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**LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE**

**OCCUPATIONAL WELFARE IN RUSSIA WITH  
SPECIAL REFERENCE TO HEALTH CARE**

**PhD THESIS**

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## **ABSTRACT**

Relying on new empirical data, derived from a survey, and supplemented by an extensive study of available secondary material, this thesis represents the first attempt systematically to explore key issues regarding occupational welfare in Russia, with special reference to health care.

The thesis is divided into three parts: a discussion of the problematic; an investigation of the evolution of policy; and an examination of primary and secondary empirical data. The fundamental theoretical problems of occupational welfare are approached in the light of research in the West, in the Soviet Union and in post-Soviet Russia with emphasis both on divergences and commonalities. It is argued that any endeavour to separate Soviet and Western experiences is artificial and ultimately unproductive. Rather, the analytical penetration of ideological barriers renders possible an examination of their fruitful interaction. On the basis of existing knowledge two perspectives of occupational welfare – social policy and organisation – are introduced. An attempt to formulate a general definition of the notion of occupational welfare is also made.

The evolution of occupational welfare and in particular its health care component are examined in their context, from the Tsarist era, during the Soviet Union and through to post-Soviet times, with a concrete aim of elucidating any continuities in policy pathways. Contemporary issues are associated with the initial outcomes of health reforms in the 1990s that are indispensable for projecting the future prospects of occupational welfare.

The empirical component of the thesis reports the results of fieldwork carried out in Moscow between 1995 and 1997. The brief was to explore the contemporary status of occupational welfare in Russia in the context of changing social policy aims and methods evolving in the course of the transformation. The attitudes of senior managers of industrial enterprises providing in-kind health services for their employees were investigated, as were employers' actual health responsibilities in the light of the introduction of compulsory health insurance legislation. It is argued that occupational welfare has a distinct sphere of operation and offers potential, not only for the survival of the service area but also for its further development in the evolving socio-political environment.

The thesis is a first step towards a deeper analysis of occupational welfare in Russia: an audit of outstanding issues, although not exhaustive, completes the account as an aid to further discussion and research.

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## PREFACE

The subject of this thesis is occupational welfare and I have chosen it for the two main reasons.

The first one is of the theoretical nature. Occupational welfare whatever it is understood is undoubtedly an integral part of economy and hence a social policy component. The idea of occupational welfare was initially introduced in scientific turnover by Titmuss and until recently has quite undeservingly received little attention. That is why it seemed so attractive to me to make an inquiry with a view of trying to build a comprehensive conceptual framework for the understanding of occupational welfare as an international phenomenon and to generate themes and hypothesis to be explored and tested through field research.

Occupational welfare is discussed in the context of state social policy, equity and equality and employment problems. It inevitably brings us to the important role of organisations and industrial enterprises in the first instance in the provision of social benefits because the distribution of responsibilities between various societal institutions is of the utmost importance.

One of the objectives of the study is to introduce Russia into international academic debate on occupational welfare that is now mainly based on the experience of the Western states and scarce information about the developing countries. It is hoped the Russian (Soviet) model and the related issues that are so little known to the world scientific community might be a contribution to the general knowledge of occupational welfare which has been accumulated elsewhere.

It is also important to define if occupational welfare is a societal phenomenon inherent in modern societies regardless of whether they are capitalist or socialist. A brief review is made of the stand taken by scholars in the West and Russia on the issues, which are likely to form the attitude towards occupational welfare. The comparison helps to understand

differences and similarities between the Western and the Russian (Soviet) patterns of occupational welfare and thus to make a conclusion whether they can be related to the same phenomenon. If the answer is "yes" then it may be suggested that Russia always belonged to the mainstream of the development of social welfare systems, and, therefore, has the right to be included into the analysis of occupational welfare that is now dominated by the Western experiences.

The study of the ways occupational welfare is implemented justifies a rather bold attempt to formulate a general definition of the very notion of occupational welfare. It is not claimed to be exhaustive but it is believed to be instrumental in research and practice.

Special reference is made to health care because of its importance in social protection when the access to and the quality of health services are one of the main indicators of people's well being. Moreover, historically welfare systems in many countries including Russia were started with the introduction of some forms of social protection in health care. The problem is viewed from a social and managerial perspective including the role of enterprises, definition and organisation.

Nowadays Russia has been going through difficult times of reforms that are aimed to create democratic society based on market economy. Transformation of the established social and economic order infringes upon every aspect of national life including welfare sector, which is closely interdependent with people's everyday life. It inevitably necessitates the creation and implementation of a new social policy.

In the past are collectivist values and state paternalistic ideology with its objectives of the gradual elimination of social inequalities, the constant increase in people's well being and the comprehensive development of individual. On the present agenda is development of the system of social protection, search for new mechanisms of the settlement of social conflicts and reconciliation of interests. A viable social policy adequate to the new conditions becomes one of the most important pre-requisites of the success of economic and political reforms.

The reforms in Russia are structural by nature as they affect the roots of the societal system. Political decisions in the social sphere might lead in the long run to the formation of a new social model. It is essential in these circumstances to define the role of various social institutions in contemporary Russian society and the ways social responsibilities are to be distributed among them.

Therefore, the fate of the institutions that belonged to the old times becomes an issue of an increasing importance. If old institutions are not for some reasons compatible with the new social organisation of the Russian society and thus should go then the questions arise about what is to come instead and what institutions will secure the social rights of the Russian people proclaimed in the Fundamental Law of the country. In this context the ways to protect people against social risks avoiding any gaps in the social protection system are among the most significant problems.

Occupational social services are one of the old institutions of social protection of people in employment in Russia. What will happen to them is important as they used to be quite widespread in the Soviet Union covering a large part of population. Today their role in Russian society is under a severe criticism. The main arguments of the opponents stress their inefficiency--social services are considered to be a burden for an enterprise and incompatible with free market economy. It is alleged that if Russian enterprises want to be competitive they should stop providing social services for employees. Recipes offered include either closure of social services belonging to enterprises or their divestiture to local authorities.

In order to have a full picture of the issue it is necessary to overview occupational welfare in Russia, its origins and evolution for at least a century and a half. It will enable us to place it within the historical context with a purpose of tracing continuity and changes in occupational welfare in various historical settings. The three periods of the Russian history are taken: the Imperial Russia (1860-1917), the Soviet Union (1917—late 1980s) and the post-Soviet Russia (late 1980s--onwards). The study shows that the

phenomenon of occupational welfare should rather be attributed to the Russian society in its historical perspective than just to the Soviet state.

The other purpose of the research is empirical. The overarching aim of the empirical study was to give a picture of modern occupational welfare in Russia through the study of occupational health care, especially enterprise health centres. It was based on the fieldwork carried out during the period of 1995-1997. The emphasis was laid on exploring the attitude of industrial enterprises to health protection of their employees in the context of changing relations with the state in this sphere. The situation was investigated in interviews with representatives of social policy network in the health sector - members of parliament, officials of government bodies and Moscow local authorities, staff of health insurance companies, industrial managers. Official documents and grey literature were extensively used in the research.

The collection of data on occupational welfare, in general, and health care, in particular, is not at present an easy task. Official statistics on the subject barely exist and it is difficult to gain the access to information at enterprise level because firms may not want to disclose data about their private plans. That is why a semi-structured questionnaire was used to find out opinions of employers still providing health services to their employees. It permitted the identification of issues which employers considered important in this matter. The sample comprised fifty industrial establishments in Moscow. Two enterprises were researched in more detail and information obtained was used to compile two case studies on enterprises, which continue successfully to invest in health care protection of their employees. The findings were compared with the data of the surveys carried out by the World Bank and other international and Russian organisations.

For the reasons mentioned above the findings of the study are limited and provisional in many respects. Yet there is ground to hope that despite the obvious limitations they can help to encourage the further exploration of such complex matter as occupational welfare and to find rational ways of making right choices in the solution of occupational welfare issues in Russia.

## **PART 1**

### **PROBLEMATIC OF OCCUPATIONAL WELFARE**

The study of occupational welfare involves the whole range of theoretical issues that have been either not thoroughly researched or simply neglected. It is particularly characteristic of Russia where up till now the term "occupational welfare" has not even been used. This thesis, therefore, is an attempt to fill this gap.

Occupational welfare is a multifaceted phenomenon with properties falling into the three main categories:

- conceptual / ideological including equality, equity and employment considerations;
- financial / economic including allocation of financial and material resources through occupational welfare and tax-related issues;
- organisational / administrative including state regulations concerning the right to contract out of compulsory welfare schemes, transferability of rights, entitlements requirements; coverage of dependents, etc.

Theoretical analysis is made against the background of Western, Soviet and post-Soviet debates. Comparative approach affords the best means available to define specific and general features of the phenomenon, differences and common grounds of the theory and practice of occupational welfare in the West and Russia. In discussion of Russian experiences emphasis is laid on the Soviet period with its model of enterprise-based social benefits, which substantially differed from what existed in the West. As the Russian society has nowadays been undergoing the process of economic and social transformation the time has not yet come to make any definite conclusions on future changes in the sphere of occupational welfare.

The special attention is paid to the place of organisations/industrial enterprises in occupational welfare, to its two perspectives (the organisation

perspective and the social policy perspective) and the role of employers/management of enterprises.

On the basis of the analysis in this part of the thesis an attempt is made to work out a general definition of the very notion of occupational welfare. It is clearly understood that the aim is very ambitious because of complexity of the subject but it is hoped that readers will be indulgent enough: it will be worthwhile even to additionally attract attention to the problem.

Finally, the role of health care in the framework of occupational welfare, definitions, principles and organisation of occupational health services, the Western and Russian / Soviet experiences in this sphere are dealt with.

## **Chapter 1**

### **On Approaches to the Subject of Occupational Welfare**

Chapter 1 is focused on the issues that are fundamental for occupational welfare – equality/equity, employment, state social policy and enterprise-based social benefits, economic efficiency, non-statutory occupational provisions, enterprise social assets. They are expounded in a form of the debates carried out by scholars in the West, the Soviet Union and post-Soviet Russia. This method has afforded a good opportunity of drawing a comparison of different, sometimes contradictory view on occupational welfare, to define divergences and common grounds in understanding the phenomenon.

#### ***1. The Western Debates on Occupational Welfare.***

##### **Occupational welfare and equality / equity.**

The problem of equality/equity in relation to occupational welfare is usually approached from the concept of citizenship and social rights. Whether occupational welfare can be considered equitable is much debated issue and there is no consensus about it.

