit linkages/trade-offs between different policies (e.g. trade-offs between certain types of flexibility and security; between employment guarantees and concessions in terms of wages or working time, etc.)**

Working time and holiday provisions in the 2009 agreements between SOZZaSS, LOZ and AFN SR and SOZZaSS, LOZ and ANS can be considered as a trade-off between reduced working time and more holidays. To avoid shortages of workers at workplace due to reduced working time *and* an extra week off in a year, the appointed mediator in the unions' dispute with AFN SR decided that the agreement shall only regulate working time, whereas more holidays are subject to regulation in establishment-level agreements. In the unions' dispute with ANS, the mediator decided that the holiday regulation shall follow the standard Labour Code provisions applicable to healthcare employees.

Another trade off in collective agreement provisions refers to the increase of base wages vs. overtime regulation (amount of overtime as well as overtime premia). Especially LOZ gave up on increases in base wages in order to keep an important and secure source of income for doctors from a high amount of overtime work. Various informal practices exist at the establishment level to maintain the possibility of overtime even beyond the maximum legally stipulated amount. This happens, e.g., by signing employment contracts with several employers (the maximum overtime regulation referrs to *one* employer), or dual working time sheets in hospitals.

Finally, pressures for trade-offs apply to pension contributions by employer. Trade unions reported a few cases of establishment-level bargaining, in which employees would prefer wage increases over pension contributions.

- **Explicit life-course approaches integrating measures over time**

The 2009 agreement between SOZZaSS, LOZ and AFN SR for the first time stipulates that employers (AFN SR members) will create feasible conditions for employees' work-life balance. This shall happen with support of trade unions and the details shall be agreed at the establishment-level. Although not an elaborated life-course approach, this development suggests a shift in the content of sector-level collective agreements in Slovakia that generally cover only a small number of traditional bargaining issues (wages, working time, meal contributions, relationship between social partners, contribution to the social fund and pension schemes, trade union membership fees).

- **Different treatment of different groups determined by age, contract, education, establishment, etc.**

The 2009 agreement between SOZZaSS, LOZ and AFN SR for the first time stipulates non-discrimination: employers (AFN SR members) must follow the principle of equal treatment to employees in their access to employment, training and learning as well as other employment conditions. A specific wage-related stipulation states that employees cannot be discriminated against in wages; and equal wage for equal work applies.

- **Measures anticipating / addressing restructuring**

Restructuring per se with implications for collective bargaining provisions and flexicurity/security in employement is not directly an issue in Slovak healthcare. Restructuring does however refer to the ongoing transformation of hospitals' organizational forms, which does bear consequences for sector-level collective bargaining. In particular, hospital transformation onto shareholder companies shall motivate their market-oriented behaviour and effective management. As employers would be less protected by state measures in case of indebtedness, such restructuring may further harden bargaining about wages, which has anyway been the most difficult bargaining issue since 2003.

- **Crisis-induced measures to ensure business survival**

The main point of dispute in collective agreements after 2006 is the wage rise issue. Employers argue that their funds are limited because of the crisis, although the crisis impact on healthcare is indirect.[47] To cope with the crisis, all mediator-stipulated decisions over collective disputes refer to a lower wage increase as initially proposed by trade unions; and a shift in time period from which wage increases shall be implemented.
These disputes derive from differing perspectives of sector-level social partners on wage rises. Whereas trade unions see remuneration in healthcare, regardless of recent collectively stipulated wage increases, not satisfactory, employers consider working conditions in healthcare in the crisis situation above-standard because of stable employment relations, no crisis-induced dismissals, and at the same time wage growth.[48]
In the 2011 bargaining round, ANS even proposed a collectively stipulated base wage reduction by 2% given the difficult financial situation of smaller hospitals. This proposal in not acceptable for trade unions. Bargaining is still in progress.

## 5.3 INTEGRATIVE AND DISTRIBUTIVE OUTCOMES

- **Extent to which negotiations on substantive issues above are seen as deliberative (zero-sum) and/or integrative (positive sum)**

Bargaining on the above substantive agenda is seen as deliberative. In recent years, a conclusion of an agreement has been increasingly difficult, with bargaining stretching over 1,5 years and ending in a collective dispute solved by an appointed mediator. The engaged partners, especially trade unions, were to some extent disappointed by the mediator's stipulations. Therefore, negotiations and their results are deliberative. However, from an analytical point of view, the fact that wage increases satisfy employees and at the same time increase their motivation, commitment and attachment to a particular employer, can also be interpreted as an integrative outcome of bargaining with benefits to both the employer and the employee. The fact that sector-level and establishment-level bargaining are well established and regularly exercised in the public healthcare sector in Slovakia can also be seen as integrative for the social partners and for the reinforcement of collective regulation of employment issues.

