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Wage-setting in the Hospital
Sector

**James Buchan,
Ankit Kumar,
Michael Schoenstein**

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**DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
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WAGE-SETTING IN THE HOSPITAL SECTOR

James Buchan*, Ankit Kumar and Michael Schoenstein

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Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs

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ABSTRACT

This paper examines wage setting mechanisms for health workers in hospitals across eight different OECD countries. It describes similarities and differences and how fixed or fluid these approaches have been in recent years through health system reforms, labour market dynamics and economic pressures. Based on a review of grey literature and expert interviews with officials from the covered countries, it finds that prior to the economic downturn, several countries had signalled a shift to more local and flexible wage setting in the hospital sector but this ambition does not seem to have been realised in full for public sector hospitals in most OECD countries. Fiscal pressures have led to some “recentralisation” of wage setting, particularly in France, Portugal and the United Kingdom. While the extent of centralisation has been a question of considerable debate, the countries covered in this paper suggest that the benefits of centralised and/ or co-ordinated wage setting generally appear to have been given more attention by policy makers. The current research base on the effectiveness of different wage setting approaches is limited. Policy-making would benefit from developing a better understanding of the impact of wage setting on improved hospital performance and quality.

RÉSUMÉ

Ce document analyse les mécanismes de détermination des salaires des agents hospitaliers dans huit pays de l’OCDE. Il décrit les similitudes et les différences entre ces mécanismes et évalue la capacité d’adaptation dont ils ont fait preuve ces dernières années face aux réformes des systèmes de santé, à la dynamique du marché du travail et aux pressions économiques. Il ressort d’un examen de la documentation parallèle et d’entretiens menés avec des experts des pays concernés que si, avant la crise économique, plusieurs pays de l’OCDE avaient annoncé que la détermination des salaires dans le secteur hospitalier allait être plus locale et flexible, la plupart d’entre eux semblent ne pas avoir complètement atteint ces objectifs dans les hôpitaux du secteur public. Les difficultés budgétaires ont en effet contraint à une « recentralisation », notamment en France, au Portugal et au Royaume-Uni. L’intérêt de la centralisation fait l’objet d’un large débat, mais dans les pays couverts dans ce document, il semblerait que les décideurs mettent généralement en avant les avantages de la centralisation et/ou de l’harmonisation de la détermination des salaires. La base de recherches sur l’efficacité des différentes approches est actuellement limitée et le processus décisionnel gagnerait à meilleure compréhension des effets de la détermination des salaires sur l’amélioration de la performance et de la qualité des hôpitaux.

EXECUTIVE SUMMARY

1. This paper on wage-setting in the health sector was prepared by the OECD Secretariat at the request of the Health Committee. The paper examines wage setting mechanisms for health workers in hospitals across different OECD countries, from a system level perspective. It seeks to describe similarities and differences and to assess how fixed or fluid these approaches have been in recent years through health system reforms, labour market dynamics and economic pressures. The paper differs from most published work on pay and wages in the health sector which tend to examine the impact on individual worker behaviour and their responses.

2. The principal aim of this paper is to provide an overview of current approaches to wage setting in the hospital sector for eight OECD countries. Descriptive information about wage setting has been coupled with a brief summary of recent dynamics, based on interviews with country based officials. The focus on hospitals is pragmatic. For many countries, these are the institutions where doctors and nurses are more likely to be salaried, and account for the main component of health spending on labour. An effort has been made to describe non-salary financial payments where these are significant, though this paper focuses on the dominant approaches and is not exhaustive in covering all sources of payment to doctors and nurses.

3. The eight OECD countries covered are Canada, France, Germany, the Netherlands, New Zealand, Norway, Portugal and the United Kingdom. The information in this paper has been compiled from academic and administrative sources, grey literature and by interviews with expert contacts from five countries (France, the Netherlands, New Zealand, Norway and Portugal). In examining these countries, the paper seeks to address three questions. The first is to determine who the key actors are in wage setting negotiations for hospital staff, and the extent to which this differs from approaches in the overall economy. Secondly, the paper reviews the level(s) at which wages are negotiated (e.g. government, geographic, skill based). Thirdly, the paper compares the extent to which decisions on wages are made at the same level as recruitment decisions for the public hospital sector (an area in which the 2013 wave of the OECD Health System Characteristics Survey provides some new data). The paper finds that:

- Prior to the economic downturn, several countries had signalled their intention to shift to more local and flexible wage setting in the hospital sector. This ambition does not seem to have been realised in practice or in full for public sector hospitals in most countries.
- Fiscal pressures have led to some “recentralisation” of wage setting, particularly in France, Portugal and the United Kingdom. It is too early to say if the suspension of “normal” wage setting processes will endure, but the natural experiment provided by the crisis suggests that centralised wage setting can be an important tool for government at times of fiscal constraint.
- While the extent of centralisation has been a question of considerable debate, the countries covered in this paper suggest that the benefits of centralised and/ or co-ordinated wage setting - simplicity, scope for co-ordination and centralised control, limited need for local management capacity, scope for transparency and pay equity - generally appear to have been given more attention by policy makers.

- Irrespective of economic conditions, differences in wage setting at the economy-wide level and in the health sector suggest that this is an area that warrants further research. Achieving a more effective alignment between wage setting mechanisms and health system performance objectives could help improve efficiency.
- The current research base on the effectiveness of different wage setting approaches in the health sector is extremely limited. There is an obvious policy benefit to developing a better understanding of the impact of wage setting as an enabler or constraint to improved hospital performance and quality.

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1. INTRODUCTION

4. The health sector is labour intensive. Any significant attempt to contain costs or improve productivity has to take account of staffing costs. Changes to health systems in OECD countries in response to the recent economic slowdown have only reinforced this. In this context, wage setting institutions and mechanisms in the health sector can play a role in influencing government policy.

5. The aim of this paper is to provide an overview of the current approach to wage setting in selected OECD countries, within the broader context of slowing health sector funding in some countries. The paper takes a system level perspective by examining the wage setting mechanisms, and seeks to assess how fixed or fluid these approaches have been in the context of pressures from health system reform, health service re-organisation, economic change and labour market dynamics. This is coupled with a brief summary of what is currently reported (by country officials) to be the key dynamics and drivers for change in how hospital staff wages are being determined.

6. In the health sector, adjustment to the crisis fell primarily on wages, not employment. In countries hard-hit by the crisis, this was achieved with a relatively centralised approach to wage-setting. However, while this can be an effective response in the short term, centralised wage-setting structures can be at odds with structural reforms that many OECD countries have pursued which are aimed at achieving greater decentralisation of hospital management. OECD countries therefore face the continuing challenge of having to adjust wage setting structures to align with and enable their long-term reform agenda.

7. The paper focuses primarily on wage setting for doctors and nurses working in hospitals. It covers eight OECD countries, including Canada, France, Germany, the Netherlands, New Zealand, Norway, Portugal and the United Kingdom. The case studies seek to address three main questions:

- (1) Who is in charge of wage-setting negotiations in the hospital sector, which are the main stakeholders involved, and how does this differ from approaches in the overall economy.
- (2) At which level or levels (e.g. government, geographic, skill based) are wages negotiated?
- (3) Is the approach to wage setting consistent with recent hospital reforms; have there been any changes in the approach to wage setting in recent years, and what are the drivers behind changes?

8. The paper differs from most published work on pay and wages in the health sector which tends to examine pay rates and pay changes as they impact on staff satisfaction and job based or labour market behaviour - the primary focus of these other studies being individual worker behaviour rather than on the system and system responsiveness. The main concerns of these published studies has been on the effectiveness of pay-for-performance mechanisms for individuals, teams or organisations (see Van Herck et al, 2010; Houle et al, 2012 for recent reviews), or on the links between pay rates and labour market behaviour, most notably on pay and nurses' labour market participation, turnover or job satisfaction (see e.g. Antonazzo et al., 2003; Chiha and Link, 2003; Tellez et al., 2009; Buchan and Black, 2011). However, it is clear that it can be difficult to "unpick" the relative effect of different elements of a pay/benefits award on health professionals' behaviour (see, e.g., Kankaanrata and Rissanen, 2009 for a recent discussion of this challenge).

9. The next section will provide examples for wage adjustments in selected OECD countries during the crisis and an overview of the literature on wage-setting in the health sector. Section three contrasts wage setting structures in the health sector with those in the overall economy across selected countries. Section four presents trends in recruitment and remuneration autonomy contrasting them with hospital autonomy in selected OECD countries, derived from the 2012-13 Health System Characteristics Survey. Section five presents findings on wage-setting structures in OECD countries and recent trends.

2. BACKGROUND

10. This section provides a brief overview of the wage adjustments in response to the economic crisis in selected OECD countries and presents an overview of perspectives on wage setting in the health sector.

2.1 Wage adjustments in response to the crisis

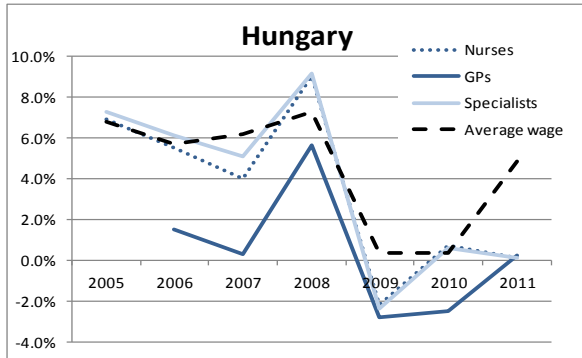
11. The remuneration of doctors and nurses, measured either in a common currency (US\$) or in comparison with the average wage of all workers in each country, varies widely across OECD countries. As expected for highly educated professionals, the remuneration of doctors (both generalists and specialists) is much higher than that of the average worker in all OECD countries. In 2009, self-employed general practitioners (GPs) in Ireland, the Netherlands and the United Kingdom earned more than three times the average wage (after deduction for their practice expenses). The income of specialists (all specialties combined) was greater than that of GPs in all countries (except in the United Kingdom), and was more than six times greater than the average wage in Belgium and the Netherlands in 2009 (OECD, 2012).

12. The remuneration of nurses is substantially lower than that of doctors in all OECD countries. Nonetheless, it is at least equal or slightly higher than the average wage of all workers in most countries, although there are a few exceptions, such as Hungary and the Slovak Republic (OECD, 2012).

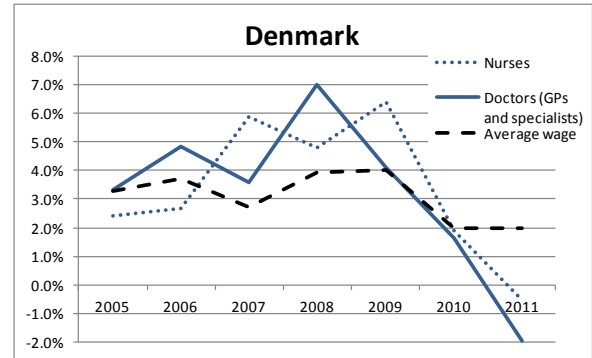
13. Given the high proportion of health spending on wages and fees of health care providers, some European countries hard hit by the recession have cut (at least temporarily) the wages or fees for doctors and nurses in response to budgetary pressure. In Hungary, the income of doctors and nurses fell in 2009, following fairly strong growth in the years prior to the crisis (particularly for specialists and nurses, less so for GPs). In Belgium and France, the remuneration of specialists continued to grow in recent years, while the income of GPs fell in 2010 and those of nurses stagnated in 2010 and 2011. In Denmark, the average income of doctors and nurses started to fall slightly in 2011 (Figure 1).