The researchers in the field often question the social nature of occupational benefits on the grounds that they serve interests of particular groups of workers rather than the entire society. While state schemes are available to all people who meet certain national requirements organisations/enterprises provide social benefits only to their employees. Unlike state welfare provisions occupational arrangements have always been designed

"not to cater for those whose welfare needs are greatest but for those who are perceived to be most valuable for the company's purposes" (Russell, 1991: 98).

Occupational welfare, as Mishra (1981) pointed out, might not be developed where it was most needed. He suggested that occupational welfare



could not be considered only as a functional equivalent of social services. He pointed out that the crucial difference between these two was that occupational welfare created inequalities between different groups of workers as a part of a reward structure of an enterprise whereas social welfare discriminated, too, but according to different, income criteria. He compared social and occupational welfare discrimination lines as quantitative (class) versus qualitative (caste).

Titmuss (1974) commented that inequality arose from such determinants as occupational and income achievements. Should people have any privileges because they were members of such corporate social structures as enterprises? He mentioned that occupational welfare could very likely undermine the unified system of social policy, as in practice it could be used

"to divide loyalties, to nourish privilege and to narrow social conscience". (Titmuss, 1974: 53)

Titmuss called occupational provisions "concealed multipliers of occupational success". Besides, it is often stressed that, first, occupational benefits increase dependence of employees on their enterprises in solving social welfare problems, and, second, if employees are excluded from mainstream social programmes social solidarity in society is weakened.

The major criticism of occupational welfare comes from the fact that it is very likely to be a source of inequality. Green and colleagues (1986) believed that occupational inequalities could substantially strengthen overall inequality in society. Titmuss noted that all three divisions of welfare (social, fiscal and occupational) should be taken into account when the effects of occupational welfare on equality in the welfare state were appraised.

But, in my view, what is missing in these debates is the subject of what the notion of equality means and whether its achievement is, in fact, the aim of the welfare state. Conflicting views on the problem are very well illustrated by Le Grand versus Powell discussion.

Le Grand in his influential "Strategy of Equality" (1982) distinguished five types of equality: equality of public expenditure, equality of final income, equality of use, equality of cost, equality of outcome. Proceeding from the

premise that the objective of the welfare state was to promote equality he came to the conclusion that

"the strategy of equality through public provision has failed" (Le Grand, 1982: 151).

Powell (1995), on the contrary, argued that, first, equality should not be defined in distribution terms only and, second, reaching equality might not be an objective of the welfare state. He stated that in fact the aim of the welfare state was to secure a minimum standard of living.

But occupational welfare is left out of this debate, which is mainly concerned with public spending. It definitely fails to secure equality of use and access because it is inseparably linked to an employee's position in an enterprise. It may even be argued that in this case a double inequality shows up as employees not only have jobs but also receive additional social benefits out of them.

Occupational welfare and especially its voluntary arrangements might not be concerned with the problem of equality and justice in society. That is expected to be solved by the state, which is supposed to look after the fairness of treatment of different groups of population. As a part of reward structure occupational welfare does not have the aim to maintain equality even at a particular enterprise to say nothing about a trade or an industry. Green and colleagues (1986) pointed at the unequal treatment of the working people (manual and non-manual/managerial, part-time/full time, etc.) under occupational schemes. Higher paid workers, as a rule, manage to get more remuneration in benefits as they are more aware of their advantages as well as have a greater ability to negotiate.

In this connection Saunders (1990) noted that it should be accepted that the modern society is unequal. It was important to decide whether inequalities were just or unjust. If a certain degree of inequality was inevitable then the problem was to agree how fair were inequalities generated by occupational welfare.

Rawls' logic as applied to the analysis of occupational welfare leads to his second principle of justice that reads as follows:

" Social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all". (Rawls, 1972: 60).

The point (b) pertains to occupational welfare, as inequalities it might generate appear in the matters incident to or arising out of employment. In the sense of Rawls' comment that inequality in distribution of wealth and income should be consistent with equal citizenship and equal opportunity it might be argued that occupational welfare in the Western societies can be considered as a fair enough system because:

- everyone has a right to choose an occupation;
- occupational plans, as a rule, cover all categories of employees, including managerial staff;
- those plans supplement state social programmes when the state fails to secure equality in society.

Dutch researchers (Brouwer and Hermans, 1999) resorted to Rawls' theory of justice to prove that special private clinics for employees financed by employers could be introduced as functioning on a just and equitable basis. Such clinics should afford a possibility for employees to avoid being on long waiting lists for medical treatment. The opposition to this idea came from the government and majority of public organisations. The Dutch government ruled against such plans on the ground they discriminate against non-employees.

Equity is also a matter of a great concern. For example, Evans (1994) pointed out that occupational provisions contributed to the unfairness of the tax system. They breached horizontal equity as an individual having the same income as another one might pay less in taxes if he or she had a higher ratio of occupational benefits. On the other hand, they were prone to violate vertical equity because higher earners were more likely to get more income in the form of occupational benefits.

### Occupational welfare and employment.

Occupational welfare is often treated from the point of view of the right to work. But connection between them is not at all straightforward. Social rights, in fact, have little relevance to understanding occupational welfare, especially as a non-statutory category (Mishra, 1981). On the other hand, occupational benefits have presently become to a certain extent institutionalised by legislation or through collective bargaining. They are often regarded as a basic entitlement or condition of employment and can be treated as rights at work (Green and colleagues, 1986), often taken for granted, thus reflecting the changing perceptions about social security. Employment tends to be accepted as a criterion of distribution of social benefits. Many scholars note that social policy issues discussed, for example, at the European Union (the EU) level are evidently dominated by employment considerations. The theoretical background for it is a gradual shift from broad social citizenship understanding of equality to equality of opportunity and overcoming social exclusion or, briefly, from welfare to workfare (Lister, 1998).

Another widely discussed problem is the influence of occupational benefits on flexibility of labour and creation of new employment (Hart, 1988). The recent evident increase in interest in occupational welfare is caused by the rising costs of employees' benefits that are borne by business and the effect they have on competitiveness. The creation of the single market in Europe leads to the lifting of all barriers to free movement of workers that puts pressure on the member countries to harmonise industrial relations and social welfare arrangements. It is worth mentioning that both policy makers and researchers in Europe seem to be more preoccupied with pension issues while, for example, in the USA discussions chiefly concentrate around health care plans.

Mitchel and Rojot (1993) argued that employees' benefits were usually viewed as addition to labour costs. Thus, it was considered that firms with higher ratio of these benefits were less competitive. They noted that such an approach distorted public policy as benefits affected compensation mix rather than level of labour costs.

### Occupational welfare and state social policy

Expectations society might have in relation to occupational welfare and how it perceives social responsibilities of business is another important issue. In this context discussions evolve around relations between occupational welfare and the state or, to be more precise, the welfare state.

Bryson (1992) pointed out that most writers on the welfare states were silent on the role occupational welfare played in the welfare state models. Rose's statement (1981) that such an omission serves social and political purposes aiming to hide advantages received by already better-off people has some rationale but seems too political. Such a neglect of occupational welfare in the welfare states typologies may be also explained by other reasons.

Occupational welfare is presumed to be an integral part of social policy but welfare state models are usually based on the explicit role of the state whereas in regulation of occupational welfare the role of state is often implicit. Therefore, occupational welfare is not considered as a mainstream.

Mishra (1981) who argued that occupational welfare consisted merely of voluntary provisions definitely included it into a non-statutory sector. Analysing two models of the capitalist welfare state, residual and institutional, he suggested that in the welfare mix underdevelopment of statutory services led to the flourishing of non-statutory sector (the residual model) and, on the contrary, well-developed statutory services made the role of non statutory agencies secondary (the institutional model). The argument is actually based on the premise that each of these two sectors is an alternative category of welfare and society expects to have a certain level of welfare at any particular moment. In case this level is not secured by the state private sector should come out to fill the vacuum and vice versa.

The models constructed by other authors (Titmuss, 1974; Esping-Andersen, 1990) dealt with the interplay between the state and market or the state and private sector, without defining what they, in fact, included into "market forces". Esping-Andersen (1990), discussing the private/public mix in pension regimes suggested a rather complicated classification of occupational

pensions plans. He took explicit government regulations to be the main criterion for their attribution as public or private.

In general, the role of occupational welfare in implementing social policy is underestimated or even completely neglected in the analysis of the welfare state (Gough, 1979). It is a one-side-effect of broadening the notion of the welfare state. Today social welfare is viewed in terms of welfare mix understood as the combination of efforts of state institutions and non-governmental agencies. Rein and Wadensjo stressed that

"the firm-state interaction is probably the overriding factor in creating a change in the welfare mix" (Rein and Wadensjo, 1997:4).

They also noted that exclusion of occupational welfare from the total welfare spending distorts understanding of the real scope of welfare states in different countries.

But even when occupational welfare becomes the subject of discourse it is often seen as something adjacent to the state welfare (see Table 1.1).

Table 1.1.

***Occupational welfare in relation to the state welfare programmes***

Brown and Small	Esping- Andersen	Rein
supplementing	complementing	reinforcing
substituting	zero-sum relationships	antagonistic

Source: Brown, J., and Small, S., 1985 ; Rein M. and Rainwater L.,1986; Esping-Andersen, G.,1996.

The classifications are based on the view that the state is a prime actor in the welfare state. It is the organiser of provision of public services and the creator of incentive structure for the development of occupational as well as private sectors in welfare (Rein and Wadensjo, 1997).

The dilemma is rather simple: occupational welfare is provided either in addition to state arrangements thus covering only a limited proportion of workforce or instead/ in absence of state programmes. Therefore, in the first

case occupational welfare is weak and in the second it largely depends on changes in state arrangements.

In my opinion, such classifications are not productive as in many instances it is very difficult -- if possible at all -- to judge whether occupational welfare has supplementary or parallel functions.

In order to determine relations between occupational welfare and state welfare it is suggested that the ratio of compulsory and voluntary contributions of employers not only to occupational welfare plans but also to public programmes in general should be taken as a criterion (Tachibanaki, 1987). These relations can be referred to as "substituting" when, for example, voluntary occupational welfare provisions are more substantial than statutory ones and the ratio of voluntary to statutory occupational welfare is high.

Brown and Small (1985) suggested that the state and occupational provisions were closely interrelated. Green and colleagues (1986) referred to relations between the state and employers in social welfare provision as "a partnership". Mishra (1981) also called an enterprise a leading partner of the state in the business of welfare. But only in a particular context it is possible to trace whether a limited scope of public provision stimulated employers to act or the state came in because of the lack or insufficiency of occupational arrangements.

Before the World War II such phenomenon as "welfare capitalism" appeared in the USA. It was a policy of corporations that apart from trying to weaken the influence of trade unions and to secure workers' allegiance was aimed to prevent the growth of state welfare provisions. In this way corporations sought to ensure their independence from the state and more effective distribution of welfare targeting it to their own employees. Thus, welfare incident to employment was viewed in the USA as an alternative to state welfare arrangements.