- **Balance between integrative and distributive elements in agreements involving explicit linkages / trade-offs**

Particular agreements do not contain explicit linkages or trade-offs. The only exception is the mediator-stipulated regulation on paid leave, confirming earlier regulation and supporting the stipulation with an argument that healthcare workers already enjoy a shorter working week, therefore shall not obtain additional paid leave beyond earlier collective stipulations. This issue can be seen as distributive, because the trade off between paid leave and working time regulation brings a compromise between employers and trade unions, rather than an improvement in overall working conditions, employee motivation, flexibility and sustainable job security.

[47] Crisis affects the state budget, which allocates less funds for health insurance companies and freezes the amount of paid health insurance premia for state-insured persons. In consequence, health insurance companies allocate less funds to particular hospitals.
[48] Source: Interview AFN SR president, 13 May, 2010.

- **Which have been the most difficult issues over which to reach agreement?**

Wages continue to be the major point of dispute and the most difficult issue over which social partners negotiate. Almost all disputes in bargaining, which had to be solved by an appointed mediator, referred to differing interests of social partners regarding the increase of wages.

- **Are gender implications identified, and if so how addressed?**

Explicit gender implications are not identified; however, the 2009 sector-level agreement between SOZZaSS, LOZ and AFN SR for the first time includes a provision on non-discrimination based on gender.

- **Which issues have had created difficulties in reaching a common position on the employer side?**

Since 2006, the structure of Slovak healthcare accounts for a clear delineation of employer organisations' operational domains. Therefore, no direct competition between them applies and each employers' association bargains with unions individually. The relationship between the two associations is formal, resembling a non-agression pact rather than true cooperation.[49]
In 2005, difficulties in finding a common position on the employer side escalated (given the different financing and preferential treatment of larger hospitals). This resulted in splitting the single employers' association into two associations of hospitals (AFN SR and ANS), which bargain individually with unions from 2006.

- **Which issues have had the potential to undermine solidarity on the trade union side?**

Wage issues do have a potential to undermine solidarity on the side of unions. However, this would happen only if varying stipulations for physicians and for other healthcare personnel would be part of collective agreements. Sector-level (multi-employer) agreements stipulate only a general % of increase in base wages and performance-related component in wages for all healthcare workers. Therefore, in sector-level bargaining, trade unions do cooperate to some extent, althouth their fundamental aims and approaches to problem solving differ (see earlier sections describing trade unions).

Another issue that has a potential to undermine union solidarity is overtime regulation (regulating the amount of overtime as well as overtime payments). Overtime work is limited by law, but at the same time paid better than standard working time. Especially in smaller hospitals, doctors work many overtime hours due to shortages of employees. At the same time, overtime payments are a source of extra salaries. This fuels a discrepancy in union goals: whereas SOZZaSS (representing mostly lower-grade healthcare personnel but also doctors) was pushing for base wage increases, LOZ (representing exclusively doctors) traded base wage increases for more overtime work.

[49] Source: interview ANS president, 8 July 2010.

## 5.4 TRENDS AND CHANGING INTERFACE OF COLLECTIVE BARGAINING WITH OTHER MODES OF GOVERNANCE

- **Has inter-sector/sector regulation via collective bargaining of flexibility and sustainable security broadened / narrowed / stayed the same in terms of the scope of the agenda?**

Key substantive issues over which bargaining happens remained the same since 2003. These include wages, working time, pension contributions, dismissal payments, social fund contributions. Some broadening of the scope in agenda is obvious from 2009, mainly in the following provisions:

- non discrimination - equal access to training, learning, employment
- creating conditions for work-life balance
- stipulations on lifelong learning
- performance-related pay component of wages and increases in this component

Agreements signed by AFN SR are seen as most progressive from the point of view of broadening the scope of the bargaining agenda.

- **Has company-level regulation via collective bargaining of flexibility and sustainable security broadened / narrowed / stayed the same in terms of the scope of the agenda?**

Given the slight broadening agenda of sector-level (multi-employer) agreements and the fact that these agreements give increasingly more room for governance via establishment-level collective agreements, it can be deduced that flexibility and security-related provisions are increasingly subject to bargaining at establishment level. It is in particular the new kind of provisions on non-discrimination, work-life balance, access to training, performance-related pay, in which sector-level agreements stipulate that regulation shall happen via establishment-level collective agreements.