14. While many of the measures driving the slowdown or cuts in wages are discretionary policies, the crisis has brought a renewed focus to the role and place of wage setting in health care. Prior to the crisis, there had been a trend in some OECD countries towards encouraging more decentralised and more autonomous health care services (particularly hospitals). This occurred as a consequence of reforms that sought to give hospital management more control over their finances, which was limited by the fact that they often had little flexibility or direct control on the pay bill - a major element in their overall expenditure – due to wage setting occurring at a national level.

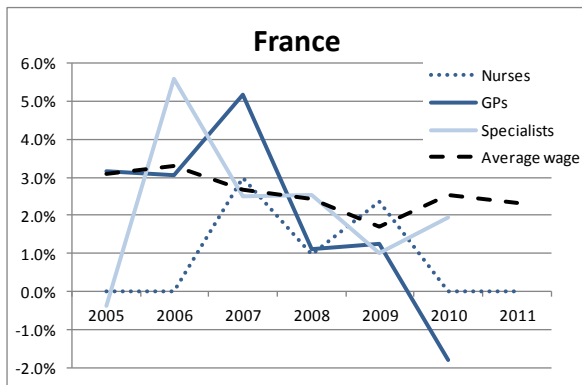
Figure 1. Evolution of the remuneration of doctors, nurses, and average wages, in nominal terms, selected countries, 2005-2011



Note: The data relate to salaried GPs and specialists

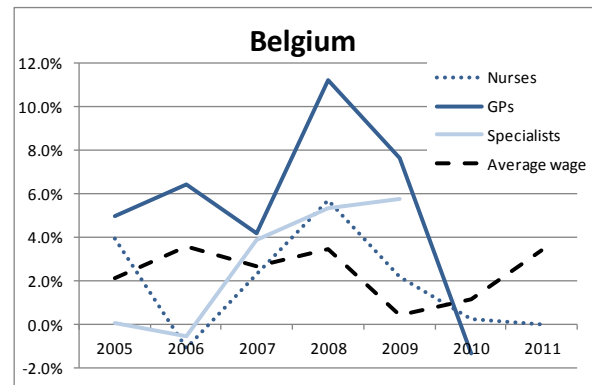


Note: The data relate to salaried GPs and specialists



Note: The data relate to self-employed GPs and specialists

Source: OECD Health Statistics 2013.



Note: The data relate to self-employed GPs and specialists

2.2 Perspectives on wage-setting

15. With the wage bill being a major source of recurring costs in most hospitals, controlling expenditure at both the hospital and system level is in part about controlling expenditure on wages. It is, however, important not to take a narrow view of the wage setting approach and its impacts. The outcome of wage setting can also be an incentive or disincentive for recruitment and retention in the health professions and for motivation to work in certain regions, specialties, working locations, and working times. Pay is not the only incentive and may not be the main incentive in some situations (other working conditions, career and education opportunities, flexible hours and participation in decision making have also frequently been identified in research as major motivators for health professionals and sources of job satisfaction) but is clearly a major and highly visible element of the contract between the organisation and the health worker. The focus of this section is on wage setting, but it is recognised that the wage setting approach and its outcomes can have both intended and unintended consequences on health care labour markets.

16. It should also be noted that much of the English-language research in this area has been conducted in the United States, where labour market dynamics and health system characteristics are very different from those in many other OECD countries. The United States has relatively low unionisation rates amongst hospital workers, localised pay determination with limited collective bargaining, and very different labour laws from many other OECD countries. There has also been a research focus, mainly in the US, on identifying the existence, or absence of monopsony in labour markets for nursing, with some researchers arguing that the monopsony effect, where there is only one major employer in a labour market, means that nurses pay rates in these labour markets are at a lower level than could be the case where there were more employers competing for nurses' skills in an open i.e. a more competitive? market. This debate is currently unresolved (see, e.g. Hirsch and Schumacher, 2005; Spetz et al., 2011).

17. Specific pressures on the established wage setting approaches can come from a range of sources. Labour market concerns may provide impetus for overall pay increases, or call into question the responsiveness of a national standardised system to varied and localised shortages in occupations, geographic regions or specialties. High cost central urban areas, and remote rural areas are two types of regions that are often identified as meriting "more" than the national average pay rates to compensate for the recruitment and retention challenge; and certain specialties which are relatively difficult to recruit to may also be identified as "deserving" above standard pay rates (Ono et al., 2014). Particular specialties that benefit may vary from country to country or hospital to hospital, but can often include high pressure work areas such as emergency rooms, and "high tech" areas such as intensive care units. In some cases the labour market pressures will focus on skilled workers who are not health sector specific, such as IT staff, for which the hospital has to compete with a range of other sectors and industries. Other pressures can include pay equity issues, particularly with high levels of women workers in the non-medical professions; structural changes in pay systems (e.g. to increase flexibility or to de-link health sector pay from the broader public sector/service); attempts to improve organizational productivity and/or the quality of care; and improving international pay competitiveness (Buchan and Black, 2011).

18. The structure and processes of wage setting reflect the evolution of broader based cultural and political developments over time and different market dynamics and organisational structures (see e.g. OECD, 2004; Grimshaw et al., 2007; Eurofound, 2014). Some key characteristics of wage setting that enable differentiation between countries include the level at which wage setting is conducted (e.g. central, sectoral, local), the extent to which different bargaining levels are linked, the timing and frequency of wage setting, the extent of direct government involvement, and of trade union/ professional involvement (see Du Caju et al, 2008; Tijdens and de Vries, 2011; Visser, 2013; Eurofund, 2014).

19. There has also been debate about the pros and cons of different models of local, regional and national-level wage setting in the public sector in many OECD countries (see, e.g., Calmfors, 1993; Wallerstein, 1999; Bender and Elliot, 2003, OECD, 2005, Buchan and Black, 2011). In particular, in the health sector, attempts at system reform have sometimes included attempts to shift the locus of pay determination from national to local level on the grounds of enabling greater managerial flexibility and decentralised authority.

20. Localised wage setting can hold the prospect of more local managerial input into pay-bill control, and the development of overall reward strategies more tailored to local needs, priorities and purposes. Counter-arguments in favour of retaining a national focus to wage setting and pay determination have been that national pay can be simpler to operate, less time-consuming, with less transaction costs for individual hospitals, with more scope for national budgetary control, and can provide the underpinning for a national career structure for health professionals. It is often also argued that trade unions and professional associations tend to favour national rather than local wage setting because it enables them to focus their efforts and maintain consistency across their membership. (See, e.g., Grimshaw et al, 2007; Buchan and North, 2008).

3. COMPARING HEALTH SECTOR WAGE-SETTING TO ECONOMY-WIDE WAGE-SETTING STRUCTURES AND PROCESSES

21. This section provides a snapshot of the extent to which wage setting for hospital workers is similar or different to wage setting in other sectors of the economy. Information on the broader wage setting approach within the country is drawn from Visser (2013) which presents headline summaries of wage setting approaches in 34 countries. Table 1 below sets out some of the key characteristics of wage setting in each case study country, firstly highlighting the dominant overall approach to wage setting in the economy (as reported by Visser , 2013), and then reporting on wage setting in the health sector, as highlighted in the country case studies reported in the Annex.

22. What is apparent in this brief overview is that in some countries (e.g. Netherlands, Norway and, to some extent Portugal) the wage setting approach for hospital workers reflects the dominant approach of national collective agreements and sectorial co-ordination. In other countries (Canada, France, New Zealand and the United Kingdom) the dominant approach across the whole economy is reported to be local level “un-coordinated” wage setting, whilst the approach in the hospital sector is more regionally or nationally focused.

23. The reasons for these differences are likely to include the fact that many hospital workers in the latter grouping of countries are employed in the public sector, and that there is higher coverage of national representation by professional associations/ trade unions than in other sectors.

Table 1. Structures and processes of wage setting: the dominant

Country:	Sector	Type of co-ordination of wage setting	Government intervention in wage bargaining	Predominant level(s) at which wage bargaining occurs	Avg length of collective agreement (years)
CAN	All	Uncoordinated	None	Local/company level	-
	Health	Mix of province level and local, collective agreements	Indirect; Province level	Province/local	
FRA	All	Uncoordinated	Influences indirectly through price setting, indexation, tax measures etc.	Sector/ company bargaining	Yearly negotiations, duration of collective agreements may exceed several years.
	Health	Nationally focused, between government, employers and unions, with local scope for “top up”	Government directly involved	National/ sub-sectoral/some local	
DEU	All	Pattern bargaining	Influences by providing an institutional framework of consultation etc.	Sector/ industry level	1.9
	Health	Wage negotiation decentralized. Contracts at federal, regional or local level and owner-specific contracts are possible. Hospital owners are free to decide about the use of contracts.	Regional and local governments (Länder, Kommunen) are involved in wage-setting as employers of hospitals. Minimum wage for a number of non-core services (general minimum wage from 2015 onwards)	Decentralized negotiations partly based on frame contracts negotiated at federal level.	
NZL	All	Uncoordinated	Influences by providing an institutional framework of consultation etc.	Local/company level	-
	Health	Employers association, unions agree national collective agreements by profession/ occupation (MECA)	Influences by providing an institutional framework of consultation	National-sectoral/ some local	2-3 years recently
NLD	All	Intra-associational (“informal centralisation”)	Influences indirectly through price setting, indexation, tax measures etc.	Sector/ industry level	2
	Health	National, sector focus, bargaining between unions and employers association	Influences indirectly through providing legal frame for collective bargaining	Sector level	Variable, not typically annual

Country:	Sector	Type of co-ordination of wage setting	Government intervention in wage bargaining	Predominant level(s) at which wage bargaining occurs	Avg length of collective agreement (years)
NOR	All	Pattern bargaining	Influences indirectly through price setting, indexation, tax measures etc.	Sector/ industry level	2
	Health	National led, collective agreement between employer association and unions; scope for local "top up"	Influences indirectly	Sector/ local	Annual: wages; bi-annual: all
PRT	All	State sponsored bargaining (including pacts)	Imposes wage settlements or suspends bargaining,	Sector/ industry level	2.5
	Health	National, agreement between gov departments, employers and unions	Direct, as funder, employer	Sector level	Pay freeze, reduction in wages and conditions
GBR	All	Uncoordinated	Some influence through institutional framework	Local/company level	-
	Health	Pay recommendations by an independent pay review body based on evidence submitted by trade unions, employers and government;	Direct, as employer and funder	National sectoral	Sequence of public sector pay "freezes"

Note: information for "all" sectors drawn from Visser, 2013; information for health sector obtained by the authors.