The development of occupational welfare inevitably stimulates changes in aims and methods of the state social policy and visa versa. The evolution of the sick pay in the UK that originated as a voluntary employer's subsidised benefit and then was made compulsory in 1986 is a good example of such a process.

The availability of state provisions gives occupational sector more flexibility both in principal and in technical and administration matters. Though the types of benefits deemed important by an employer may not be the same workers would prefer. Supporters of private plans often argue that flexibility of occupational arrangements which can be more clearly cut to meet individual needs is their major advantage. Non-statutory forms of welfare are more developed in countries with low state social expenditure. The experience of the USA shows that absence or insufficient level of protection offered by public schemes encouraged provision of occupational benefits. In its turn the spread of occupational plans could be a prerequisite for the state to curb social welfare spending, to withdraw from welfare provision or at least to change its priorities.

Anyway, in the analysis of occupational welfare the methods of implementation of social policy reflected in the public/private mix should be taken into consideration. It is important to know, for example, whether occupational welfare is provided exclusively on a voluntary basis. It means the lack of enforcement of the state regulations directly imposing welfare provision on enterprises rather than their absence, which would be just impossible to imagine nowadays.

Quite a number of writers stressed the role of government as an employer because in many countries first social security plans covered solely state employees. They can be considered as occupational leading in practice to the creation of private market. Esping-Andersen (1990) noted that the state in its role as an employer often pioneered the idea of occupational welfare evidently overlapping state welfare.

The state promotion of occupational welfare can take different forms. Esping-Andersen (1990) distinguished direct (through taxation) and indirect (meagre state benefits, strict eligibility criteria, etc.) methods. One of the most effective levers of the state influence on occupational welfare is legislation, which according to Esping-Andersen's division is a direct measure. Rein and Rainwater (1986) argued that there were three ways by which the state could intervene with occupational welfare: mandating, stimulating and subsidising.



It is very important that a careful analysis is made why the state chooses one of the above-mentioned options and what consequences it might have. All researchers in the field mention that taxation policy is the principal reason for both employers and employees in favour of introduction of occupational plans. Preferential tax regime of occupational welfare allows comparing it with fiscal welfare, the main difference between them being that the former is directly incident to employment (Bryson, 1992). Tax concessions can be regarded as one of the incentives that accelerated the development of occupational welfare (Green and colleagues, 1986).

Apart of creating unfavourable attitude to occupational benefits of those groups of population, which do not receive them, such practices lead to the narrowing of tax base. In this case, as Titmuss (1974) noted, the price of occupational welfare is shared by the entire society.

Finally, it should be always kept in mind that occupational welfare is inseparable from political implications. Green and colleagues (1986) wrote that in the cases of pensions and NHS there was little pressure in Britain for the improvement of state provisions because those in power could expect better occupational arrangements for themselves.

#### Occupational welfare and non-statutory provisions

Western scholars' point of view on relation of occupational welfare to non-statutory provisions and agencies deserves to be mentioned. The latter usually include charity, mutual aid and individual initiative. Mishra (1981) stated that development of occupational welfare alongside the expansion of social services implied among other things a change in the private welfare mix reflected in the growth of a share of occupational welfare in relation to other non-statutory welfare provisions. Stevens (1986) gave an excellent account of how employer sponsored benefits in the USA proved to be more successful in providing protection against social risks than other non-statutory provision. The reasons were mainly economic: mutual aid societies and charities failed to cope with growing financial demands.

Occupational welfare is greatly influenced by trade unions. Stevens (1986) mentioned that employee benefits as a reward for work were used in the struggle for control over a workplace. It might be suggested that in the long run both employers and trade unions used occupational welfare provisions as a means to counter the actions of each other to secure the loyalty of workers.

The experience of the UK and the USA proves that the role of trade unions in provision of occupational welfare may vary depending on political and economic situation. In the USA they are active partners in negotiating occupational schemes and thus initiating welfare provisions. On the contrary, until recently British occupational programmes were started by management, probably because trade unions had more possibilities to lobby introduction of state welfare provisions through their alliance with the Labour Party.

## ***2. The Soviet Debates on Occupational Welfare***

The peculiarity of the subject to be discussed further is that Soviet scholars did not use the term "occupational welfare" at all. It does not mean that theoretical problems flowing from this notion were not explored. It was made by the study of the role of enterprise-based services in social policy, equality and equity, social funds of enterprises as a part of public consumption funds. It is worth noting that Soviet researchers agreed that practice of occupational welfare in the Soviet Union was well ahead of its theoretical conceptualisation. As a result many relevant problems failed to have been properly studied. (Дегтярь (Degtyar), 1987).

### Occupational welfare and equality/equity. <sup>1</sup>

The problem of social equality in the Soviet society was understood in terms of social status rather than in purely distributional terms. All individuals were regarded equals as members of society. It was presumed that they all worked if they were able to and satisfied their needs even in case they could not work; actively participated in public life; possessed equal civil rights and

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<sup>1</sup> Though in the Soviet Union debates on social equality and equity were carried out in the framework set by official ideology it does not mean, however, that the problem should not be dealt with.

bore equal responsibilities. The ultimate principle of justice of communist society was expressed in the maxim "to everyone- according to his needs, from everyone -- according to his abilities".

Nevertheless it was acknowledged that social equality could not be fully achieved in socialist society as it was a lower stage of communism. Some inequalities were explained by the specific historical background (Engels (1961) noted that the perception of justice itself was a product of historical development) and by the lack of resources society had to satisfy all needs of all people. Differences between social groups were expressed, for example, in income status dependent of distribution according to work. The importance of material stimuli was admitted, especially in 1970s-1980s when the rate of growth of the national economy decreased (Микульский (Mikul'sky and colleagues), 1987).

Equity was a major concern of Soviet scholars mainly because of economic/ property considerations. Since the means of production were in public ownership all people were equal in relation to it. They were considered to be co-owners of enterprises and possessors of equal rights to outcomes of their activities. In this context occupational welfare was incremental as it was available only to those in employment and sometimes their dependants. However, as it existed side by side with the state system of social protection that covered all social risks and all citizens, the employed could get social services through two systems, namely, the state and enterprise, often duplicating each other. To solve the arising principal ideological problem of finding arguments to justify such a situation the idea of a preferential treatment of workers was put forward. As the social and economic status of any stratum of population was measured by its contribution to development of economic basis of the new society those people who contributed more to welfare of society were to be rewarded more. Industrial workers came the first on the list as the main productive force. It was considered to be just especially because workers' input to the growth of the national economy would in the end enable all citizens to benefit through public ownership of the means of production.

### Occupational welfare and employment

Soviet researchers were aware of the problems embedded into the system of benefits and services incident to employment, which undermined application of the principle of equality in welfare system. Among them were the following.

First, occupational provisions implied discriminatory distribution of goods and benefits: large and rich enterprises were able to provide more for their employees than the smaller ones. It resulted in great diversity of provision of social services.

Second, when social benefits and entitlements were linked to peoples' employment the quitting by a worker of his/her job meant loss of access to them. Due to shortage of many consumer goods and services a lot of what people needed could not be freely purchased or acquired in other places than enterprises.

Third, elite groups, first of all governmental and Communist party officials were granted privileges inaccessible to general public, such as special shops and hospitals, country houses (*dachas*), chauffeured cars, etc. Their legitimacy was questionable from the point of view of the egalitarian concept of social justice proclaimed at that time.

Employment figured prominently in debate on socialist social justice that implied:

- equal position in relation to means of production;
- securing employment for every economically active person;
- remuneration in accordance with labour input.

It was admitted that an enterprise being an integral unit of the national economy and society had a certain degree of autonomy and thus its own interests, which might differ from those of society at large (Полозов (Polozov), 1978). An increasing independence of enterprises in provision of social benefits could lead to serious distortions in correlation of public and enterprise interests. In order to counteract the tendency and reconcile those interests it was suggested that the role of local authorities in coordination of social welfare activities on their territory had to be augmented.

### Enterprise-based social benefits and state social policy

The provision of enterprise-based social benefits was always considered in the Soviet Union to be a part of social policy. This assumption was not subject to criticism and discussion around it was limited to the problems of how enterprises had to provide social services in kind for their workers through social funds and social assets.

Social welfare activities of Soviet enterprises were aimed at the adjustment of global social policy goals to specific circumstances and at their use in the framework of the mainstream welfare system as a channel of provision of supplementary social welfare benefits for the employed.

The place of Soviet enterprises in economy and society determined in its turn the role of enterprise-based social services in social policy. As all enterprises were publicly owned these services were not exactly "employer-provided", in fact they were "state provided" via employer as some employment was considered to have strategic importance for the development of the national economy. The industrialisation policy proclaimed at the 14th Communist Party Congress in 1925 required a high concentration of all resources including human. It changed the face of industry and led to unprecedented increase in the number of enterprises, all state-owned, and industrial workers.

The fact that in the mainstream Soviet research enterprise social funds were included into the notion of the public consumption funds (*obtchestvenniye fondi potrebleniya*) is an important evidence of enterprise-based social welfare being a part of social policy.

The aggregate means allocated by socialist society for consumption by population were divided – as suggested by Marx (Маркс, 1961) – into:

- wages/salaries;
- public consumption funds (PCF) consisting of centralised funds accumulated in the state budget via taxation system and decentralised funds formed in enterprises.

Centralised public consumption funds were set up to promote equality between members of society by enabling them to fully realise their potential

abilities as inequalities arising from distribution according to labour input rather than needs, differences in family status and personal abilities could not be eliminated through personal income. Through public consumption funds those needs were satisfied that were considered important from the point of view of society. They were excluded from individual choice based to a large extent on individual income. These funds covered services that were regarded as fundamental for the whole society as distinct from purely individual needs dependent on income and choice of an individual.

It was argued that combination of goods and services distributed individually according to labour input (wages/salaries) and collective provision of services to all people regardless of their income status through public consumption funds by health care system, educational, cultural, recreation and sport institutions, construction of housing, etc., as well as cash payments to support the disabled, the elderly and children (pensions, stipends, family benefits) was the most effective and efficient way to meet needs of all members of society (Микульский (Mikukl'sky, 1976).

Social funds created at enterprises out of their means on the basis of performance indicators formed the decentralised part of the public consumption funds. Their aim was to meet social needs of the employed and to counterweight the negative effect of distribution according to labour input on workers.<sup>2</sup> The decentralised public consumption funds were viewed as a junior partner of the centralised ones, a temporary measure on the road to the communist system of distribution of social welfare according to people's needs. It was argued that those funds helped to create material incentives for the employed.