- **In the absence of inter-sector / sector bargaining on flexibility and sustainable security, have company level collective agreements become more widespread / less widespread / neither?**

Not applicable to Slovakia, because sector-level bargaining is equally important as establishment-level bargaining in healthcare.

# 6. Industrial relations at tripartite level – flexibility and security as part of substantive agenda of tripartite negotiations and peak-level social partners' goals

## 6.1 FLEXICURITY AS A SUBSTANTIVE AGENDA IN TRIPARTITE NEGOTIATIONS[50]

[50] This section draws on a content analysis and keyword search of all tripartite sessions taking place in Slovakia since 2001. Summary notes on each tripartite session are available (in Slovak) at the HSR website

Slovakia is a country with a functioning tripartite-level social concertation within the tripartite Economic and Social Council of the Slovak Republic (*Hospodárska a sociálna rada, HSR*).[51] The council serves as an advisory body to the government, consisting of governmental representatives, representatives of trade unions (the single peak federation KOZ SR), representatives of employers (two peak employers' associations: AZZZ SR and RUZ SR), and representatives of the Federation of cities and municipalities (ZMOS).

The tripartite Economic and Social Council has covered the issue of flexibility/security in several negotiation rounds between 2001-2010. Between 2001 and the spring of 2008, social partners have addressed flexibility and security issues almost exclusively within the debates of Labour Code amendments. These debates focused, e.g., on more flexible hiring and firing (external flexibility) rather than on a substantial debate on flexicurity and the inclusion of flexicurity provisions into the regulation of formal employment contracts. The Ministry of Labour, Social Affairs and Family (MPSVR) brought the *"EU Green Book on modernisation of the Labour Law with the aim of meeting the challenges of the 21st century"* into discussion during the meeting of April 28th 2008. Social partners discussed the definition of flexicurity as an "integrated approach where both flexibility, social security and protection of employee are granted; there is no universal model which could be applied in every state."[52] In the same meeting, the HSR agreed to launch a working group in order to produce a document on flexicurity by the end of September 2008. This document would serve as the basis for further discussions on flexicurity within the HSR. The strategic aim of this process (working group, document and further discussions) should have led to creating a *"National System of Flexicurity"*.

In august 2008, all previous action was stopped on the initiative of MPSVR, which suggested to include the flexicurity agenda into the *"National program of reforms"*[53]. Representatives appointed by tripartite-level social partners would be part of the steering team and expert teams for the implementation of the *"National system of flexicurity"*[54]. Upon an agreement of social partners, MPSVR was preparing the *"National system of flexicurity"* based on the operational program *"Employment and Social Inclusion"*. Following a country-specific advice of the EC to Slovakia, the *"National system of flexicurity"* sets its strategic goals mainly in lifelong learning and a reform of education (primary, secondary and tertiary) to better align employee skills with labour market demands. Another goal has been an improved access of unemployed to jobs.

In 2009, the Education Centre of MPSVR launched a call for a monitoring project on Slovakia's preparation for the National System of Flexicurity. As part of this project, in

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http://www.vlada.gov.sk/2802/zaznamy-z-rokovania-hospodarskej-a-socialnej-rady.php. Evidence selected for this session is limited to the substantive agenda relevant for flexibility and security.

[51] Transcripts from meetings of ESCSR: http://www.vlada.gov.sk/2802/zaznamy-z-rokovania-hospodarskej-a-socialnej-rady.php?page=0 [accessed May 3, 2010].

[52] Transcript of the ESCSR meeting from April 28th 2008: http://www.vlada.gov.sk/7053/zaznam-z-plenarneho-zasadnutia-hospodarskej-a-socialnej-rady-slovenskej-republiky-konaneho-dna-28-4-2008.php [accessed May 3, 2010].

[53] National program of reforms 2008-2010: http://www.minedu.sk/data/USERDATA/EUZAL/LSaNPR/NPR_2008-2010.pdf [accessed May 3, 2010].

[54] Report on the National System of Flexicurity: http://www.rokovania.sk/appl/rhsp.nsf/0/90D462E2EF0CFF23C1257435003F15A6/$FILE/Zdroj.html [accessed May 3, 2010].