4. TRENDS IN PUBLIC HOSPITAL RECRUITMENT AND REMUNERATION STRUCTURES

24. The role of public hospitals is a particularly important subcomponent of the hospital sector for several OECD countries. This section uses the OECD's Health Systems Characteristics Survey (2012) to provide an overview of the degree of autonomy of public hospitals in wage-setting and recruitment decisions relative to the governments that manage them. Over the past decades, many OECD countries have undertaken structural reforms which have emphasised the importance of devolving responsibility and increasing the autonomy of hospital managers at the local level in order to foster more efficient service provision. This section seeks to augment the information on health sector wage-setting with a recent snapshot of recruitment and remuneration in public hospitals.

25. While not focusing on wage setting in a systematic way, the OECD Health System Characteristics Survey contained a novel question on the allocation of responsibilities for setting wages and recruiting staff for salaried medical professionals in public hospitals (see Appendix 1). Responses are summarised in Table 2 below. Belgium, Japan, Korea, and the Netherlands have been excluded in light of the small number of public hospitals.

26. The Survey suggests that national level negotiations are the predominant means of setting salaries for medical staff working in public hospitals. Sixteen out of the twenty six countries had national level negotiations and a further seven had subnational level negotiations. Only Poland, the United States and Sweden indicated that public hospital managers have autonomy over pay levels. Country responses to the Survey were consistent with findings for the eight countries considered in depth in this paper, and confirm that for the public sector at least, very few countries have a fully decentralised approach to the setting of wages at the hospital level.

27. However, several countries identified that they provide their public hospital managers with autonomy over the recruitment of staff. Seventeen countries responded that public hospital managers have autonomy in recruitment. Five countries – Greece, Ireland, Israel, Italy and Spain – noted that central or subnational government are responsible for recruitment of staff for public hospitals. Both Australia and Portugal noted that recruitment was determined by public hospitals but in negotiation with (or by approval of) central and subnational government.

28. A large number of countries share the combination of centralised wage setting and decentralised recruitment. Of particular interest is that 14 countries set medical staff remuneration in public hospitals at a national or subnational level, but then provide responsibility to hospital managers for recruitment. It is important to note that the Survey question asked only about *recruitment* and not about *employment* and hence the ability to retrench staff. On this basis, these results do not provide enough information to infer that public hospital managers have the ability to substantially influence their overall wage bill even if wages are negotiated centrally.

Table 2. Recruitment, remuneration and contracts for medical staff in the public sector: the extent of decentralisation

Country	Work contracts of salaried medical staff		
	Responsibility for recruitment		Remuneration levels
Australia	Central or subnational Govt and hospital negotiates with local authorities	State government	Subnational level negotiation
Austria	Hospital manager autonomy	Hospital	Subnational level negotiation
Canada	n.a.	n.a.	Subnational level negotiation
Chile	Hospital manager autonomy	Hospital	National level negotiation
Czech Republic	Hospital manager autonomy	Hospital	National level negotiation
Denmark	Hospital manager autonomy	Hospital	National level negotiation
Finland	Hospital manager autonomy	Hospital*	National level negotiation
France	Hospital manager autonomy	State government	National level negotiation
Germany	Hospital manager autonomy	Hospital	Subnational level negotiation
Greece	Central or Subnational Govt	Central Government	National level negotiation
Hungary	Hospital manager autonomy	Hospital	National level negotiation
Iceland	Hospital manager autonomy	Hospital	National level negotiation
Ireland*	Central or Subnational Govt		National level negotiation
Israel	Central or Subnational Govt	Hospital	National level negotiation
Italy	Central or Subnational Govt	Hospital	National level negotiation
Mexico	Hospital negotiates with local authorities	Central Government	Subnational level negotiation
New Zealand	Hospital manager autonomy	Hospital	National level negotiation
Norway*	Hospital manager autonomy	Hospital	National level negotiation
Poland	Hospital manager autonomy	Hospital	Hospital manager autonomy
Portugal*	Hospital negotiates with local authorities and central or subnational govt	Hospital	National level negotiation
Slovenia*	Hospital manager autonomy	Hospital	National level negotiation
Spain	Central or subnational govt	State government	Subnational level negotiation
Sweden	Hospital manager autonomy	Hospital	Hospital manager autonomy
Switzerland	Hospital manager autonomy	Hospital	Subnational level negotiation
United Kingdom	Hospital manager autonomy	Hospital	National level negotiation
United States	Hospital manager autonomy	Hospital	Hospital manager autonomy

Notes: *Norway: work contracts are with hospital districts; Ireland: The Health Service Executive is the key employer; Portugal: Hospitals that have become 'public enterprises' are responsible for their work contracts. However, staff working before hospitals were converted to public enterprises (in 2012) have work contracts with central government. Slovenia: A public healthcare provider organization must receive approval from the Ministry of Health for any new employment.

Source: OECD, Health Systems Characteristics Survey, 2012

29. Work contracts for salaried medical staff were predominately negotiated with the public hospital. Nineteen countries responded that work contracts of salaried medical staff had their contracts with the hospital. Responses broadly mirror the allocation of responsibility for recruitment, with the exception of France where work contracts are with the state government, which covers about two thirds of salaried doctors, the rest being locally recruited. It is likely that this reflects specific administrative arrangements that are unique to these countries, and need not imply that salaries are set by public hospitals themselves. However, it is worth noting that the three countries which had hospital autonomy over pay levels (US, Poland and Sweden) also have hospital level contracts.

30. These survey results reinforce that the split of responsibilities in public hospitals is distinct from that in the economy at large where decisions on recruitment and pay are more commonly set at the firm level. The dominance of hospital manager autonomy in recruitment demonstrates that governments have been willing to cede some control over staffing to hospitals, but that wage setting has been maintained at a centralised level. These stylised observations ought to be interpreted with care, noting that they only provide a high level overview, and that the size and role of public hospitals varies considerably across countries. Nonetheless, the results suggest that public hospital managers face a different set of norms when it comes to setting wages than exist for other sectors of the economy, and that this is the case for most OECD countries.

31. For some countries, a significant challenge may relate to the dependence of both public and private hospital services on the same pool of doctors. While one dimension of this challenge can be that private hospitals attract staff with higher wages than those offered by public hospitals, another dimension is the possibility of dual practice arrangements for individual doctors which allows them to combine public and private service provision. Dual practice may, on the one hand, make it more attractive for physicians to provide services outside public hospitals, but it may also provide an additional basis for doctors to “top up” their public salaries or fees, so that they can continue to make at least part of their time available to public service provision.

32. The impact of dual practice varies from country to country, based on its extent, and on the presence or absence of regulatory policies (Table 3). A recent systematic review of dual practice found that there are three main categories of dual practice regulation mechanisms that have been used by national policy makers: 1) total banning of dual practice; 2) allow dual practice with restrictions; 3) allow dual practice without restrictions. The authors of the review concluded that the “most effective mechanisms” to regulate dual practice are likely to be multi-dimensional (Kiwanuka et al., 2011).

Table 3: Dual practice

Always allowed	Allowed in certain cases	Not allowed
Austria	Canada	Germany
Belgium	Greece	Hungary
Chile	Iceland	Ireland
Czech Republic	Italy	Korea
Denmark	Japan	Luxembourg
Finland	Poland	Norway
France	Portugal	Sweden
Israel	Slovenia	
Mexico	Spain	
Netherlands	United States	
New Zealand		
Switzerland		
United Kingdom		

Source: 2012-13 OECD Health System Characteristics Survey, as of February 2014.

5. WAGE SETTING FEATURES COMPARED ACROSS COUNTRIES

33. This section turns to a more detailed view of wage-setting in the hospital sector in OECD countries. The sections above have identified how wage-setting structures and processes in health are different from those in other sectors of the economy and that for public hospitals, governments have ceded some control of staffing, although less so of remuneration decisions. The aim of this section is to examine three features of wage setting (adapted from Du Caju et al., 2008): collective bargaining; centralisation; and co-ordination in detail across eight countries, and to highlight recent trends.

5.1 Collective bargaining

34. This feature focuses on the extent to which wage setting is conducted collectively, between representatives of employers/government, and employees/workers. In terms of the dimension of **collective bargaining**, all countries report that trade unions and professional associations are recognised as representing the hospital workforce, or parts of it; the actual level of union membership (coverage) varies significantly across different countries, and different occupations/professions, but collective agreements normally cover the entire workforce in designated occupations and/or sectors, irrespective of their membership status. In all the eight countries, employers are also reported to be involved directly in negotiations and achieving collective agreements; in some (such as Canada, Netherlands, Norway, New Zealand and the UK) they are represented in national wage setting (Province level in federated Canada) by an employers' association which has a specialist wage setting capacity (table 4).

Table 4: Collective bargaining of hospital wage-setting in selected OECD countries

Country	Collective bargaining
Canada	Collective bargaining with recognised trade unions for most staff; most physicians paid by fee-for-service
France	Collective bargaining between employers, government and recognised trade unions for most staff; some physicians, working in private sector are fee-for-service. Other staff covered by national agreements
Germany	Collective bargaining between unions and employers association is most common
Netherlands	Collective bargaining between unions/professional associations and hospital managers/employers. Most staff are salaried employees; about half of physicians are paid by individual fee-for-service
New Zealand	Wage bargaining in the public sector health services between trade unions and hospital managers/employers.
Norway	Hospitals employers' organisation leads bargaining and wage setting. Collective agreements for all employees; with each representative trade union. High level of unionisation.
Portugal	Government, unions and employers' representatives are involved in wage setting, underpinned by legal agreements.
UK	Negotiations/collective agreements between government department, NHS employers and recognised professional associations and trade unions. NHS staff (the vast majority of hospital workers) are salaried.

Source: compiled by the authors

35. Canada is an example of how the approach to wage-setting in hospitals may differ for different occupations groups. Physician compensation is for the most part separate from the hospital/regional health authority structure. Physicians negotiate separately with a provincial government entity for almost all of their compensation. Since the introduction of the public medical care system in Canada in the 1960s, the majority of physicians in Canada have been compensated through fee-for-service payments (FFS). Over time, the use of different alternative payment programs (APP) has become more prominent. APP's include payment methods such as salary, sessional, capitation, block funding, contract and other types of service agreements. Nationally, 28% of physicians' clinical earnings were paid through APPs in 2011-12 (see Annex). This represented an increase from 2003–2004, when APPs represented 19% of physicians' clinical earnings.

36. For registered nurses and other hospital employees, the main focus of wage setting is at province level. Two examples of the province level wage setting approach for non-physician staff, from Alberta and Ontario are described in the Annex.

37. In France, across three sub-sectors of public, private-not-for-profit and private-for-profit hospitals, there is an important role for collective agreements. The primary focus of wage setting in the health sectors is at the national level, between unions and employers (often including government). However, while a collective agreement defines the salary scales for public hospitals, such agreements for private (both for and not-for-profit) hospitals define a minimum conventional wage and working conditions that individual hospitals may choose to exceed.