Soviet scholars distinguished a few specific features of the decentralised public consumption funds:

- the range of needs covered was limited in comparison with that of the centralised ones;

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<sup>2</sup> Social funds of enterprises also included expenditures on their social infrastructure that was not financed from PCF.

- the size of social funds differed depending on revenues of a particular enterprise;
- the importance of the funds flew from the shortage of consumer goods and services and it would decrease with the development of local social services (Антосенков (Antosenkov), 1987).

In general the Soviet debate disclosed a positive attitude towards welfare provisions in enterprises on the following grounds. First, they were to improve living standards of workers and to satisfy their growing social needs. It was argued that at enterprise level resources could be used more effectively because the needs of each individual were easier to be taken into account thus giving additional opportunity to contribute to people's well being. This aspect was especially emphasised in 1970s-1980s when the lack of resources for social needs, underdevelopment of social infrastructure and shortages of consumer goods became evident.

Second, occupational provisions were believed to be important for stabilising labour force and fostering attachment of the employed to their enterprises.

Third, enterprise social services were to play the economic-stimulating role. In order to raise efficiency of the national economy material incentives for workers had to be reinforced. Apart from wages and salaries social benefits were intended to stimulate better work and it was for this purpose that social funds of an enterprise were formed on the basis of its performance indicators. That is why some authors argued that those funds acquired economic rather than social meaning.

During the first decades of the Soviet power when the welfare system was being set up the prevalence of economic function of enterprise social services over the social one did not bother Soviet scholars too much. But with the maturity of the system and changes in social policy priorities they were definitely faced with the dilemma of what function -- social-needs or economic-achievement -- was predominant. One of the approaches suggested that as enterprise based social services originated as the decentralised part of the public consumption funds they were first of all to meet social needs of

employees and had to be gradually transferred to local authorities to provide services to the entire population (Порогин (Rogovin), 1984; Антосенков (Antosenkov), 1987). On the contrary, noting that amount of social funds had to be determined by the outcomes of enterprise activities Zagorul'kin and Kolesnikov (Загорулькин и Колесников, 1983) implicitly acknowledged that economic-stimulating function was more important than that of meeting social needs of the employed.

This contradiction could not go unnoticed. By the 1980s some Soviet researchers came to admit that these functions were inseparable and flew out of the nature of enterprise social services. For example, Degtyar (Дегтярь, 1984) argued that it was necessary to find a proper balance between their social and economic rationale. She even suggested that in order to solve the problem it could be productive to consider enterprise social funds as a distinct phenomenon with its special tasks and priorities prone to changes from time to rather than just a part of the public consumption funds.

Another important issue that drew Soviet scholars' attention was the optimal scale of social funds of enterprises. Quite a number of studies dealt with criteria of selection of a performance indicator to which their formation should be linked.

The late Soviet debate on occupational welfare is well summarised in the following passage:

"..The enterprise resources supplement the means allocated from state budget, the latter forming the resource basis for fulfilment of social guarantees. Under the present circumstances in the course of the improvement of management mechanisms the role of social funds of enterprises in satisfying certain social needs of employees has been increasing. They reinforce material incentives. At the same time the growing importance of social funds leads to the strengthening of unevenness in the distribution of public consumption funds among different groups of population with substantial variations between employees of various industries and enterprises. These disparities... do not always reflect the difference in their labour input. Therefore, in future it would be necessary to take more drastic measures to eliminate those disparities ... which arise from a different size of social funds at particular enterprises." (Миккульский (Mikul'sky), 1983: 27-28.).



### ***3. The Post- Soviet Debates on Occupational Welfare.***

#### **Occupational welfare and economic efficiency**

One of the major issues at stake is correlation between social plans and economic status of an enterprise. Some authors suggest that social plans contribute to deterioration in enterprise financial status and enterprises owning social assets are at a disadvantage (Boycko and Shleifer, 1994). The logic is rather simple: less social spending -- more money left for other purposes, including expansion of production.

Enterprise-based social provisions are often treated negatively as the expression of paternalistic intentions of employers. Those ones who try to maintain social infrastructure are accused of behaving as kings of small states with everything at hand and a possibility to exercise considerable power. This point of view negative as far as social responsibilities of enterprises were concerned was expressed in the survey of the Expert Institute of the Union of Industrialists and Entrepreneurs.

The survey was carried out in 1992 to study factors that affected behaviour of enterprises in the new environment. It contends that there is the reverse relationship between financial status of an enterprise and its social expenditures. Indicators of enterprises with developed social infrastructure are usually worse than those of enterprises, which choose to invest in production. Therefore, enterprises that experience financial difficulties endeavour to cut social expenditures first.

Russian enterprises seek for profit many of them trying to withdraw their position as mini-states (Preker, 1994). The main reason is that

"extensive provisioning of social services ... diverts enterprises from their core activities" (Freinkman, L. and Starodubrovskaya, L., 1996: 4).

It prevents them from being competitive and slows down the process of restructuring, including privatisation. It is even argued that enterprise social obligations may reduce interest of potential foreign investors (Rein and colleagues, 1997). Kosmarsky and colleagues (Космарский, 1996) note that in

many cases social expenditures are the only ones that an enterprise can control and thus economise on.

Under the pretext that social expenses are not productive the necessity to include social responsibilities in the list of enterprise functions is neglected. Whereas a lot has been said about how much social benefits cost nothing is mentioned about positive effects of such spending, for example, on workers' health and recreation, etc. Is it all about financial matters only or there is a place for changing attitudes?

### Occupational welfare and enterprise social assets

During the Soviet period a vast material infrastructure was built up by thousands of enterprises. It consisted of dwelling houses, health and sport facilities, kindergartens, children's camps, etc, which came under the notion of social assets and were aimed to satisfy vital social needs of members of society.

In the post-Soviet Russia in atmosphere of general enthusiasm around the concepts of complete restructuring of economy and inefficiency of enterprise social programmes the problems of social assets have moved to the forefront with no unanimity among scholars on the subject.

Jackman (1995(b)) analysing economic efficiency of enterprise social assets questions a widely held view that provision of social services is inefficient for enterprises. He argues that some social services may be as efficiently provided by large enterprises as by government and form a part of local systems of social facilities in co-operation with local authorities. The withering away of enterprise-based social services is a result of the natural process of changing employment structure from larger to more decentralised production units and there is no point in doing something about social assets before the restructuring of employment is achieved.

Some writers think that in principle the participation of enterprises in social protection via social assets is not a bad thing at all though it requires substantial financial resources. In the face of crisis many enterprises have to cancel their social programmes but when they will have money they are not only likely but

should start them again (Родионова (Rodionova), 1993). Teplikhin and colleagues (1995) argue that social assets do not greatly affect the financial status of an enterprise.

Some experts think that maintenance of social infrastructure, especially if it is crucial for community, can increase the power of an enterprise, even an unprofitable one, to negotiate subsidies with the federal government or local administration and survive in economically groundless situation (OECD, 1995).

At the same time Leksin and Shvetzov (Лексин и Швецов, 1998) suggest that keeping social assets can be economically rational only if they:

- are profitable;
- contribute to better motivation of personnel under the conditions of tax and other indulgences.

They have come to the conclusion that in the current situation in Russia privatised enterprises have no economic incentives to maintain social assets: higher wages are more important than social benefits; these assets are used not only by workers but local population as well while to run them enterprises incurs costs both direct ( energy, repairs, etc.) and indirect ( employment of managerial staff ).

If the final verdict is that social expenditures run against enterprise nature the further logical step would be to cancel social programmes and to divest of social assets. There are various views on the ways it can be implemented.

The OECD survey (1996) suggests that the decision on the use of social facilities, including such options as keeping, selling, closing down, donating, should be left to an enterprise itself which is fully consistent with the principles of free market.

Tratch and colleagues (1996) argue that in transitional economies the so-called institutional approach to social assets as a form of enterprise social spending should be used. While in most studies social spending is looked at as a variable dependent of such characteristics of an enterprise as its size, industry, composition of workforce, etc., the state-enterprise interaction, especially in the field of regulating property ownership, is more important. In this

case the divestiture of social assets should to a large extent depend on government regulations of the two major issues, namely

"whom the property can be transferred and whether a transfer allows any change of use" (Schaffer, 1995(b): 261).

Lippold (1996) notes that as the state and enterprise are interconnected in social welfare the former should regulate the process of divestiture. He comes to broader understanding of enterprise-based social services suggesting that policy towards them should be formulated in the framework of overall social policy goals.

If it is recognised that occupational provisions developed as a substitute of state arrangements (Космарский (Kosmarsky and colleagues, 1996) then they should be cancelled only when either the state or market can offer more that is not the case in today's Russia because:

- there is an obvious decline in the state social services. Local authorities are often short of funds to maintain social assets to say nothing about acquiring any new ones. In practice the transfer of social facilities of enterprises to local authorities is likely to end in closing them down that would weaken social protection of population;
- many people cannot afford to buy social services in market as the purchasing power of population falls down.

#### ***4. Comparison of Western and Russian/Soviet Approaches to Occupational Welfare.***

The Soviet period has been chosen for comparison with the Western practices quite intentionally. It fully corresponds with the objective of this thesis to give a comprehensive description of occupational welfare taken in different societal environment.

For a long time drastic differences in ideology did not permit Western and Soviet researchers to approach the matters pertaining to occupational welfare in a similar way. Soviet scholars proceeding from the Marxist theory were

always critical about social policy and concept of the welfare state in the West.<sup>3</sup> Their Western counterparts representing the non-Marxist traditions spoke in a critical tone evaluating Soviet social policy. Both sides tried to stress those features of each other's systems they thought of as negative and different from their theory and practice.

Reluctance of Western employers to provide social assistance to their employees and class conflict as a driving force of the development of occupational welfare were favourite issues in the Soviet discussion on occupational welfare in the West.

Western studies on the Soviet social policy failed to give a profound analysis of the channels of delivering welfare services in the Soviet Union other than the state.<sup>4</sup> It was assumed that through public ownership of the means of production, centralised government financing of welfare programmes and political dictatorship the Soviet state controlled and regulated every aspect of society's life and thus was fully responsible for the provision of social welfare. Mishra (1981), one of the first Western scholars who covered Soviet experience in his analysis of welfare state, described socialist welfare system as the structural model of the welfare state.

The problems related to occupational welfare in the Soviet Union were viewed through the state welfare programmes or industrial relations leaving out a broader outlook on an enterprise as a social rather than technical and economic unit. For example, the mechanism of setting up social funds at Soviet enterprises vitally important for development of occupational welfare was discussed only as a part of either planning process or managerial instruments (Bornstein (ed.), 1981; Feiwel, 1972; Hardt and McMillan (ed.), 1988; Commander and Jackman, 1993).