2009-2010, several organizations (i.e. the Law Faculty of Trnava University and Trexima s.r.o.) elaborated reports monitoring the legislative situation a social security system in Slovakia from a flexicurity perspective. This contributed to the *Proposed Action Plan for the Implementation of the National System of Flexicurity*. The project was funded by the operational program Employment and Social Inclusion of the European Social Fund.

- **Transposition of the national flexicurity agenda and preparatory action into the tripartite council**

On December 4th 2009 HSR officials agreed on debating the *"National system of flexicurity"* in 2010. However, the HSR agenda in 2010 excluded this point[55]., excluding the debate on the National System of Flexicurity. On April 30th 2010 in a press release in the Slovak Press Agency the Minister of Labour, Social Affairs and Family, Viera Tomanová[56], admitted that the government failed in creating the *"National system of flexicurity"*, referring to global economic crisis and high demands on putting such types of systems into practice as reasons for the failure.

The HSR negotiation agenda for 2011 does not include the National System of Flexicurity; however, the National Program of Reforms is scheduled for a debate in Spring 2011 (March and April). Two other HSR meetings in Autumn 2011 shall handle issues that are directly or indirectly related to flexicurity: the *Strategy on Lifelong Learning* and the update to the *National Action Plan for Gender Equality.*

- **Overview of laws affected by and/or referred to during the tripartite flexicurity debate**

- Act 5/2004 on employment services and its amendments
- Draft Act on regional development support
- EC Directive 1997/81/ES from December 15th 1997 (framework agreement on part-time work)
- EC Directive 1990/70/ES from June 28th 1999 (framework agreement on temporary work)
- Act 311/2001 (the Slovak Labour Code) and its later amendments

[55] Due to parliamentary elections in June 2010, the HSR agenda has initially been set only for January-June 2010. After the elections and change in government, the agenda for the second part of 2010 for HSR meetings has been set

[56] News Agency of the Slovak Republic: http://www.tasr.sk/25.axd?k=20100430TBB00590 (viewed on May 3rd 2010)

## 6.2 APPROACHES OF PEAK-LEVEL SOCIAL PARTNERS TO FLEXICURITY

Acknowledging that flexicurity remained outside the main points of interest in the tripartite council, the author interviewed representatives of KOZ SR, AZZZ and RUZ involved in the HSR in order to obtain evidence on the approach that each partner adopted on flexicurity. Slovak trade unions do use a Slovak translation of the term 'flexicurity', introduced by the Secretary of State to the Ministry of Labour, Family and Social Affairs within the National Flexicurity Plan. Employers' associations do not accept the Slovak translation of the term 'flexicurity' and argue that flexibility and security are two distinct concepts that cannot be merged. Approaches of particular organizations help evaluating to what extent flexicurity is a priority in trade unions' and employer associations' agenda; and helps understanding the overall context of flexicurity debates in Slovakia, especially the lack of interest in placing flexicurity into the spotlight of debates within the tripartite council. The next section presents the approaches of peak-level organizations to flexicurity.

- **Trade union confederations' (KOZ SR) approach to flexicurity**[57]

KOZ SR does not directly participate in collective bargaining on flexicurity measures, neither is actively involved in flexicurity-related policies. KOZ SR regularly monitors the activities of European bodies in the issue of flexicurity, in order to follow the 2006 call of the European Commission that member states should pay attention to balancing flexibility with security of employees. KOZ SR's involvement in shaping flexicurity measures in Slovakia remains indirect: flexicurity is predominantly discussed in a broader context of Labour Code amendments in the tripartite council. KOZ SR advisors participate in a working group on flexicurity, which prepares internal documents for the HSR. Nevertheless, attention that social partners in HSR paid to flexicurity remained marginal, as presented above. The only exception and evidence on KOZ's approach to flexicurity is a written document, elaborated in April 2010, on KOZ SR's approach to flexicurity. The summary of this document is presented below.

- **General trade union attitudes towards flexicurity, its context and its implementation in the labour market**

- Flexicurity shall be viewed/monitored in the context of global labour market developoments. The Slovak labour market cannot be separated from challenges that labour markets face in a broader context.
- Legal regulation is especially important in shaping the character of working conditions within the EU and global context. EU should not foster a competitive advantage of low wages, but of diversified quality production. Legal regulation is central for achieving this aim and accordingly implementing flexicurity provisions in EU member states.
- A greater exposure of workers to international challenges and their increased vulnerability is also crucial for understanding the context in which flexicurity shall be implemented.

[57] This section is based on the interview with KOZ SR's advisor for social partnership in HSR (interviewed on 3 May 2010) and Ondruška (2010).