38. In Germany, wage-setting is partly collective and partly hospital-specific. Furthermore, wage-setting negotiations for physicians and nurses are undertaken separately. The key actors in negotiations differ according to the type of hospital ownership. For public hospitals, nurses usually are represented by Ver.di (Vereinigte Dienstleistungsgewerkschaft, a trade union) while physicians are represented by Ver.di or the Marburger Bund (Vertretung der Krankenhausärzte) with separate collective framework contracts. Private-not-for-profit hospitals often have special "collective" contracts for nurses and physicians as do private-for-profit hospitals. In addition, hospital owners can decide to use individual contracts. It should also be noted that wage negotiations can differ regionally (partly referring to collective framework contracts). Thus, wage-setting for nurses and physicians differs according to region and hospital owner (Destatis, 2013, Faioli et al., 2014).

39. In the Netherlands, collective agreements are also very common, with collective bargaining between unions/ professional associations and hospital managers/employers. The approach is underpinned by laws on collective bargaining, and there are different bargaining units established for different health care sub-sectors. The relatively small size and un-differentiated labour market conditions across the country were reported as a factor in sustaining a coherent national approach, and enabling the system to take account of different labour market issues at the national level. While actual union membership in the sector was reported at approximately 40% of the workforce, all staff are covered by the results of negotiations, and an estimated 90% of health sector employers were reported to be members of their employer associations/bodies, which has helped maintain a nationally consistent approach.

40. In New Zealand collective bargaining includes a diverse set of trade unions. Bargaining occurs within the legislative framework of the Employment Relations Act 2000 (ERA), which sets out the obligations of the parties - the health board employers and the various trade unions/professional associations. The key principle is that the parties "bargain in good faith"; the ERA also sets out the procedural requirements for bargaining. The trade unions are a mix of professionally focused organisations (e.g. New Zealand Nurses Organisation; Association of Salaried Medical Specialists; NZ Resident Doctors Association), general public sector trade unions (e.g. Public Service Association) and broader based trade unions (e.g. Service and Food Workers Union). Only organisations registered as trade unions in accordance

with the requirements of the ERA can represent workers in collective bargaining. Different unions bargain separately for their membership categories, however, one or more unions may bargain together with the agreement of members. In 2008 and again in 2011, several unions bargained together resulting in the same terms of settlement applying to several different workforces. Over time there has been a shift towards greater alignment/co-ordination of different agreements.

41. In Norway, wage-setting is collective. Furthermore it is part of cross-sectoral, coordinated bargaining process (see Annex). A long tradition of collective wage bargaining and a high degree of unionisation support this approach. The organisation of hospital employers leads the bargaining and wage-setting process with each representative trade union, leading to collective agreements for all employees.

42. Despite the deep impact of the crisis on wage-setting in Portugal overall (see Annex) the negotiations continue to be collective. Government, unions and employers' representatives are involved in wage setting, underpinned by legal agreements.

43. In the United Kingdom negotiations or collective agreements are made between government, NHS employers, and recognised professional associations and trade unions. NHS staff is predominantly salaried and unionised to a relatively high degree. In practice, independent review bodies "price" a pay structure and system that has been negotiated collectively and agreed by these players.

5.2 Centralisation

44. In terms of **centralisation** of wage setting, most countries reported a core national/sector wide model. Across France, the Netherlands, New Zealand, Norway, Portugal and the UK the primary focus is currently at the national level, either across the whole health sector, or at the sub-sector level (or specialities) within health. While working through national agreements is at the heart of policy, France, Norway and the UK (to an extent) provided scope for "top up" wage setting at a local level. New Zealand also has some separate regional or local collective agreements, which in part are a legacy of a previous decentralised wage setting model. Among the countries examined, Canada had the greatest focus at the Province level. Germany exhibited a mixed pattern of wage contracts negotiated at the federal level or at the level of hospital owners, and a trend towards fragmentation in the form of wage-setting but hospitals are free to apply framework contracts negotiated at national level (Table 5).

Table 5. Centralisation of hospital wage-setting in selected OECD countries

Country	Centralisation
Canada	Province (regional) level, sector based, with supplementary local (hospital) agreements
France	National based, with local supplementary "top up" agreements. Three sub sectors negotiate separately (public; private not for profit; private for profit).
Germany	Decentralised bargaining at local or regional level, with some exceptions for national agreements for public sector workers
Netherlands	National level, sectoral, with different bargaining units for sub sectors
New Zealand	National, sectoral and sub sectoral: wage setting is primarily conducted at a national level through the negotiation of Multi-Employer Collective Agreements (MECA).
Norway	National sectoral agreement covers "national minimum": pay, pensions, leave entitlement etc. ; there is also scope for individual enterprise level for supplementary negotiations for pay rates above the national agreement level
Portugal	The "normal" approach was based on the national dialogue between government and the unions, but with a pre- crisis trend towards hospital level autonomy.
UK	Main focus is at national level; sector wide within NHS. Pay Review bodies; national collective agreements. There is scope within foundation trusts for local wage setting, but mainly only used for recruitment "top ups"

Source: compiled by the authors

45. In Canada, the provinces and territories are primarily responsible for the administration and delivery of healthcare services, and are also the focal point for wage setting for hospitals. The actual model of wage setting varies in different provinces, with the main bargaining agents for hospital employers ranging from employers' associations, regional health authorities, health departments or a provincial-wide bargaining unit. As such, each province has its own approach to wage setting.

46. In France, the primary focus of wage setting in the health sector is at the national level, between unions and employers (often including government). These national agreements define minimum levels of pay across public and private hospitals.

47. In Germany wage-setting is decentralized. In general each hospital is in charge of negotiating their tariff treaty, however for hospitals owned by Länder, regional agreements are possible, and for hospitals owned by municipalities, a nation-wide tariff-treaty (TVÖD-K) is negotiated. Furthermore private not-for-profit hospitals run by church-affiliated organisations negotiate their own nation-wide pay agreements.

48. In the Netherlands wage-setting is conducted mainly at the national level, though there are different bargaining units for sub-sectors. However, there are exceptions for doctors. While the wages of most health professionals and other hospital staff are determined nationally, there are two different approaches for hospital doctors. Some are paid by payroll (salaried); for this group wage setting is conducted through national negotiation. The second group are characterized as "entrepreneurs" and they negotiate individually at the hospital where they have their primary workplace, and are "paid per product"-e.g. fee-for-service. It was reported that the distribution of doctors across these two types of payment system was "about 50/50".

49. New Zealand is unusual in its history of wage-setting. For some main categories of health professionals, such as nurses, it has shifted from national to local pay determination since the beginning of the 1990s, and then reversed this trend, moving back to a national focus. Local pay determination was introduced as part of health sector reform in the early 1990s which established public hospitals as autonomous "Crown Health Enterprises". Subsequent government changes, and concern about nursing shortages and pay equity issues led to a reversal, first to wage setting at regional level and then (in 2004) to a return to national level wage setting (Buchan and North, 2008). Bargaining for national workforces (e.g. doctors, nurses, radiation therapists, etc.) is primarily conducted at the national level through the negotiation of Multi-Employer Collective Agreements (MECA) between the relevant union and the 20 District Health Boards (DHBs). In addition to the national focus there is some wage setting through bargaining at regional/DHB level for some staff groups (see Annex).

50. Wage setting in Norway provides an example for high levels of centralization with room for some local additional payments or benefits. The national sectoral agreement for the health sector covers a national minimum package for pay, pension benefits, leave entitlements etc. On this basis, individual enterprises, e.g. hospitals, may negotiate supplementary pay and benefits that go above the nationally agreed minimum level.

51. For Portugal the economic crisis had an impact on the degree of centralisation of wage-setting. Prior to the crisis there was a wage setting process developed for a "normal" situation, which has now been suspended because of the need for the country to address the impact of the financial crisis, and to comply with the requirements of financial support agreements and MoU with the International Monetary Fund, the European Commission and the European Central Bank. The "normal" approach to the process of wage setting in the hospital sector in Portugal was based on the national dialogue between government (Ministries of health and finance) and the unions. There was however a trend towards increased devolution of management responsibility within the health system (see Annex). However, the global financial crisis

has halted the shift to a hospital level focus, and to some extent reversed the primary focus on wage setting back to the national level. This is partly due to the need to contain financial costs and align wage setting processes across the whole public sector.

52. In the United Kingdom, pay rates for doctors, nurses and other staff working in NHS hospitals are based on nationally agreed pay structures, with separate systems for doctors, nurses and other health professions, and for other NHS staff. There is some limited scope for local supplemental payments to staff, where hospitals have sufficient funds and can demonstrate that they have recruitment and retention difficulties. Independent pay Review Bodies make national pay increase recommendations. These are committees of independent experts appointed by government, and with a secretariat provided by the Office of Manpower Economics. The Review Bodies make their decisions based on evidence submitted to them by trade unions, employers and government, and on any additional research which they have commissioned, but in recent years some elements of the Review Body approach have been suspended as part of more stringent public sector wage control (see country report in Annex for details).

5.3 Co-ordination

53. In terms of **co-ordination and government involvement**, all countries report some co-ordination of wage setting across the health/hospital sector, either by health sector (or sub-sector) collective framework agreements at the national level (e.g. France, the Netherlands, Norway, Portugal, UK) or at the Province level (Canada), or across local governments (Germany). Cross sectoral co-ordination within the broader public sector is also reported in some countries (e.g. New Zealand) whilst Norway reports a broader cross sectoral co-ordinated approach based on “front runner” industries setting the benchmark for wage setting. Reflecting the high level of public sector funding and provision, most countries reported direct or indirect government involvement in wage setting. In Portugal and the UK this reflects a situation where the government is the main funder and/ or employer of the hospital workforce. In “normal” times, an annual cycle of wage setting was reported in France, Portugal and the UK; in Norway, a bi-annual process is reported. For the remaining countries, the reported cycle of wage setting has varied between 18 months and 3 years (Table 6).

Table 6. Coordination of hospital wage-setting in selected OECD countries

Country	Co-ordination and government involvement
Canada	Two to three year agreements common. Some province level government involvement either directly, or via employer agencies
France	Government directly involved. The focus is on nationally led collectively determined adjustments to pay within an established national framework.
Germany	None, except as an employer in public sector wage negotiations
Netherlands	National approach is underpinned by laws on collective bargaining. National agreements usually for a longer time period than one year.
New Zealand	Government involved, and co-ordination across public sector. [Trend from?] 18 to 24 or 36 months time period.
Norway	Coordinated wage setting across industries and sectors. Government sets the tone; fixed annual/ bi-annual cycle of national bargaining.
Portugal	Post crisis cost/wage containment and alignment across the whole public sector. Central government has assumed the leadership of wage setting processes.
UK	Government involved via Department of Health participation in national negotiations; close alignment of national pay framework for different NHS occupations. Normally an annual cycle of wage setting.

54. In Canada, two to three-year agreements are common, though this varies from province to province. In some provinces, there is direct government involvement in wage-setting negotiations, or involvement through employer associations, i.e. the government being involved in wage bargaining in its role as an employer.

55. In France government is directly involved in wage-setting in hospitals, its focus being on nationally-led, collectively agreed adjustments to pay levels within an established national framework.