### Divergences

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<sup>3</sup> The Soviet perspective is very well explored by Zinin and Kashchenko (Зинин и Кашенко, 1986).

<sup>4</sup> McAuley (1979) suggested that only resources to be used collectively as social consumption funds should be considered as a component of the Soviet welfare state. Being rather critical about welfare policies in the Soviet society, he regarded the Soviet welfare state as the authorities' second main set of instruments of influencing income distribution and argued that there was no clear evidence whatsoever for claims that socialist society was inherently more equal than capitalist.

The most important divergences in theoretical approaches to occupational welfare in the West and in the Soviet Union are as follows.

a) In the West the problem has always been to find ways to incorporate an enterprise into social policy and to adjust occupational welfare to the needs of society; in the Soviet Union researchers tried to justify the necessity of enterprise-based social benefits as a channel of distribution of social welfare other than the state. A positive stand towards occupational welfare adopted in the Soviet literature — its necessity was recognised and its social policy role had never been questioned — inevitably led to theoretic discussion being limited to finding ways to organise it in a more effective and efficient way.

b) While in the West discussion on equality/equity issues in connection with occupational welfare has been carried out in the framework of concept of citizenship and democratic polity, in the Soviet Union it was provoked by economic-public- ownership- of- the means- of- production considerations.

c) Clarke (1993(a)) pointed out that the main difference between the Western and socialist countries was that in the latter working status influenced the workers' social identity in a much more fundamental way.

### Common grounds

Nevertheless, there are noteworthy common grounds in the Western and Russian/Soviet Union theoretical approaches to occupational welfare.

a) Even a brief account of explorations in Soviet social sciences which are unfortunately underestimated in the West reveals the following paradox: in spite of different ideologies issues that drew attention of the Soviet researchers were to a large extent the same their Western counterparts were interested in. Discussion on occupational welfare was dominated by the two main themes: equality/ equity considerations and interaction between the state and occupational welfare.

b) The industrialisation postulate contends that at the stage of industrialisation and urbanisation all advanced countries faced similar social problems leading to a need for social welfare though, of course, historical backgrounds inevitably influenced processes of setting the scope of social

rights and social protection of people (Madison, 1968; Rimlinger, 1971). It is relevant to both the West and the Soviet Union.

c) As some Western researchers noted the drive for industrialisation and full employment in the Soviet Union since the early 1930s as well as efforts to practically implement the basic principles of the socialist distribution "to everyone according to his work " and " those who do not work do not eat " led to social welfare system including occupational welfare becoming largely work-related and connected to labour market that made it somewhat reminiscent of the Western system. In the course of formation of the Soviet welfare state emphasis shifted from providing social security to increasing economic productivity (Schwarz, 1953; McAuley, 1979). The term "social or socialised wage" was often used to show that social services provided through public consumption funds were aimed at rising the efficiency of the labour market. The stress was laid on necessity to improve human factor of production and encourage labour incentives (Hubbard,1942; Osborn,1970). Distribution of social benefits was largely based on employment criteria (enterprise-based benefits in kind, pensions and sickness pay in accordance with the lengths of work in organisation, eligibility criteria for a number of benefits). Occupational welfare was first of all aimed to cut labour turnover, to create workers' dependence on an enterprise and to establish a new form of social control and labour discipline (Rimlinger,1971; Clarke and colleagues,1993). Dixon and Makarov (1992) even suggested that socialist welfare system was in fact based on the principles of occupational rewards and residual welfare. Manning, on his part, argued that

"...Soviet welfare was, in Titmuss's terms, largely reminiscent of occupational welfare..." (Manning, 1992: 43)

### ***Conclusions***

My main conclusion from what has been set forth before is that occupational welfare is a widely spread phenomenon, a means of providing a specific kind of social protection to those in employment, a significant form of social welfare. The time has come to make a try at working out the integrative

theory of occupational welfare that would absorb the most promising ideas and positive experience.

Transformation of the Russian society has naturally brought changes in debate on the role of an enterprise in social protection of the working people. It is now greatly influenced by approaches towards theory and practice of occupational welfare dominating the Western discussions that are prominently reflected in the works of Russian scholars.

The emphasis is mainly laid on the necessity for Russian enterprises to restructure their activities. The need to increase production output and improve financial status of enterprises as well as to encourage individual social responsibility are advanced to prove that there is no place for occupational social plans. The conception is set forth in the papers prepared under the auspices of such international organisations as the World Bank, EBRD, OECD and is evidently prompted by the ideas of market-oriented transformation of the Russian society. It practically neglects the fact that the bulk of enterprises' social expenditures in Russia fall on the statutory social security contributions to various social funds which problems are discussed in terms of taxation policy only.

The analysis of debates on occupational welfare shows that the problems discussed in the West, on one hand, and in the USSR, on the other, have much common ground. Besides, there is a diversity of opinions among the Western scholars as well.

The present dominant ideological stand on this division of welfare in the post-Soviet Russia is its rejection as the Soviet type institution incompatible with market economy. It may be such an attitude that has led to some serious flaws in the discussion.

It does not touch upon, for example, correlation of social benefits and wages/salaries. In the Soviet Union low wages were compensated by stable low prices, full employment, growth of social services provided through the public consumption funds. Nowadays this system ceased to work while the majority of population cannot afford to buy social services outside the state or enterprise



schemes because wages/salaries are still too low amounting to only 15 per cent of production costs.

Little attention is paid to significance of enterprise social programmes, their place in social policy during the transition period and necessity to develop new model of occupational welfare. No methodology of organising and managing specific occupational plans in order to reach both social and economic objectives is suggested.

The social image of Russian industry and business is presented in liberal terms of development of "a free enterprise" as one of the primary guaranties of continuation of democratic reforms in Russia but, regrettably, not much is said about the role of enterprises in social protection of employees taken in a broader framework as an integral part of social policy.

The key issue after all is what will happen to occupational provisions. The importance of the enterprise-based social services should not be measured exclusively in terms of financial burden on an enterprise. What also matters is their contribution to production process and availability of social services especially housing, kindergartens and health facilities outside an enterprise via market or the state system.

Weakness of state social welfare at the federal and local levels coupled with widespread poverty adds to significance of occupational welfare. Workers at enterprises that provide social benefits are in a relatively better position as they can rely on their enterprises in meeting some of their social needs. In this way employers help the employed to survive the crisis. Paradoxically, this fact is definitely more appreciated by foreign rather than Russian observers (Le Cacheux, 1996).

## Chapter 2

### Two Perspectives and General Definition of Occupational Welfare

The main objectives of this chapter are to analyse the two perspectives of occupational welfare -- social policy and organisational -- which are proposed by the author to be introduced in this study and to try to substantiate a possibility of working out general definition of the phenomenon. Forms and methods of provision of occupational welfare are outlined as well.

#### **1. The Two Perspectives of Occupational Welfare.**

In the process of research two facets of occupational welfare clearly transpired. One is displayed in matters concerning contribution of occupational welfare to social policy and, thus, may be called the social policy perspective.

Occupational welfare also means services and benefits incident to or arising out of employment or, otherwise, supplied through organisations of various kinds including industrial enterprises. Issues of their environment (society, the state, etc.), structure, and management are sufficiently covered in literature but there is one function which has not yet been properly studied, that of securing social welfare of their members. It becomes essential to try to fill in this gap by exploring the organisation perspective of occupational welfare, the more so that nowadays the role of different institutions in social policy and the structure of welfare mix are under thorough scrutiny.

Table 2.1 provides a guideline for further discussion on the two perspectives.

Table 2.1

#### **Occupational welfare perspectives**

<i>internal dimension</i>	<i>external dimension</i>
<u>organisation perspective</u>	<u>social policy perspective</u>
why <u>organisation</u> is for or against?	why <u>society</u> is for or against?

Source: compiled by the author.

### The social policy perspective

This thesis is based on the postulate that from the point of view of society occupational provisions are an integral part of the unitary system of social policy, concerned with the promotion of well being of all members of the modern society ( the social policy perspective).

Most popular conceptual question posed is whether occupational benefits are a private or public endeavour or they are about providing private solutions for public problems (see, for example, Shalev, 1996). But it is a wrong question to ask: a problem becomes public if its existence is acknowledged by society and measures are undertaken to settle it in the interests of society. In this context any form of its solution will certainly get public approval that makes the problem public. To put it another way private provision will not be "private" in the sense the word is used in dictionary or every day's life. In our case, it only underlines the importance of the social policy perspective.

The nature and extent of an enterprise involvement in social welfare is controversial subject with contradictory ideas set forth in debates. Today there is no consensus as to what social responsibilities of an enterprise should consist of. Moreover, Friedman (1962), for example, argued that an enterprise fully fulfilled its social obligations by maximising profit, securing employment and paying fair wages. Thus, social benefits should be regarded as inappropriate and even harmful for successful economic performance of an enterprise which reflects quite a popular view that social expenses are non-productive and mainly philanthropic.

Titmuss (1974) was the first to contribute to the understanding of occupational provisions as a "division of welfare" and to explore them as a welfare phenomenon. He argued that all collective interventions to meet certain needs of an individual or/and to serve the wider interests of society might be broadly grouped into three major categories of welfare: social welfare, fiscal welfare and occupational welfare. He also claimed that such a division was based more on an organisational division of method rather than fundamental differences in functions or aims. The unity of welfare channels was stressed because in the long run they all served the same goal.

The social policy perspective is indispensable in solving the problem crucial to the theory of occupational welfare because it gives an answer to the question why organisations should be involved in provision of social services at all.

It can only be regretted that, as careful searching shows, occupational welfare does not explicitly feature in the works of representatives of the scientific management and the human relations schools. Taylor (1911), for example, is interested in wages as an important economic stimulus for workers and in fair remuneration as a motivation factor that has nothing to do with occupational welfare. The human relations school concentrates on social aspects, first of all, on employees' participation in social relations. Occupational welfare is viewed from the standpoint that it might be easier for an enterprise to use social welfare plans to stimulate employees rather than to change social relations inside, for example, by extending employees' influence over the decision-making process that requires much more organisational and psychological efforts than granting social welfare benefits. Occupational benefits are also seen as merely one of the instruments of managerial strategy ensuring loyalty of employees and helping to increase productivity alongside with regulation of general level of wages, opportunities for promotion, training and development.