- KOZ SR presents its critique of precarious work despite the fact that flexible labour markets have brought employment growth.
- KOZ SR agrees with the statement that no single solution is feasible for all member states; rather, each member states should adjust/develop flexicurity tools to particular labour market conditions.
- KOZ SR claims that the discussion on flexicurity shall not be limited to external flexibility, i.e., flexibility of employment contracts, its legal regulation and labour market tools. KOZ SR argues that flexicurity shall be considered as a complex matter, covering a variety of dimensions, in order to create win-win situations for all involved parties, namely, achieving a balance in the rights/obligations of employees and employers. More attention should be given to internal flexibility – especially working time flexibility over longer periods of time (i.e., working time annualization) and functional flexibility.

- **Trade union attitudes to institutional underpinning of flexicurity**

First, KOZ SR points to the necessity of revising/adjusting the system of workplace protection and the related institutions/process of collective bargaining, in order to introduce a balance between flexibility and security in all forms of employment contracts (including precarious work). KOZ SR believes this is important in the context of solving segmentation between different employment forms.
Second, KOZ SR finds important to elaborate additional tools to support job mobility from less attractive to attractive workplaces.
Third, KOZ SR fosters a strengthening of legal stipulations and transparency in rights/obligations for employers and employees, which should improve the implementation of labour law
Fourth, KOZ SR appeals to follow the Directives of the European Commission, in particular those that resulted from a general agreement of EU-level social partners
Fifth, KOZ SR supports work-life balance that shall contribute to an effective use of European workers' potential
Sixth, the discussion/dialogue on flexicurity needs to develop in an environment of institutional trust where each party is ready to bear responsibility for relevant policies and their implementation

- **Trade union attitudes towards flexicurity as a topic in collective bargaining**

KOZ SR maintains that the fundamentals for a successful implementation of any flexicurity model is a welfare state that is able to guarantee a high degree of social protection, together with a stable and transparent legal framework for collective bargaining and social dialogue. The legal framework should motivate social partners to contribute to the flexicurity project and to engage in fruitful bargaining about the use of flexicurity tools. In bargaining about flexicurity, KOZ SR maintains that the dialogue should be extended in three directions:

- First, it is necessary to strengthen the role of social partners in the discussion on flexicurity and in bringing about labour market reforms in general. Social partners should have more opportunities to debate, influence and take on responsibility for defining and shaping flexicurity measures and their implementation.

- Second, greater attention should be paid to gender differences in the bargaining process
- Third, trade unions support the process of exploring alternative processes (?) that help supporting employability, lifelong learning, improvement in productivity and innovativeness

All of the above requires a tighter link between the flexicurity debate and social dialogue and collective bargaining processes in general at all levels in EU member states.

- **KOZ SR's note on particular types of flexibility in the flexicurity context**

KOZ SR in principle supports selected forms of flexibility, but only if particular measures derive from collective bargaining, and if flexibility is implemented in a legal context that provides for a high level of job security. In particular, KOZ SR supports internal flexibility as an alternative to external flexibility. However, it is important to define the dimensions of flexibility accordingly, because if internal flexibility is too high it may yield a degradation of working conditions, increase of uncertainty, and barriers between harmonizing employees' work with leisure.

In internal flexibility, KOZ SR fosters an extension of time periods, in which working time is defined. Instead of weekly working time, the law and/or collective agreements should introduce working time flexibility arrangements over periods beyond a standard working week, which should also benefit the employer by increasing labour productivity and thus competitiveness of firms. Next, KOZ SR fosters lifelong working time flexibility, or in other words, flexible arrangements over the entire career of an employee in order to coordinate work and leisure. Forms of such arrangements are, e.g., working time accounts, working time annualization, workplace agreements over flexible working time, parental leave, paid leave for education and training, and flexible contracts.

Next to internal flexibility, KOZ SR also fosters functional flexibility through workplace mobility; in particular, through broadening the work content of particular employees. Functional flexibility can only be effective if implemented in stable and decent employment conditions, where employees share the responsibility for firm performance and cooperative forms of work, i.e. teamwork, is fostered. Functional flexibility that will balance the rights and obligations of workers and employers requires continuous learning and a functioning infrastructure of training and lifelong learning. Functional flexibility shall also be a key point in collective bargaining, where social partners should together balance the needs of employers and their employees; and define the appropriate wage levels given the increasing skills of employees.