56. In Germany, government is not involved in wage setting, although municipal and Länder governments play a role as employers. However this is changing slightly with the introduction of a minimum wage in long-term care (which is a separate sector in terms of wage-setting, whose wage negotiations are independent from those in the healthcare sector) and a future national minimum wage, although this concerns mainly hospital staff providing non-core services such as facility management or catering. The length of agreements varies.

57. In the Netherlands, wage-setting is underpinned by a legal collective bargaining framework. The relatively small size and un-differentiated labour market conditions across the country were reported as a factor in sustaining a coherent national approach, and enabling the system to take account of different labour market issues at the national level. The time period of national wage agreements in the sector can vary from one agreement to the next. The length of the agreement depends on factors at the time of agreement, though it was reported that national agreements were “not typically” annual, and usually for a longer time period. There was no reported change in the typical time period of agreements in more recent years.

58. Wage bargaining in the public sector health services in New Zealand is highly co-ordinated. Public sector health organisations comprise 20 District Health Boards (DHB's) who meet annually to agree a national employment strategy, identify common interests, assess the collective financial situation, etc. An Employment Relations Strategy Group (ERSG) represents the 20 DHB's; it includes DHB managers/executives, and has support from experts from a national DHB “shared services” agency. The ERSG develops a national bargaining strategy, which then goes to the 20 DHB Chief Executives for endorsement. The DHBs develop a specific bargaining strategy for each collective agreement as it expires. As noted earlier there are separate national (“Multi Employer”) agreements with different professions and trade unions. This bargaining strategy is aligned to the national bargaining strategy and, as required under the NZ Public Health and Disability Act 2000, sent to the Director General of Health for consultation, against the Government Expectations for Pay and Employment Conditions in the State Sector. Additional local/regional bargaining is led by local DHB managers, with support from the shared services agency if required. Under the terms of the ERA, no collective agreement can have a term longer than 3 years. In recent years there has been some shift from 18 to 24 or 36 month agreements, reflecting the changing financial situation. There is a move towards more regional collaboration between hospitals/DHB's on service provision which has indirect implications for local wage setting.

59. There is also a high level of co-ordination in Norway. There is an annual cycle of pay determination across sectors and industries, including health. The government sets the benchmark by setting the next year's budget, and this then becomes the marker for wage bargaining (e.g. the budget signals “increase will be 3.5% next year”). The approach to wage negotiations is based on the principle that wage growth must be at a level which industries exposed to international competition can tolerate. The main purpose is to coordinate wage setting across industries and sectors and thereby contribute to moderate inflation and wage growth. The Government places emphasis on continued collaboration with the social partners on income policy, and one element of this collaboration on income policy is to ensure that the social partners and the authorities have, as far as possible, a shared understanding of the situation in the Norwegian economy, and that the parties to collective wage negotiations agree as far as possible on the

statistical material underlying the negotiations. This material is compiled and provided by the Norwegian Technical Calculation Committee for Wage Settlements, for which the Ministry of Labour and Social Affairs has administrative responsibility (Ministry of Labour and Social Affairs, Norway).

60. In Portugal the adjustment requirements set out in the memorandum of understanding with the European Commission, the European Central bank and the International Monetary Fund provide a basis for a co-ordinated wage setting process across all public services, including health. The central government has assumed the leadership of wage-setting in this process.

61. In the United Kingdom, government is involved in wage-setting as the pre-eminent funder of both training and employment in the sector. The vast majority of hospital-based care in the United Kingdom is provided by the public sector National Health Service (NHS). Pay rates for doctors, nurses and other staff working in NHS hospitals are based on nationally agreed pay structures, with separate agreements for doctors, nurses and other health professions, and for other NHS staff.

5.4 Recent trends and changes

62. In terms of **recent trends and changes** in the wage setting approach, the influence of fiscal pressures were reported in several countries. France, Portugal and the UK each identified significant recent changes in the approach to wage setting for hospital staff, driven by the economic crisis and its aftermath. In Portugal there have been actual cuts in pay levels and other benefits; in the UK and France there have been “freezes” in pay rises and/or entitlements and suspensions of elements of the usual wage setting approach. For these countries, this has been implemented in part by a marked shift towards the re-centralisation of the focus of wage setting. These efforts may be characterized as temporary, and have generally been part of a broader focus on controlling public sector costs and enabling cross-sectoral co-ordination.

63. In contrast, New Zealand, the Netherlands and Norway reported little recent change in the overall approach to wage setting, but noted that economic conditions are a factor in determining the timing of wage setting and in influencing wage setting outcomes.

64. Germany reported some shift towards greater fragmentation of bargaining, reflecting a complex interplay of factors including privatisation of hospitals and outsourcing of non-core services which multiply the number of employers. At the same time, the introduction of a minimum wage is a counteracting this development, though mainly for lower skilled occupations in the hospital sector (Table 7).

Table 7: Reported recent trends and changes in hospital wage-setting in selected OECD countries

Country	Recent trends/ changes
Canada	Cost containment pressures
France	Since the economic crisis, cost containment pressures - no increase in annual “index” national wage adjustment since 2010.
Germany	Fragmentation driven by privatisation of hospitals and/or outsourcing of certain service areas, counteracted by introduction of minimum wage.
Netherlands	None reported. No change in wage setting time period in recent years.
New Zealand	A trend towards greater alignment/ co-ordination of different agreements, and, some shift from 18 to 24 or 36 month agreements - reportedly reflecting the changing financial situation.
Norway	No changes reported
Portugal	Current suspension of “normal” approach. Actual cuts in pay and pensions, pay “freezes” etc.
UK	Impact of economic crisis has led to pay “freezes” and partial suspension of elements of the normal wage setting approach-; NHS trust employers advocating for more local “flexibility”.

Source: compiled by the authors

6. CONCLUSION

65. Wage setting mechanisms, processes and outcomes are always of central importance to the performance of the labour-intensive health sector. In addition, in the current era of cost containment in several OECD countries, many governments have chosen to adapt their wage setting approach to help the health sector absorb shocks to the overall government finances due to the crisis and thus maintain service capacity. Despite the significant costs incurred by wages and their importance as a lever to influence services and performance, there is relatively little research examining wage-setting structures specifically in the health sector.

66. By examining wage-setting in hospitals, this paper finds that

- Wage setting in the health sector is in some countries structured differently from wage-setting in the rest of the economy, with a tendency towards a more centralised approach in health.
- Wage setting in public hospitals, which make up a large share of capacity in many OECD countries, and where governments are often funders/employers, are largely centralised while some responsibility for recruitment has been decentralised.
- Several OECD countries report that there had been a policy emphasis towards greater autonomy for hospital management in the period before the crisis. As a response to the economic crisis, several OECD countries report increased central government control over wage setting in hospitals, including the suspension of some aspects of the “normal” approach. It is unclear for how long this will continue.
- In the short run, centralization has worked to make wages a shock absorber, and help preserve employment and service capacity. In the long term, a continuation of these centralized wage setting measures may run counter to structural reforms in the hospital sector that seek to provide greater autonomy to hospital management.

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ANNEX 1. HEALTH SYSTEM CHARACTERISTICS SURVEY

Question: Please provide information on the regulation of recruitment and remuneration of medical staff in public hospitals.

a) Recruitment of *medical staff*

- Hospital managers have complete autonomy
- Hospitals must negotiate with local authorities
- Central or sub-national level of government decides
- Not applicable (physicians are always or most often self-employed and therefore not recruited or appointed)

b) Remuneration level of *medical staff*

- Hospital managers have complete autonomy
- A pay scale is set or negotiated at the national level
- A pay scale is set or negotiated at a sub-national level (e.g. province, region, canton, etc.)
- Not applicable (physicians are not salaried)

c) Are work contracts of the *salaried medical staff* officially with:

- The hospital
- Local authority
- State government
- Central government
- Not applicable (self-employed physicians)

Comments/clarifications (if any):

ANNEX 2. COUNTRY REPORTS ON WAGE-SETTING

1. Canada

Table 8: Overview Canada

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Collective bargaining with recognised trade unions for most staff; most physicians paid by fee – for- service	Province [regional] level, sector based, with supplementary local [hospital] agreements	Two-three year agreements common. Some province level government involvement either directly, or via employer agencies	Cost containment pressures

67. In Canada, the provinces and territories (PT) are primarily responsible for the administration and delivery of healthcare services, and are also the focal point for wage setting for hospitals. The actual model of wage setting varies in different provinces, with the main bargaining agents for hospital employers ranging from employers' associations, regional health authorities, health departments or a provincial-wide bargaining unit. As such, each province has its own approach to wage setting.

68. Physician compensation is for the most part separate from the hospital/regional health authority structure. Physicians negotiate separately with a provincial government entity for almost all of their compensation. Since the introduction of the public medical care system in Canada in the 1960s, the majority of physicians in Canada have been compensated through fee for service payments (FFS). Over time, the use of different alternative payment programs (APP) has become more prominent. APP's include payment methods such as salary, sessional, capitation, block funding, contract and other types of service agreements. Nationally, 28% of physicians' clinical earnings were paid through APPs in 2011-12 (see Table 9 below). This represented an increase from 2003–2004, when APPs represented 19% of physicians' clinical earnings.

69. Each province negotiates with its physician group whether a service should be paid under a fee-for-service plan payment or an alternative plan payment. Thus one province may pay for a service through the fee-for-service plan, whereas another province may pay for the same service within an alternative plan. In addition, jurisdictions may vary with respect to how alternative payments are allocated to physicians. For example, alternative payments may represent a relatively small percentage of income for most physicians in one province, while in another province some physicians might be paid primarily through alternative plans, with others paid primarily through fee-for-service arrangements.

Table 9. Percentage Distribution of Physician Payments by Type of Payment (fee for service or alternatives) and Province, Canada, 2011–2012

	NL	PEI	NS	NB	Que	Ont	Man	Sask	Alta	BC	Total
FFS	65.5	59.0	53.3	65.1	76.4	65.3	68.4	66.3	85.6	80.7	71.6
Alt	34.5	41.0	46.7	34.9	23.6	34.7	31.6	33.7	14.4	19.3	28.4

Source: Canadian Institute for Health Information https://secure.cihi.ca/free_products/PSBR-2011_2012_EN.pdf and https://secure.cihi.ca/free_products/physicians_payment_aib_2010_e.pdf

70. For registered nurses and other hospital employees, the main focus of wage setting is at province level. Two examples of the province level wage setting approach for non-physician staff are described below.

71. In the province of Alberta, Alberta Health Services, essentially a province wide authority that reports to the provincial Ministry of Health, negotiates collective agreements with four separate union groups: direct nursing care or nursing instruction, auxiliary nursing care, paramedical professional or technical services, and general support services.

72. Employees are assigned to one of the four bargaining units based on the person's actual function, not upon occupational title. Each of the four bargaining units is regulated as province-wide. Collective agreements are negotiated and agreed at province level; recent agreements have been for a three year period: e.g. the agreement for auxiliary nursing was with the Alberta Union of Provincial Employees (AUPE) who represent approximately 14,000 auxiliary nursing staff at Alberta Health Services, including licensed practical nurses, health care aides and psychiatric aides, and the current collective agreement was negotiated for a three-year term and expires on March 31, 2015.