The importance of the idea of corporate social responsibility (CSR), however attractive the notion may seem, is insignificant for the purpose of conceptualising occupational welfare, especially in the following aspects. First, under "social responsibility" non-material things such as, for instance, equal opportunities or treatment of foreign labour are very often understood. Second, it is likely to be the reaction of pragmatic employers urging corporations to introduce welfare arrangements voluntarily before the state will step in with compulsory regulations. Third, it is evidently about social responsibilities of an enterprise to the wider community and necessity to cross over the boundaries of an enterprise because if an enterprise provides social services exclusively for its employees it is exposed to the accusation of being self-contained by ignoring the interests of local community (Brown, 1961).

The role of organisations in social welfare is explored in this paper in the industrial enterprise aspect because of the centrality of production process in the modern industrialised society to say nothing of the fact that the problem itself cropped up in connection with industrial undertakings.

Mishra (1981) analysing the origins of occupational provisions in the terms of socio-technocratic demands of industrialisation and capitalism suggested two main reasons for the provisions to emerge:

- ▶ the growing importance of labour as human factor of production;
- ▶ the nature of work in industrial establishments where labour force is concentrated in large-scale enterprises organised on bureaucratic lines.

As the system of measures to promote people's well being occupational provisions may be considered as social services, or "occupational social services" (Titmuss, 1974). Their emergence alongside social and fiscal welfare is the evidence of increasing diversity and interdependency in modern social policy

Employees form a special category of population as they are not only members of society but of particular organisations as well. That is why they take a specific position in relation to social protection the burden of which, according to Rein and Rainwater (1986), could be distributed between three principal sectors: enterprise, the state, and mutual aid and private charity, each expected to play its part in securing employees' well-being.

Most people in developed countries are recruited into the labour force and it is quite logical to suggest that financial and administrative resources of enterprises should be used to provide social protection for employees and possibly their dependents on permanent and stable basis. Titmuss (1974) looked at occupational welfare as a means of collective intervention more efficient than individual efforts. Economically welfare provisions in industrial establishments which can mobilise resources and finance large schemes based on economy of scale differ favourably from such forms of welfare protection as self-help or mutual assistance emerging as alternatives to competitive ideology.

Titmuss stressed that workers may need welfare provisions not as increments to their standard of living but as

"practical compensation for dis-services, for social costs and social insecurities which are the product of rapidly changing, industrial-urban society" (Titmuss, 1968:133).

It is recognised that complicated social relationships have led to the emergence of social risks beyond control of an individual for which he/she cannot be held responsible on individual basis. In the existing economic and social situation certain redistribution of resources in society is needed if it wants to secure a decent standard of living for its members. The problem is how such redistribution could be made especially when the role of the state in securing social welfare in market economy has become the subject of scrutiny and criticism and provision of some social services by voluntary and private agencies has increased. In their midst an enterprise appears to be able to bear social responsibilities in society not only economically and technologically but as socially independent unit.<sup>5</sup>

The emergence of occupational welfare means that relations between employers and employees become more social than individual, thus reflecting social recognition of needs and dependencies in an enterprise. In the socio-individual equation of risk sharing a significant role in meeting basic social needs of employees is played by employer. Kerr notes, that

"in the logic of industrialisation, the responsibility for guaranteeing the minimum welfare and security of industrial man rests in large measure upon his managers and his government " (Kerr, 1973:180).

It is the social policy perspective that helps to explain why organisations provide social benefits at all. Occupational welfare is undoubtedly stimulated by social policy considerations expressing intentions of society: occupational programmes appear to be an integral part of the unitary system of social welfare rather than merely organisation "business". They are carried out

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<sup>5</sup> As debate on social role of organisations is usually carried out in the framework of their social responsibilities it is necessary to remember the distinction between such terms as "social" and "social welfare".

because they are important from the point of view of social policy, which sanctions occupational arrangements.

The development of occupational welfare like any other institution of contemporary society depends to a considerable extent on the state as the overseer of social policy in society. Interaction between the state, society and organisations, in particular, in the provision of social welfare for the working people assumes ever-greater importance because it is necessary to distribute welfare in society in a way that preserves both social justice and economic efficiency.

#### The organisation perspective

The attitude of industry towards occupational welfare, its willingness and capacity to accept welfare obligations (the organisation perspective) greatly vary depending on particular enterprise and industry. It results from the fact that there is no consensus among employers on the scope social responsibilities of business.

Some employers tend to rely on the state that plays the leading role in social welfare and are reluctant to provide occupational benefits considering them as interfering with market efficiency and weakening competitiveness and financial status of an enterprise. Besides the provision of "remuneration package" instead of simply paying wages/salaries puts additional administrative burden on employers. Even if they accepted certain welfare responsibilities for their employees, they would hardly agree to extend them to dependents and retired as well as to cover some risks. Wilson (1979) posed a question whether employers were likely to reap any net benefits out of the provision of social services to their employees.

There is not enough evidence, both empirical and conceptual, to prove whether occupational welfare is the moral commitment of a good employer, the reminiscent of the poor relief aimed at a more effective way to target resources to the working ( means deserving) poor, or the recreation-of-human-capital part of economic efficiency. It may also be considered as expression of social responsibilities of entrepreneurs to their employees and society at large or a

part of their obligations to the state. In the latter case occupational welfare becomes a branch of the state welfare provision when employers hardly have any choice to provide welfare services to their employees or not.

Mann (1989) grouped factors potentially significant for the main stakeholders in occupational welfare. He explored motives of different social actors and the ways they influenced provision of social services. The state was introduced not simply as an actor with its own ideology but as the one who influenced decisions of other actors, including employers. The management-related issues comprised: management philosophies, including paternalism; management industrial relations strategy, for example, harmonisation; preservation of company image to the public; management response to labour market pressures by attracting and retaining labour.

In his classification of enterprise motives Domanski mentioned economic -- to "enhance economic performance", social -- "to stabilise social order" and ideological -- "pursuit of moral imperatives" (Domanski, 1997: 65)

Both classifications are actually much alike and summarise ideas expressed elsewhere. Correlations between occupational welfare and paternalism should be especially mentioned.

Domanski (1997) dwelt at length on the subject. His interpretation of the phenomenon was somewhat controversial mixing causes and consequences. He looked at all enterprise social provisions as paternalistic. Such a loose use of this term is characteristic of a number of writers.

Mann (1989) made a distinction between paternalism as a managerial belief and as a managerial strategy used by management to secure workers loyalty until it brought any evident results. Joseph (1992) stressed that the notion of paternalism could be evaluated both positively and negatively. It may be beneficial to employees but, on the other hand, justify their dependency on and submissions to employers.

I argue that what is important in defining paternalism are motives. Drawing parallel between father-child relations and occupational welfare only those provisions may be considered paternalistic which are made by an employer with the sole intention to do good for his employees and with no gain for him



envisaged. Paternalism should be cleared from other reasons for employer to provide social benefits: if it is done to maintain social order at an enterprise, to attract labour force, to stimulate higher productivity, etc. the prime motive is employer interests rather than welfare of employees.

I suggest that organisation interests to provide occupational welfare should be divided into "pragmatic-profit" and "social-paternalistic" as presented in Table 2.2

Table 2.2

**Organisation interests in occupational welfare**

<b>Pragmatic-- Profit</b>		<b>Social-- Paternalistic</b>	
production	employers' economic gains	employers' social gains	employees' welfare

Source: compiled by the author.

The pragmatic-profit approach implies manipulating employees in one way or the other. The aim is to bring tangible results to an enterprise, first of all, such as, for example, improvement in performance indicators or product quality, customer services, etc. This is in conformity with the mainstream of the management science today that recognises the importance of human relations at work. It is generally assumed that social benefits in-cash or in-kind contribute to motivating, attracting and retaining employees and provision of welfare services helps to increase productivity not handicapped by employees' personal problems.<sup>6</sup>

<sup>6</sup> There is no convincing proof of a direct link between occupational benefits and productivity, though there is some evidence for a link between dissatisfaction, absenteeism and labour turnover.

Whatever changes in industrial structure and labour market happen the maintenance of efficient work force remains the key imperative. Occupational welfare is believed to be an instrument of building up internal labour market to attract and retain labour force as well as investment in human capital, first of all in employers' interests (Green and colleagues, 1986). Mishra (1981) looked at occupational benefits as a share of managerial rewards favoured by tax exemptions, a form of income maintenance for highly paid employees to counter progressive taxation. Occupational schemes are often operated as a part of management process when they are shaped in accordance with profitability criterion. The social-paternalistic approach has two dimensions, namely social and welfare. The first one includes maintenance of social order by securing social peace in an enterprise and

"a will to instil acceptance of the social hegemony of the employer" (Domanski, 1997:65).

Occupational welfare, thus, is aimed to strengthen attachment of workers to the employing enterprise. Good industrial relationships at this level help to cultivate community spirit and foster human relations.

The welfare dimension is aimed at improving living standards of employees and increasing their consumption of social services, especially when contributing to social welfare of employees is not unduly costly to the enterprise (Zoetewij, 1986).

In many cases it is difficult to draw a distinct line between the pragmatic-profit and social-paternalistic factors which are by no means mutually exclusive. Decisions to provide occupational welfare can be prompted by considerations of both profit and employers' social responsibility towards employees.

The attitude of employees towards occupational benefits is on the whole positive. Resulting in the increase of their well-being they may be attractive for employees for a number of reasons including taxation. Occupational benefits are usually taxable at a lower value and, thus, employees are to pay less in taxes than on equivalent sum in salaries/wages. Real earnings may be also increased by overcoming salaries/wages structures that can be regulated by

law. Besides, it is the matter of status and prestige, convenience and comfort, protection against social risks that counts.

To sum up, the major contradiction and ambiguity of occupational welfare inherent in its nature lie in the fact that the internal and external perspectives are not mutually exclusive (see Table 2.1). Moreover, they are inseparable and influence each other with occupational welfare finding itself at their intersection. Interests of organisations and society can overlap as the aim of the former pursued by providing social welfare benefits coincides with that of the latter to secure social protection for its members. Interaction of these counterparts in social welfare is actually one of the driving forces in the development of occupational welfare.

Dualism of occupational welfare was stressed by Stevens (1986) who considered it as a hybrid social institution. She pointed out that employees' benefits were a half way between reward for work as alternative to wages and public sector programmes and a right; a compromise between human needs and citizenship rights, on one hand, and market efficiency considerations, on the other.

## ***2. Forms of Provision of Occupational Welfare***

The specific forms of the provision of occupational benefits to employees are outlined further on. In doing so it is necessary to have the following in mind.

First, employees may share cost of occupational welfare contributing to occupational plans. In this case the latter are employer-subsidised but not employer-financed.

Second, occupational provisions other than social security may not be taken into account when calculating both employers' and employees' contributions to compulsory social security schemes.