- **Flexicurity in the agenda of employers' associations**

Both employers' associations, AZZZ and RUZ, remain critical of the flexicurity concept as such, of its transposition across EU countries across different institutional domains, as well as of the current state of flexicurity debates in Slovakia, in particupar, in the HSR. At the same time, AZZZ and RUZ differ in their approach to flexicurity, in particular, in whether such a concept is useful and desired in the Slovak labour market. AZZZ does find flexicurity useful as a concept, but claims that the current institutional, financial, legal and cultural context in Slovakia is immature for implementing a wide ranging set of tools that would yield the desired level of flexicurity. In contrast, RUZ claims that flexicurity is a

problematic concept, with a problematic operationalization, which the Slovak labour market does not even need and is not prepared for.

AZZZ is a long-existing employers' association participating in HSR. AZZZ is in principle not against the flexicurity concept, or in other words, does not adopt a straightforward negative approach to flexicurity as RUZ does. AZZZ finds flexicurity a useful concept, which could be implemented directly through Labour Code provisions and not necessarily with trade union involvement. However, AZZZ remains skeptical of flexicurity's implementation in the Slovak conditions, arguing that operationalizing flexicurity and implementing flexicurity measures would be meaningful only if more jobs would be available in the Slovak economy. Second, AZZZ does not find the Slovak labour market prepared for implementing flexicurity measures and argues that the transposition/implementation of flexicurity is possible (if possible) only in the long run.
As for flexibility measures, AZZZ finds several forms of flexibility useful. First, it is financial flexibility in form of variable pay depending on employees' motivation, commitment and productivity. Second, internal flexibility in terms of working time, where employees would have the choice to work more if desired. Currently many blue-collar workers work in second jobs in the informal economy parallel with their standard employment in the formal economy; therefore AZZZ does not find a limitation in working time stipulated by the Labour Code as a solution for maximum working time regulation. Third, AZZZ argues for a lowering of payroll taxes, which would yield more jobs in the economy as a precondition for external flexibility and for giving employees more choice for switching between jobs. Finally, AZZZ finds on the job training and lifelong learning as positive tools for both employers and employees, but argues that employers should be more motivated for creating conditions for training/learning, i.e., through tax bonuses or similar measures. The current legal system is unsatisfactory for supporting employers to a desired extent in training/learning initiatives; therefore, employers have to find individual means how to provide training in the current legally hostile conditions.
AZZZ also takes a particular approach to security. Questioning the concept of security, AZZZ argues that security is not an alone standing concept, but is closely related to public finance. Any operationalization of security should question the link between security and public finance. Security should be responsible and sustainable, or in other words, should not place too high burdens on public finance in a long-term perspective. AZZZ also views security as related to flexibility: security is only possible in a highly flexible labour market, where security means high job mobility derived from high external flexibility and enough available jobs.

RUZ is a young peak-level employers' organization. Although RUZ participates in the tripartite HSR, it remains highly critical of tripartism, arguing that industrial relations and social dialogue should be anchored at the company level, where discussions/negotiations can yield real results. In contrast, RUZ argues that tripartism in its current form is merely a façade for negotiations, because the scope of action of HSR is set in a way that HSR only discusses laws that have already been prepared or even approved. The perspective of RUZ on a functioning tripartism is that HSR would bring solutions to particular problems of particular sectors in depth, i.e., by creating specialized committees that would work out real solutions, instead of discussing merely legal regulation.

RUZ remains positive about particular forms of flexibility. Related to that, RUZ is highly critical of the current labour regulation, which hinders the extent of flexibility that RUZ considers to be optimal for both employers and employees. First, RUZ criticizes regulation for being too rigid and not allowing a desired degree of external and internal flexibility in the labour market (e.g., for job seekers to find jobs or to work as many hours as individuals would wish). RUZ argues that the labour market should be more regulated by market forces itself, and the demand for and supply of labour would serve as a cristalizing mechanism for setting moral standards in employment relationships and keep unserious employers out of the labour market. Second, RUZ opposes minimum wage and argues for more financial flexibility and solidarity in an employment relation without external pressures (e.g., in successful times, employers should share their profits with employees, but in difficult times, employees should accept lower wages). Third, RUZ supports employability and multiple skills of employees in order to flexibly move between jobs. For this, training and lifelong learning is essential. RUZ claims not to have capacities for security such training/learning for members' employees. At the same time, RUZ criticizes trade unions for too little attention and activities to secure a desired level of employability of workers. In sum, RUZ supports the increase of flexibility, but is unclear about which institution/organizations shall have enough power to implement and monitor flexibility measures in the Slovak labour market.

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