(See <http://www.alrb.gov.ab.ca/bulletins/10bulletin.html>, <http://www.albertahealthservices.ca/8611.asp#june3-una>)

73. In the province of Ontario, Hospital Employee Relations Services (HERS) of the Ontario Hospital Association (OHA) coordinates and implements the central bargaining process on behalf of voluntarily participating hospitals, with seven major unions representing hospital workers in Ontario. This process occurs at province level. The OHA negotiates with:

- Ontario Nurses' Association (142 hospitals covering approximately 55,000 employees)
- Ontario Public Sector Employees Union (46 hospitals covering approximately 9,000 employees)
- Canadian Union of Public Employees (54 hospitals covering approximately 20,000 employees)
- Service Employees International Union (34 hospitals covering approximately 15,000 employees)
- Canadian Auto Workers (8 hospitals covering approximately 750 employees)
- Professional Association of Interns and Residents of Ontario (20 hospitals covering approximately 4,000 residents)
- Professional Institute of the Public Service of Canada (10 hospitals covering approximately 100 employees)

74. The collective bargaining process at province level leads to a standard central contracts, with local hospital appendices. The agreement set out provisions respecting conditions of employment,

including pay rates, overtime, annual leave etc., other fringe benefits, and the right or duties of the parties to the agreement. The “core” province wide agreement is supplemented by a separate appendix agreed between each hospital management and local union representatives; this varies in content but can cover such issues as local working patterns, local public holidays etc. The pay rates negotiated at province level (expressed as hourly rates: for different years of service and for different categories of nurse) provide the province wide benchmark. For example, for registered nurses, the most recent province level collective agreement, between OHSA and the Ontario Nurses Association, included a province wide core agreement and 146 additional hospital level agreements, and was for a three year period, expiring at the end of March 2014.

75. Economic constraints are reported to be a recent factor requiring consideration during wage negotiations. For example, at the time of writing (April 2014) the main parties negotiating a new 3 year contract for registered nurses pay in Ontario have not been able to conclude negotiations on a new province agreement, with OHA stating that this is due to financial restraint: “Despite the best efforts of all parties, the bargaining teams continued to be challenged by what is currently affordable for the province during such an unprecedented time of financial restraint”.

(See <http://www.oha.com/Services/EmployeeRelations/CollectiveAgreements/Pages/Default.aspx> and <http://www.oha.com/News/MediaCentre/Documents/March%2014,%202014%20-%20OHA%20Statement%20re.%20Status%20of%20Collective%20Bargaining%20with%20ONA.pdf> for more details)

Summary

76. In summary, the wage setting approach in Canada is focused primarily at province level, with different mechanisms in place for physicians’ payments and for other staff. Most physicians are primarily reimbursed through fee- for- service, but with varying levels of alternative payment types, such as salaries, in different provinces. Wages for nurses and other staff are mainly determined through multi- year collective bargaining at province level, between recognised trade unions and province level bodies representing government and employers. At least one province, Ontario, reports that current economic constraint is a factor in the current round of wage setting.

2. France

Table 10. Overview France

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Collective bargaining between employers, government and recognised trade unions for most staff; some physicians, working in private sector are fee - for- service. Other staff covered by national agreements	National based, with local supplementary “top up” agreements. Three sub sectors negotiate separately [public; private not for profit; private for profit].	Government directly involved. Nationally agreed framework or “convention”. The focus is on nationally led collectively determined adjustments to pay within an established national frame which has legal underpinning	Since the economic crisis, cost containment pressures- no increase in normally annual “indice” national wage adjustment since 2010; major review of the not- for- profit national agreement in 2014.

77. In France, the primary focus of wage setting in the health sector is at the national level, between unions and employers (often including government). There are three different wage setting blocs covering elements of the overall hospital and health sector:

1. **Public sector-** (approximately 800,000 workers), where the wage setting process is between government and unions. The workers are salaried civil servants covered by national agreements, based on pay grades/ salary scales which have been developed and agreed nationally; employees may earn between 1 and 3% more as compared to the national “basis” in continental France, and between 40 and 53% more overseas (French Guyana, Guadeloupe, Martinique, Reunion Island). National agreements can be supplemented by local (hospital level) agreements with unions but mainly on working conditions, not on wages. Where there is reportedly requirement for local wage top ups or for specific positions that are difficult to recruit (e.g. IT, nurse anaesthetist, anaesthesiologist) margins are narrow and exclude changes in pay grades/ salary scales themselves. In the public sector, wages are based on salary grid (or structure), expressed in points (“Indices Majorés”) translated in €, according to the official value of the Indice Majoré (except for the category of medical staff which are not earning wages but are remunerated by “emoluments” expressed in Euros). The salary grid and value of the Indice majoré are negotiated at national level, between unions and government. During the period between the 1980’s and mid 2000’s the value of the Indice Majoré was increased on an annual basis. However, since 2010 there has been no new increase (see Table 11):

Table 11. Indice majoré, France, 2002 – 2012

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
EUR	5 212,84	5 249,33	5 275,58	5 328,47	5 397,95	5 441,13	5 468,34	5 512,17	5 556,35	5 556,35	5 556,35

Source: Ministère de la décentralisation et de la fonction publique, <http://www.fonction-publique.gouv.fr/fonction-publique/statut-et-remunerations-4>

2. Private not for profit hospitals (approx. 300,000 salaried workers), where there is also a national focus, based on labour agreements between trade unions and employers. Hospital doctors and other staff are all salaried. The national agreement defines the minimum conventional wages and other aspect of working conditions. This agreement is negotiated between unions and employers at a national level and covers minimum wage levels etc.; individual hospitals may pay above the level set by the national agreement.
3. Private for profit / commercial (150,000 staff) where staff are salaried, other than fee for service based doctors. For the non-medical, salaried staff, as in the not-for-profit sector, a national agreement defines the minimum conventional wages and working conditions.

78. In both parts of private sector (profit-making and not-for-profit), the minimum conventional wages can be amended by each employer, who can pay more than the level set by national agreement.

Summary

79. In summary, wages for the workforce across the three main parts of the health sector in France are mainly nationally set and predominately paid as salaries, apart from doctors in the private for profit sector where fee for service is used (see Dormont and Milcent, 2012). The wage setting process is annual, working within the nationally agreed framework or “convention” which has legal underpinning.

80. In the not-for-profit private sectors, the last national agreement dated back to 1951 but was completely reviewed and agreed upon by trade unions in 2014. In the public sector the agreement was usually annually reviewed until 2010, but since then the evaluation of wages has reportedly depended more on political or social priorities than on a fixed annual process.

81. Recent changes have included, since 2009 in the private sector, annual mandatory negotiations for every enterprise (covering a broader scope than only wages negotiations), and, in the public sector: since 2010, no revaluation of "Indice majoré".

3. Germany

Table 12: Overview Germany

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Collective bargaining between unions and employers association is most common	Decentralised bargaining at local or regional level, with some exceptions for national agreements for public sector workers	None, except as an employer in public sector wage negotiations	Fragmentation driven by privatisation of hospitals and/or outsourcing of certain services areas, counteracted by introduction of minimum wage (introduced for certain groups of staff since.

82. Wage setting in Germany is collective and decentralized. Nurses and other hospital staff are represented in wage negotiations by Vereinigte Dienstleistungsgewerkschaften (Ver.Di), which represents workers in service sectors more generally, whereas doctors have a choice between Ver.Di that negotiates a separate tariff treaty for doctors and Marburger Bund which represents only hospital doctors. Until 2010, there was also another labour union, the Christian labour union federation (CDGB), though it has since

been declared unfit for wage-setting due a lack of membership and hence representativeness (Destatis, 2013, Faioli et al, 2014).

83. Hospitals have several options in terms of involvement in wage setting. They may (1) be part of an employers association negotiating on their behalf with the labour union for a sector-wide tariff treaty, or refrain from joining an employers association but still use their negotiated treaties, or (2) they may negotiate a firm specific tariff treaty which may cover one or more hospitals owned by the same owner, or (3) they may negotiate on their own with the works council for a firm-specific agreement, or (4) they may do without a tariff treaty altogether.

84. In 2010 (latest available data), coverage of tariff treaties differed between the share of workers covered and the share of firms in health and social sector covered.

Table 13. Coverage of workers and firms in the health and social sector by tariff treaties, Germany, 2010

% covered in 2010	Sector-wide tariff treaty	Firm-specific tariff treaty	Firm-specific agreement	No treaty
Workers	36	8	23	32
Firms	18	5	16	60

Source: Statistisches Bundesamt (2014) Tarifdatenbank: Tarifbindung nach Betrieben und Wirtschaftszweigen, accessed on 20 April 2014, available at https://www.destatis.de/DE/ZahlenFakten/GesamtwirtschaftUmwelt/VerdiensteArbeitskosten/Tarifverdienste/Tabellen_Tarifbindung/Tarifbindung_Betriebe.html

85. For hospitals that have tariff treaties, negotiations take place on a local level for hospital-specific tariff treaties, or at a regional (Länder) level for treaties between associations and labour unions (Statistisches Bundesamt, 2013).

- Public hospitals can fall into three categories of ownership: municipal, federal or Länder.
- The vast majority of public hospitals are owned by municipalities and their employees fall under tariff treaties negotiated by the association of municipalities with the relevant labour unions, covering all municipal employees. This negotiation is carried out in conjunction with the Federal government, thus creating a single tariff treaty for employees of the federal government and municipalities (TVÖD). The treaty also covers a handful of federally-owned army hospitals.
- University hospitals owned by Länder governments are covered by a tariff treaty negotiated by the Länder government with the relevant unions for all public employees in a given Land (TVÖD-L).
- Not for profit private hospitals are largely run by denominational welfare organisations linked to the Catholic or Protestant Church. Their employees are paid according to a tariff treaty of these churches covering all employees of these welfare organisations (for example, kindergarten teachers, or social workers) negotiated on a nation-wide level between the Churches ‘welfare organisations and relevant unions.
- Private for profit hospitals negotiate their own tariff treaty either for complete chains or individual hospitals.

86. The annual average change in monthly wages in the health and social sector in Germany has been flat in 2006 and 2007 and increasing since. Immediately following the crisis, wages increased by 4% in

2008 and 3.1% in 2009 driven by the largely unaffected labour market in Germany. The years of 2010 and 2011 saw about 1% increase each year, while wage growth has been stronger since then with 3.1% in 2012 and 2.9% in 2013 (Table 14, Statistisches Bundesamt, 2013).