Third, there is distinction between costs of occupational social services to employers and benefits to employees, the former being easier to assess.

### Occupational welfare as provision of social benefits other than salaries /wages

There are different viewpoints on economic nature of occupational welfare though consensus exists among scholars that procuring social benefits other than salaries and wages is one of its most significant features. Some researchers (Zoetewij, 1986) believe that occupational benefits substitute a part of salaries/wages while others view them as a supplement to a regular pay. Here many substantive questions in analysis of occupational welfare arise. If occupational benefits form a part of salaries/wages then why do employers and employees opt for social benefits instead of monetary payments? Can this fact be explained only by tax advantages? If occupational benefits are supplementary, then why do employers spend additional money on their employees? Is this a reflection of managerial policies or broad understanding by business of its social role?

Unfortunately, no solid evidence has been found to give convincing replies to these questions. However, one thing is indisputable: there are two separate parts of employees' compensation mix: wage/salary system and benefits.

### The voluntary or statutory provision of occupational benefits

The voluntary or statutory nature of occupational welfare is a very important issue. In this respect occupational programmes can be:

- employer-initiated as voluntary commitment;
- employee-negotiated, as a rule through collective bargaining;
- statutory introduced by the state.

Voluntary character of occupational welfare flows out of the fact that in principle employers are free to decide what to do or not to do. Some of them see no obligation to provide employees with anything else than fair wages. The others may consider that they just cannot afford social benefits or find it more efficient to allocate additional resources to increase wages. They may carry out occupational programmes and be entitled to opt out of the state social schemes. But in reality such an ideal situation does not exist because there are three actors in the field of occupational welfare: employers, employees and the

state. Occupational provisions can be made compulsory through collective bargaining or as a clause of contract between employer and employee. Trade unions play important part in regulating labour relations.

As far as the state is concerned it either sets rules for occupational schemes, usually protecting employees' interests, or makes explicit the necessity of introduction of such schemes. For example, employers' contributions under social security and superannuation plans may be reckoned as their statutory social obligations. Some occupational welfare arrangements may not be imposed by statute but nevertheless overseen by the state.

There is no consensus as to whether voluntary and compulsory provisions should both be included into occupational welfare. Mishra (1981) insisted on its voluntary nature arguing that state interference would change its independence. Bryson (1992), on the contrary, described occupational welfare in the framework of the welfare state. Titmuss (1974) viewed occupational welfare as an intervention undertaken, first, collectively and, second, in the interests of the wider society thus looking at it as a part of not only the welfare state but of the state welfare. In the author's opinion, implementation of occupational welfare provisions makes it explicit that they should include both voluntary and statutory ones.

#### Types of occupational benefits

As there are a great variety of occupational benefits it is of a paramount importance for theory of occupational welfare to find out whether they are occupational and what criteria are used at that. Endeavours to get an answer have not been entirely satisfying. Titmuss who pioneered research on occupational welfare did not expand his ideas in detail. His well known definition is a descriptive one offering a more or less full list of what he thought had to be included into occupational welfare, namely:

"pensions for employees and dependants; child allowances; death benefits; health and welfare services; personal expenses on travelling, dress and entertainment; meal vouchers; cars and season tickets; accommodation; holiday expenses; children school fees; sickness benefits; medical expenses;

education and training grants; cheap meals; unemployment benefit; medical bills and an incalculable variety of benefits in kind ranging from obvious forms of realisable goods to the most intangible forms of amenity" (Titmuss, 1974: 51).

Unfortunately, Titmuss did not explain what criterion he used to include one social benefit or another into his notion of occupational welfare. Practice and research have convincingly proved that benefits other than mentioned in the Titmuss's list may be attributed to occupational welfare. Rein noted that

" "Occupational welfare " is perhaps a more informative description, implying as it does that benefits depend on the job one holds within a firm" (Rein in Shalev (ed.), 1996:29).

There are some social advantages that people get only through employment. Bryson, for example, included into occupational welfare " those benefits that accrue to wage and salary earners over and above their pay...." (Bryson, 1992:131) having in view profit sharing as a way to increase employees' welfare. Barr, in turn, argued that

"in addition to wage income firms (individually or on an industry-wide basis, voluntary or under legal compulsions) provide occupational welfare in the face of sickness, injury or retirement." ( Barr, 1993:6).

Many suggestions on occupational welfare elements have one trait in common -- they are usually made from the organisation perspective definitely ignoring the social policy perspective, whereas all benefits meeting the requirements of both perspectives should be taken into account

A difficult problem to solve is whether social insurance contributions paid by employers should be treated as occupational welfare. They are mentioned in Titmuss's definition as well as in the findings by Reid and Robertson (1986) but, on the contrary, are not discussed in the study of Green and colleagues (1986). Tachibanaki (1987) considered them as the sub-category of the non-obligatory non-wage labour costs. It is also argued that as statutory social insurance levies are compulsory and universally charged they do not belong to occupational welfare. I believe that employers' social insurance contributions

have to be ascribed to occupational welfare because they are definitely a matter incident to employment, separated from salary/wage system and important for both organisation and society as a form of financing social services.

#### Methods of provision of occupational benefits

Occupational welfare encompasses both in-kind and cash benefits. They differ from each other by methods of:

- financing;
- provision;
- administration.

Occupational benefits may be financed directly or indirectly. The ones that provide employees with goods and services in-kind or with money (vouchers, etc.) that is spent in the market are directly financed by enterprises while the others are financed indirectly.

Methods of provision and administration of occupational plans are very diverse. Benefits provided in-kind are usually administered by an enterprise. Voluntary insurance schemes are often administered by an enterprise but services they offer are provided via insurance company thus provision being separated from administration. In the case of social security contributions an enterprise either may not perform administrative functions or do it if benefits are statutory regulated.

Tachibanaki (1987) drew a distinction between welfare contributions paid by enterprises to either government or non-governmental institutions. From the point of view of control and spending he divided occupational benefits into:

- social security type, as made statutory by the state (France, Germany);
- operating through market, for example, private insurance (the USA, Japan);
- more or less equal combination of both (the UK, Canada).

### ***3. Towards General Definition of Occupational Welfare***

Occupational welfare is a complex and controversial phenomenon. Contention around it begins with the lack of universally accepted understanding among researchers as to what this notion really means that leads to the absence of a clear-cut framework for analysis. In such a situation the working out of general definition, which can be used in comparative study, is badly needed. It should in concise form express the very essence of the phenomenon and characterise it as precisely and exhaustively as possible.

There are several reasons why occupational welfare as a system of social benefits has not yet been satisfactorily defined. The following three are the most frequently suggested. First, when the welfare state models are constructed the state is always placed in the centre. Much less attention is paid to other sources of welfare despite the fact that there is an increasing comprehension that the notion of the welfare state incorporates not only the state welfare provisions but a public/private mix. Second, scarcity of statistical coverage of occupational plans, especially non-statutory, is another factor that obviously hampers the extension of knowledge about occupational welfare. It is difficult to elucidate financial and other aspects of organisation-based social programmes as organisations may not want to disclose them. Brown and Small (1985) noted that identifying who actually paid for occupational welfare was really a "frustrating task". Esping- Andersen (1996) went so far as to suggest that due to the lack of information it was too early to make generalisations about occupational welfare. Third, a great diversity of occupational welfare provisions in different countries makes it hard to bring many ways this phenomenon displays itself to some general definition.

But, comparison between the Western and Soviet experiences which belong to principally different societies and ideologies testifies to the fact that similarities in occupational provisions are much greater than divergences and, therefore, can be brought to one definition.



### Divergences

The major difference between Western and Soviet practice lies in the way enterprise is incorporated into society and the ways the state intervenes in its life. These differences explain the variations in forms and methods of provision of occupational welfare, namely the voluntary/compulsory and cash/in-kind benefits.

a). Soviet enterprises, as a rule, granted social benefits in-kind via enterprise-based social assets which were called "*sotzial'naya sfera predpriyaty*" (social sphere of enterprises) whereas their Western counterparts purchased social benefits outside using, in particular, insurance mechanisms which were not developed in the Soviet Union.

b). There were differences in methods the state used to intervene in the life of enterprises and in correlation of voluntary and compulsory procurement of occupational welfare provisions. The Soviet state had much more authority to impose social welfare obligations upon enterprises and, therefore, most of them were mandatory. For example, the size of social funds, namely the amount of resources to be spent on enterprise-based social benefits was regulated by statute. On the contrary, statutory social security was more substantial in the West.<sup>7</sup>

### Similarities

Closer look at occupational welfare in the Soviet Union reveals that it has much in common with the Western practice.

a) Occupational welfare was:

- ▶ an integral part of the unitary system of social policy in the country ( the social policy perspective);
- ▶ incident to or arising out of work/employment (the organisation perspective);
- ▶ covering benefits other than wages and salaries;

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<sup>7</sup> The structure of taxation system in the West and Soviet Union was different. In the West share of corporate taxation reaches about 10 per cent of total tax revenues as average with income tax amounting to nearly 30 per cent. In the Soviet Union taxes paid by enterprises were equivalent to 90 per cent of the state revenues while income tax was only 8 per cent

► financed and provided by employers.

b) Though Soviet enterprises belonged to the state they were nevertheless organisationally independent entities with their own balance sheet. They paid taxes, had rights to use and manage the assets assigned to them, dispose of their own financial resources which were separated from those used by the state via budget system. In that way the state left some of them with enterprises instead of distributing through the centralised channels.<sup>8</sup> Soviet enterprises enjoyed a considerable discretion in choosing concrete methods of provision of occupational services.<sup>9</sup> Therefore, they had a certain degree of autonomy from the state that make them resemble their Western counterparts.

c). Schaffer (1995(b)) argued that cost of social benefits provided by Russian enterprises as their contribution to social welfare was comparable with social expenditures of Western industrial undertakings. More or less reliable data relevant to the subject come from the labour costs statistics enabling to draw a general conclusion as to non-wage spending which usually includes occupational benefits. For example, Table A.1 in the Appendix A show non-wage labour costs in manufacturing in the seventeen developed countries in 1995. They make a sizeable share of the total labour costs averaging 39.2 percent (ranging from 50.3 per cent for Italy to 27.5 per cent for Australia). The structure of labour costs of Russian enterprises (see Table A.2 in Appendix A) is quite similar. Indeed, occupational provisions are rather popular in most developed countries.

The comparison of occupational welfare in the West and in the Soviet Union reveals a lot of similarities in the scope of financing and the range of benefits provided under the two systems – capitalist and socialist — which at the first glance seem to be so different. Soviet enterprises were separated from the state in operational terms, thus being a special channel of distribution of social benefits.