Table 14. Annual change in monthly wages in the health sector, Germany, 2006-2013

Year	2006	2007	2008	2009	2010	2011	2012	2013
% change	0.0	0.0	4.0	3.1	0.9	1.0	3.1	2.9

Source: Statistisches Bundesamt (2014) Verdienste und Arbeitskosten, 4. Vierteljahr 2013, erschienen am 28.02.2014, available at <https://www.destatis.de/DE/Publikationen/Thematisch/VerdiensteArbeitskosten/Tarifverdienste/TarifverdienstLangeReihe.html>

Summary

87. Overall, wage-setting structures in the German hospital sector have become more fragmented since the 1990s. Two developments play a role in this. First, privatisation of hospitals, including both complete privatisation and partial outsourcing of some support services (such as facility management, catering, and laboratory services) has caused a multiplication of employers (Faioli et al, 2014). Second, some developments have been counteracting this fragmentation to some extent, such as the disappearance (after legal challenge to its representativeness) of the Christian labour union Federation from wage setting negotiations and the introduction of a minimum wage for long term care staff in 2010 which is still valid until the end of 2014 and stands to be replaced by a common minimum wage regulation (BMAS, 2010). This fragmentation is facilitated by the multiple choices available to hospitals in how to structure their wage arrangements.

4. Netherlands

Table 15. Overview Netherlands

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Collective bargaining between unions/ professional associations and hospital managers/employers. Most staff are salaried employees; about half of physicians are paid by individual fee-for-service	National level, sectoral, with different bargaining units for sub sectors	National approach is underpinned by laws on collective bargaining. National agreements for a longer time period than one year.	None reported. No change in wage setting time period in recent years.

88. In the Netherlands, the focus of wage setting is primarily at national level, with collective bargaining between unions/ professional associations and hospital managers/employers. The national approach is underpinned by laws on collective bargaining, and there are different bargaining units established for different sub sectors. The relatively small size and un-differentiated labour market conditions across the country were reported as a factor in sustaining a coherent national approach, and enabling the system to take account of different labour market issues at national level. While actual union membership in the sector was reported at approximately 40% of the workforce, all staff are covered by the results of negotiations, and an estimated 90% of health sector employers were reported to be members of

their employer associations/ bodies. Along with size, this has helped maintain the importance of a nationally consistent approach.

89. The time period of national agreements on wages in the sector can vary from one agreement to the next. The length of the agreement depends on factors at the time of agreement, though it was reported that national agreements were “not typically” annual, and usually for a longer time period. There was no reported change in the typical time period of agreements in more recent years.

90. While the wages of most health professionals and other hospital staff is determined nationally, there are two different approaches for hospital doctors. Some are paid by payroll (salaried); for this group wage setting is conducted through national negotiation. The second group are characterized as “entrepreneurs” and they negotiate individually at the hospital where they have their primary workplace, and are “paid per product”- e.g. fee for service. It was reported that the distribution of doctors across these two types of payment system was “about 50/50”, in terms of overall numbers.

91. The system in the Netherlands was described as a “stable process”, with low level of strikes or industrial action, and that there was currently no significant pressure for change: “*No one wants to change the system*”. However it was noted that the broader economic situation and the need to cut public expenditure did have some impact.

Summary

92. In the Netherlands, the main focus of wage setting is primarily at national level, with collective bargaining between unions/ professional associations and hospital managers/employers. The national approach is underpinned by laws on collective bargaining, and there are different bargaining units established for different sub sectors within health.

5. New Zealand

Table 16. Overview New Zealand

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Wage bargaining in the public sector health services in New Zealand is conducted between trade unions and hospital managers/employers (District Health Boards- DHB's).	National, sectoral and sub sectoral: wage setting for national workforces (e.g, nurses) is primarily conducted at a national level through the negotiation of Multi-Employer Collective Agreements (MECA) between the relevant union and the 20 DHBs. In addition, there are some regionally and locally negotiated agreements.	Government involved, co-ordination across public sector. DHBs bargaining strategy is aligned to overall public sector national bargaining strategy and, (required under the NZ Public Health and Disability Act), sent to the Director General of Health for consultation, against the Government Expectations for Pay and Employment Conditions in the State Sector	Shift from local to regional to national MECA for nurses 10-15 years ago. More recently, there is a reported shift from “claims based “ bargaining approach an “interest bargaining” approach; a trend towards greater alignment/ co-ordination of different agreements, and, in recent years, there has been some shift from 18 to 24 or 36 month agreements- reportedly reflecting the changing financial situation.

93. Wage bargaining in the public sector health services in New Zealand is conducted between trade unions and hospital managers/employers, with the latter comprising 20 District Health Boards (DHB's). Bargaining for national workforces (e.g. doctors, nurses, radiation therapists, etc.) is primarily conducted at a national level through the negotiation of Multi-Employer Collective Agreements (MECA) between the relevant union and the 20 DHBs. In addition to the national focus there is some wage setting through bargaining at regional/DHB level for some staff groups. There are a small number of regional negotiations - e.g. the 3 DHB's in the city of Auckland have an agreement on mental health nurses- Auckland is a high cost of living area and regional bargaining minimises the potential for staff to move between the 3 DHBs seeking higher wage rates. There is also DHB level bargaining for some groups such as pharmacists and manual workers for single employer collective agreements I.T. development staff with specialised skills tend to be recruited on individualised contracts.

94. In terms of wage setting for some key categories of health professionals, such as nurses, one of the issues that makes New Zealand unusual is that across the twenty five year period since the beginning of the 1990's it has shifted from national to local pay determination, and then reversed this trend, moving back to a national focus for pay determination. Local pay determination was introduced as part of health sector reform in the early 1990's which established public hospitals as autonomous "Crown Health Enterprises". Subsequent government changes, and concern about nursing shortages and pay equity issues led to a reversal, first to wage setting at regional level and then (in 2004) to a return to national level wage setting. This has created a situation where many of the stakeholders in the wage setting process have detailed experience of the pros and cons of actual involvement in different models and levels of wage setting- not just a theoretical understanding (Buchan and North, 2008)

95. Bargaining occurs within the legislative framework of the Employment Relations Act 2000 (ERA), which sets out the obligations of the parties. The key principle is that the parties "bargain in good faith"; the ERA also sets out the procedural requirements for bargaining. The trade unions are a mix of professionally focused organisations (e.g. New Zealand Nurses Organisation; Association of Salaried Medical Specialists; NZ Resident Doctors Association), general public sector trade unions (e.g. Public Service Association) and broader based trade unions (e.g. Service and Food Workers Union). Only organisations registered as trade unions in accordance with the requirements of the ERA can represent workers in collective bargaining. Different unions bargain separately for their membership, however one or more unions may bargain together with the agreement of members. In 2008 and again in 2011 several unions bargained together resulting in the same terms of settlement applying to several different workforces. Over time there has been a shift towards greater alignment/ co-ordination of different agreements.

96. The 20 DHB's meet annually to agree a national employment strategy, identify common interests, assess the collective financial situation, etc. An Employment Relations Strategy Group (ERSG) represents the 20 DHB's; it includes DHB managers/ executives, and has support from experts from a national DHB "shared services" agency. The ERSG develops a national bargaining strategy, which then goes to the 20 DHB Chief Executives for endorsement. The DHBs develop a specific bargaining strategy for each collective agreement as it expires. This bargaining strategy is aligned to the national bargaining strategy and, as required under the NZ Public Health and Disability Act 2000, sent to the Director General of Health for consultation, against the Government Expectations for Pay and Employment Conditions in the State Sector. The additional local/regional bargaining is led by local DHB managers, with support from the shared services agency if required. Trade unions normally initiate bargaining 60 days from expiry of the current agreement [employers can do it 40 days from expiry]. Unions must take any proposed wage setting agreement to membership ballot for final approval.

97. Under the terms of the ERA, no collective agreement can have a term longer than 3 years. In recent years there has been some shift from 18 to 24 or 36 month agreements, reflecting the changing financial situation.

98. The DHBs' collaborative approach to bargaining results in employment terms and conditions that are consistent across the DHBs for health staff covered by a MECA. This collaborative approach also reportedly ensures regional/DHB collective agreements are aligned with the national bargaining strategy. There is a move towards more regional collaboration between hospitals/ DHB's on service provision which has indirect implications for local wage setting.

99. There is a reported shift in style of bargaining, rather than focus, over the years from a "claims based" bargaining approach (characterized as a transactional process, with winners and losers) to an "interest bargaining" approach- where there is a focus on shared interests, in recognition of the stake health workers have in their workplace.

Summary

100. Wage bargaining in the public sector health services in New Zealand is conducted between trade unions and hospital managers/employers (District Health Boards- DHB's). Wage setting for national workforces (e.g. doctors, nurses) is primarily conducted at a national level through the negotiation of Multi-Employer Collective Agreements (MECA) between the relevant union and the 20 DHBs. In addition, some regional and local agreements are in place. There is a co-ordinated approach to wage setting, and some shift in recent years from 18 to 24 or 36 month agreements- reflecting the changing financial situation.

6. Norway

Table 17. Overview Norway

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Hospitals employers' organisation leads bargaining and wage setting. Collective agreements for all employees; with each representative trade union. High level of unionisation.	National sectoral agreement covers "national minimum": pay, pensions, leave entitlement etc. ; there is also scope for individual enterprise level for supplementary negotiations for pay rates above the national agreement level	Coordinated wage setting across industries and sectors. Government sets the tone; fixed annual/ bi-annual cycle of national bargaining, following a defined sequence, with so called "front runner" industries going first	No changes reported

101. In Norway there is an annual cycle of pay determination across sectors and industries beyond health. The government sets the benchmark by setting the next year's budget, and this then becomes the marker for wage bargaining [e.g. the budget signals "increase will be 3.5% next year"]. The approach to wage negotiations is based on the principle that wage growth must be at a level which industries exposed to international competition can tolerate.

102. The main purpose is to coordinate wage setting across industries and sectors and thereby contribute to moderate inflation and wage growth. The Government places emphasis on continued

collaboration with the social partners on income policy, and one element of this collaboration on income policy is to ensure that the social partners and the authorities have, as far as possible, a shared understanding of the situation in the Norwegian economy, and that the parties to collective wage negotiations agree as far as possible on the statistical material underlying the negotiations. This material is compiled and provided by the Norwegian Technical Calculation Committee for Wage Settlements, for which the Ministry of Labour and Social Affairs has administrative responsibility (Ministry of Labour and Social Affairs, Norway).

103. There is then a fixed cycle of national bargaining, following a defined sequence, with so called “front runner” industries going first- e.g. those that compete internationally, such as engineering, shipbuilding etc. Each of these industries will set wages by collective bargaining, both at national and local level. The wage setting agreements reached by these sectors then set the marker/benchmark for bargaining in others. It is reportedly “difficult for other sectors to give more”, as if this happens, the “front runners” agreements are opened up for re-negotiation. In this process, the government is not directly involved in the wage setting process in the health sector, but it has issued the budget, which sets the tone.

104. The vast majority of health workers are salaried employees. The hospital is the employer and the government “owns” the hospitals but is not the employer. Prior to 2002 hospital staff were either employed by the state or by the county, but now all are hospital employees. The level of unionisation of the workforce is reportedly very high- approximately 95% for doctors and nurses, and each profession is represented by own national union- e.g. NNA for nurses.

105. The health system is structured in 4 regions and 20 “enterprises”, on a geographical basis, with several hospitals or more in each “enterprise”. At national level the hospitals employers have their own organisation which leads the national bargaining and wage setting- SPEKTER (Arbeidsgiverforeningen Spekter). There are collective agreements for all employees; with each representative trade union having its own agreement with SPEKTER. These national agreements cover pay and other key aspects such as pensions, leave entitlement etc. This is “Part A” of the wage setting process, at national level; there is a scope for “Part B” which is at individual enterprise level- where there can be supplementary negotiations for pay rates above the national agreement level, for example if there is a shortage or “difficult” to fill post.

106. The central negotiations (part A) involve the social partners (Spekter and the five main unions; respectively LO (The Norwegian Confederation of Trade Unions), YS (The Confederation of Vocational Unions), Akademikerne (The Federation of Norwegian Professional Associations), SAN and Unio. These negotiations primarily concern collective regulations of general social agreements. Further negotiations depend on which unions the association is a member of and historical reasons and background. At national level Spekter negotiates with some of the professional associations (like The Norwegian Medical Association, The Norwegian Nurse Association etc.). The participation in these negotiations is limited to the largest associations. The negotiations primarily concern centrally managed pay systems, working hours etc.

107. The local stakeholders (hospital management and the local federations) conduct local negotiations for ‘part B’. These negotiations primarily concern locally managed pay systems for associations who also conduct negotiations at national levels. Associations that do not conduct “A” level negotiations have a decentralized model of negotiation that relates to questions like locally managed pay systems, and working hours etc.

108. The agreement structure is based on a so called “minimum agreement” – this implies that stakeholders at a lower/local level cannot negotiate agreements that may result in worse/lesser conditions for the employees than the stakeholders at a higher, national level have already agreed.

109. All main health professional groups and most other health workers are salaried. There is a fixed cycle of this national process: with a bi-annual process relating to the overall collective agreement (main negotiations) and in interim years a focus only on wage setting (mid-term settlement). Trade unions can legally strike every year; both at the time of the main negotiations and in interim years.

Summary

110. The wage setting approach in Norway is therefore primarily a structured national annual process, with broader bi-annual collective agreement negotiations, and with scope for locally negotiated top up to wages. No significant changes were reported in this national system in the last 10 years; it is regarded as a stable process, and is underpinned by a long history of collective agreements. The employer body (SPEKTER) has an objective of achieving a change so that the major focus of the wage-setting process would be conducted between local stakeholders, because in their view these parties possess the necessary knowledge about the local requirements, but most of the unions and associations are reportedly not in favour of such a change.

7. Portugal

Table 18. Overview Portugal

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Government, unions and employers representatives are involved in wage setting, underpinned by legal agreements.	The “normal” approach to the process of wage setting in the hospital sector in Portugal was based on the national dialogue between government (Ministries of health and finance) and the unions. From approx. 2002 onwards hospitals were being designated as “public enterprises”- being given greater autonomy, “delinked” from the broader public sector, and with greater responsibility for wage setting.	Post crisis cost/wage containment and alignment across the whole public sector determined by the agreement of a programme of economic and financial assistance. Central government has assumed the leadership of wage setting processes and broader labour negotiations, but representatives of hospital employers also participate in this national process.	Current suspension of “normal” approach. This has halted the shift to public enterprises and to an extent reversed back to national level because of the need to contain financial costs and align wage setting processes across the whole public sector at national/ central level. Actual cuts in pay and pensions, pay “freezes” etc. are also evident in recent years

111. Any description of the wage setting process in Portugal must recognise that the pre- and post-economic crisis situation is markedly different. Prior to the crisis there was a wage setting process developed for a “normal” situation, which has now been suspended because of the need for the country to address the impact of the financial crisis, and to comply with the requirements of financial support agreements and MoU with the International Monetary Fund, the European Commission and the European Central Bank. (The so called “Troika”).

112. The “normal” approach to the process of wage setting in the hospital sector in Portugal was based on the national dialogue between government (Ministries of health and finance) and the unions. There was however a trend towards increased devolution of management responsibility within the health system. From approx. 2002 onwards however there was a government led change with hospitals being designated as “public enterprises”- being given greater autonomy, “delinked” from the broader public sector, and with greater responsibility and autonomy on financial and management issues, including wage setting, which could then be undertaken at hospital level. In effect, a two-tier model of wage setting was emerging with a dual focus at national and hospital level.

113. However, the global financial crisis has impacted on the wage setting approach in Portugal in several ways. Firstly it has halted the shift to a hospital level focus, and to an extent reversed this back to national level as the primary focus on wage setting. This is part because of the need to contain financial costs and align wage setting processes across the whole public sector at national/ central level.

114. This containment and alignment approach across the whole public sector was determined by the agreement of a programme of economic and financial assistance, and a MoU, by Portugal, with the IMF / EC / EB, in 2011. Under this agreement, enterprises were required by new budget laws to re-align with the broader public sector, which has meant that individual hospitals are now included in the overall pay “freeze”, with no salary progression, the reduction of remunerations and other additional wage benefits such as overtime rates, reduced leave entitlements, and reductions in pension benefits.

115. Secondly, beginning in 2009, there was also a significant change in the structure of public sector administration, creating a new structure of career grades and paths, but leaving untouched some categories of so called “special ones” for future negotiation and redefinition. These include medical doctors, nurses, and other professions specific to the health field.

116. Also in 2009, the first step in the negotiating process in health sector was undertaken with medical doctors and nurses; as far as doctors are concerned this new convention and career structure was completed in 2012, and continues to be monitored under a specific Tripartite Committee (Ministries of Health, and Finance and the two trade unions) set up for that purpose. The new convention reduced the variable amount in the overall pay of doctors, and increased relatively the amount consolidated into “basic” -set- pay. The same approach is now underway with national negotiations for nurses, involving the government departments responsible for health and public administration, hospital representatives and the nursing unions. Similar processes are also being initiated for other health professionals and workers.

117. The significant change since the crisis in Portugal has been that hospitals (enterprises) have essentially lost their capacity to determine wages, with central government assuming the leadership of wage setting processes and broader labour negotiations, although representatives of hospital employers participate in this national process.

Summary

118. Overall the wage setting framework has a two stream approach: firstly there are negotiations covering the public sector workforce in “traditional” public sector settings (central and regional administrative departments and the Regional Health Administrations, comprising almost all Primary Health Care provision) and secondly there are Labour Code type negotiations, based on a convention approach (national agreement between employers and representative unions) applicable to the workforce in “public enterprise” type institutions, such as hospitals and local health units. Despite the reported reductions in salaries and the freezing in wage increases, yearly general negotiations are continuing between the Government and the Unions for the entire public sector.

8. United Kingdom

Table 19. Overview United Kingdom

Collective bargaining	Centralisation	Co-ordination and government involvement	Recent trends/ changes
Negotiations/collective agreements between government department, NHS employers and recognised professional associations and trade unions. NHS staff (the vast majority of hospital workers) are salaried.	Main focus is at national level; sector wide within NHS. Pay Review bodies independently set annual recommendations for increases in pay; national collective agreements underpin this approach, and set out other terms and conditions- working hours, leave etc. There is scope within foundation trusts for local wage setting, but mainly only used for recruitment “top ups”	Government involved via Department of Health participation in national negotiations; close alignment of national pay framework for different NHS occupations. Normally an annual cycle of wage setting.	Impact of economic crisis has led to pay “freezes” and partial suspension of elements of the normal wage setting approach- Review Body recommendations not accepted fully by government; NHS trust employers advocating for more local “flexibility”.

119. The vast majority of hospital based care in the United Kingdom is provided with the public sector National Health Service (NHS). Pay rates for doctors, nurses and other staff working in NHS hospitals are based on nationally agreed pay structures, with separate systems for doctors, for nurses and other health professions, and for other NHS staff.

120. For the doctors, and nurses and other health professions, the national pay increase recommendations are made by independent pay Review Bodies. These are committees of independent experts appointed by government, and with a secretariat provided by the Office of Manpower Economics. The Review Bodies make their decisions based on evidence submitted to the Review Bodies by trade unions, employers and government, and on any additional research which they have commissioned (see: <https://www.gov.uk/government/organisations/nhs-pay-review-body/about>) There is some limited scope for local supplemental payments to staff, where hospitals have sufficient funds and can demonstrate that they have recruitment and retention difficulties.

121. The doctors and dentists pay Review Body was set up in 1971 and covers more than 200,000 NHS salaried hospital medical staff, dentists and general practitioners; the Review Body for NHS nurses, other health professionals and staff was established in 1983, and covers approximately 1.36 million staff (Review Body, 2014). Other review Bodies cover other groups of public sector staff: school teachers, the armed forces, and prison service. In normal times the Review Body process is an annual cycle of evidence taking and pay recommendations, but as a result of public sector austerity measures there have been government imposed public sector pay freezes in recent years, and the role of these Review Bodies has been constrained and reduced.

122. The Review Bodies “price” a pay structure and system which has been negotiated collectively and agreed at national level between government, employers and trade unions/ professional associations. Main associations/ trade unions include profession specific associations (e.g. British Medical Association and Royal College of Nursing) and general health sector or public sector trade unions (e.g. UNISON).

123. In recent decades, broader based plans for NHS reform have included proposals that NHS wage setting should be shifted to a more localised approach, to support local management autonomy and control. Increased autonomy for NHS hospitals (“foundation trusts”) was first established in 2004, and most hospitals in NHS England now have “trust” status, which gives them greater freedom to make their own decisions on staffing and pay, but in practice only a few hospitals have ever withdrawn from the NHS national pay system.

124. The last significant reforms of the pay structures for NHS staff were at the beginning of last decade, with new national contracts and pay structures were negotiated and implemented for general practitioners, for hospital based salaried medical consultants, and for other NHS staff, including nurses. The main stated objectives of these reforms were to improve recruitment and retention, increase flexibility within a national framework, and improve productivity; independent review of the reformed structures noted increases in staffing, but found little evidence of productivity changes (National Audit Office, 2007; National Audit office 2008; Buchan and Evans, 2009; National Audit Office, 2009).

125. The need to contain NHS funding has meant that there has been an increasing focus on achieving savings on the NHS staff paybill in recent years. This has meant that in several recent years, aspects of the “normal” wage setting process have been suspended. The pay Review Bodies have not always been required by government to issue annual recommendations, and the government has also initiated public sector wide pay “freezes” as well as increases to pension contributions by staff. The Foundation Trust Network, which represents hospital employers, is arguing the need for a radical change in how NHS pay is determined, with greater emphasis on local flexibility in wage setting (Foundation Trust Network, 2012).

126. Most recently, in March 2014 the government in England announced it would not fully implement the 2014-15 recommendations of the Review Bodies for doctors and for other NHS professionals as these were “unaffordable” (BBC, 2014). At the time of writing this chapter there are reports that the government is offering a “trade off” to protect NHS staff jobs if other aspects of wage setting, such as overtime pay rates and shift pay rates, are opened up to new negotiation.

Summary

127. Whilst the system remains nationally focused, based on collective agreements, key aspects of the independent review process supported by the Review Bodies have largely been suspended during the time of public sector funding austerity and wage restraint.

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