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<sup>8</sup> It is often argued that taxes paid by Soviet enterprises were a mere reallocation of the state resources rather than real taxes.

<sup>9</sup> Zaslavskaya and Rivkina (Заславская и Рывкина, 1989) consider the possession of social infrastructure as one of the integral characteristics of organisation in the Soviet Union together with a certain degree of autonomy, availability of fixed and current assets and proper staffing.

The most significant similarity in the Western and Russian patterns of occupational welfare is that it is a part of social policy. Soviet enterprises were heavily involved in occupational provisions in-kind, but the same were available to workers in the Western countries, too. Occupational welfare in the USSR was heavily regulated by the state, but it was one of the many ways the state intervened into the life of society, in general, and an enterprise, in particular, which also happened in the Western countries. Therefore, the importance of Soviet/Russian experience for understanding occupational welfare is that it stresses the social policy perspective that is not so apparent when Western theory and practice are discussed.

#### Towards general definition

Analysis of occupational welfare theory and practice in Russia as related to the West undoubtedly enriches the understanding of this phenomenon and enables to lay foundation for its general definition.

It is to be remembered that there are already a few denotations of social benefits which employees get through employment: occupational benefits, employee benefits, corporate welfare and fringe benefits as most popular (for example, Brown and Small (1985), saw no difference between such things as occupational welfare and fringe benefits). The term "occupational welfare", offered by Titmuss, is, to my mind, the best one as it covers issues ignored by other terms. First, it most appropriately reflects integrity of and correlation between work/employment and welfare in terms of semantics, and, second, it underlines some features of these benefits, which, in Titmuss's opinion, allows incorporating the phenomenon in mainstream research on social policy and social welfare.

The word "occupational" means "incident to or arising out of employment" and thus indicates that welfare benefits in question are inseparably linked to employment. The other word in the denotation -- "welfare" -- presupposes provision for the purpose of improving the well-being of the working people of a variety of benefits in-cash and in-kind ranging, as Titmuss puts it,

" from obvious forms of realisable goods to the most intangible forms of amenity" (Titmuss, 1974: 51 ).

I suggest that taking into account practical experience and body of knowledge amassed in the course of intensive study of occupational welfare and its properties by quite a number of scholars all over the world the general definition of occupational welfare might be construed as follows:

*Occupational welfare as an integral part of comprehensive social policy is provision of social services and benefits other than salaries and wages, incident to or arising out of employment, in various forms, voluntary or statutory, offered through employer in compliance with the interests of an individual, organisation, the state and society.*

The definition is by no means claimed to be exhaustive but it is seen as laying ground for a further discussion on definition of occupational welfare. It is deemed to be instrumental to analysis of similarities and differences in occupational welfare in various countries that is particularly important for today's Russia with a view of globalisation of all processes in the world and movement of Russian society towards mainstream of history. Occupational welfare, however insignificantly the phenomenon might seem against such backgrounds, has its own role to play in these developments.

### **Conclusions**

Occupational welfare is a means, organisational and financial, of providing a specific kind of social protection to a very numerous part of population, namely those in employment, and, therefore, can be considered as a significant form of social welfare. Its importance stems from the fact that it is a function of organisations of various kinds, which play an important role in contemporary society.

The assumption that occupational welfare has been developing in two main perspectives -- social policy and organisation -- opens up new possibilities of

deeper understanding of its gist and properties. Naturally, it does not mean that other trends should not exist and be explored.

Occupational welfare lies at the crossroad of interests of society and organisation. In this context I believe that the social policy perspective is indispensable for placing occupational welfare in the framework of general social policy that regrettably is often neglected. The Soviet experience may essentially contribute to remedying the situation.

Variety of forms, types and methods of occupational welfare provisions in different countries springs up from national traditions and political, economic and social peculiarities. The task is to discern similarities in diversity that is made in the thesis by citing theories and experiences of the West and the Soviet Russia, which were antipodes in ideology and practice.

Relating Russian theoretical treatment and practice of occupational welfare to what exists in the developed countries shows that it is a societal institution compatible with different modes of society organisation. Therefore, occupational welfare in Soviet Russia can be considered as one of its models rather than a unique product of the Soviet state.

The proposed definition of occupational welfare flowing from this premise is hoped to be a workable concept that can be applied in research. It is on no account supposed to be made mandatory either on international or national levels.

## **Chapter 3**

### **Occupational Welfare and Organisation: Conceptual Framework**

Chapter 3 further develops a conceptual framework for understanding occupational welfare, emphasising interdependence between its social policy and organisation dimensions. It is discussed in terms of theories of organisations and management. The choice is prompted by the fact that there is not much research available on the nature of Russian to say nothing about Soviet organisations in general, and industrial enterprises, in particular. Therefore, it is useful for the purpose of developing the theory of occupational welfare to summarise Western approaches to organisations, their relationships with the state and society and the way the latter influences processes inside organisations, to organisation as a system of social relations with the view of applying them to the Russian case.

The place of industrial managers who are members of organisation and society at large and, thus, important players in occupational welfare, is examined in the context of the West, the Soviet period and contemporary Russia. Their increasing powers in enterprise and social and economic life of society justify the focus of the fieldwork on senior managers of Russian industrial enterprises.

#### ***1. Theories of Organisations and Their Environment***

##### Theories of organisations: main approaches

Organisation naturally attracts much attention and is studied from different standpoints. There are quite a number of theories explaining its nature and role in modern society. According to Brown (1992), for example, the main themes in understanding industrial organisations fall into four groups:

- system thinking conceptualises organisations as open socio-technical systems consisting of four main elements -- formal structure, informal structure, occupational structure and tradition;

- contingency theory explains organisational structure and functioning as contingent upon environment within which organisations operate;
- social action approach argues that structure of an organisation is the consequence of the patterns of action of social actors who pursue certain goals albeit within constraints set by the actions of others.
- labour process theories view organisations as control structures and focus on the ways managers /employers use to control their employees.<sup>10</sup>

### The state and society as part of organisation environment

Taking organisations as a starting point the state and society at large are discussed as a part of the organisation's *environment*; however, the latter might be conceptualised differently. Functionalism, for example, suggests that all social institutions are interdependent and always tend to equilibrium and stability. According to the conflict theories social structures consist of unequally advantageous groups, whose interests are in conflict and organisations are crystallisations of the class society, involved in a struggle over contradictory interests.

In spite of divergences there are some basic ideas accepted by the majority of researchers.

First, mainstream today recognises the importance of environment for organisations, which cannot be understood if taken in isolation from their environment. The main elements of organisation's external environment are the state and society.

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<sup>10</sup> In Russia words “manager” and “employer” are often used interchangeably, meaning somebody whose position in an enterprise empowers him/her to take or ultimately influence decisions to give work to other persons. But strictly speaking, the term “employer” is a broader one and can mean owners, owners who manage and managers.

Unfortunately, it is very difficult to estimate the number of people in each category. According to official Russian statistics, people working in the national economy are “those on a contract” and “those not on a contract”. Owners evidently come under the second heading and are mentioned separately as private entrepreneurs who have their own business and can hire other people. Among employed on a contract there are managers who sign labour contract themselves but being in charge of running enterprise can decide on giving work to another person. The category owners/managers takes on people in intermediate position and they are likely to be counted as owners first.

Second, organisations interact with environment which means that various external factors influence processes inside organisations, although such theories, as population ecology, suggest that this is a one-way process, when an organisation adapts to a changing environment acquiring shape which suits its domain best. Others look at organisations as active force, which not only reacts to changes taking place outside but also actively influences them. The labour process theory locates organisations within the overall conception of the structure and dynamics of the capitalist society.

Contingency theory emphasises the following aspects of environment. First, there is a range of external factors, which influence the organisation, and, second, different departments in an organisation can operate in different environments. Therefore, on one hand, organisations interact with their environments and, on the other hand, environment is a source of change: in order to survive organisations have to change.

Resource dependence theory suggests that organisations depend on the support of resource-supplying constituencies necessary for their survival, including the state, management and employees. As a result, they should first of all satisfy the interests of such constituencies to secure their support, for its withdrawals threaten the survival of organisation. Watson notes that such analysis

" successfully relates the micro or small scale processes of organisational functioning to the macro or political-economic dimension of societal processes" ( Watson, 1987: 204)

Third, comparative studies of organisations reveal the importance of differences in culture within and between societies. They are important factors in explaining disparity in organisational behaviour between countries.

The argument that significant differences in organisations across the world can be attributed to culture representing a key factor in organisational behaviour is, perhaps, prevalent today (Hofstede, 1980). However, one should be wary of overstating such a view, since some academics come to a somewhat different conclusion pointing at the convergence of organisational



culture. For example, Hickson and colleagues (1979) suggest that there is a relationship between factors such as size and technology and structure that transcends culture. Bureaucracy is the same in all societies and bureaucratic structures are likely to emerge in particular sectors of the economy. On a more general level, many commentators have followed Kerr and colleagues (1973) in suggesting that industrial and post-industrial societies would, in any case, become more alike as they develop in the future.

Different approaches to analysis of relations between organisations and their environment are useful for conceptualising interdependence of the two perspectives of occupational welfare but with certain limitations. Firstly, the theories discussed above fail to specifically take into account the welfare state as a part of organisation environment. The latter is usually discussed from the point of view of an enterprise producing goods or services. However, in modern society the environment may influence processes within organisations in many other ways including the welfare state as a set of institutional arrangements and ideology. Secondly, interaction of the state and enterprise in social welfare is often put in the framework of social legitimacy of an enterprise, which implies that enterprises should be responsive to social criticism. If they fail to do so their legitimacy becomes problematic. Therefore, the question is how to incorporate an organisation into the broader democratic social and political environment.

Industrial enterprises are usually viewed as one of the types of organisations operating in industry (Brown, 1992). Therefore, a general theory of organisations is applied to them as well. The next step would be to define whether or not enterprises in capitalist and former socialist countries might be analysed in terms of the mainstream theories of organisations.

The contradiction that follows was well reflected by Morgan who argues that

" the fundamentally different relationships between state, economy and civil society make for a very different pattern of organisation" ( Morgan, 1990:198).

At the same time he notes that there are forces that operate across state and societal boundaries.

The theories of organisations mentioned above have been developed in the West and definitely informed by the Western practices reflecting the problems of organisations in the capitalist society. The theory of a socialist enterprise is not well developed as it used to be seen as an extension of the state. Domanski (1997) suggested that socialist enterprises performed a gate-keeping function. It can be argued that there were certain limitations in explicit application of Western approaches to the Soviet organisations, for example, difference in environment and the ways it influenced Soviet organisations (see Morgan, 1990, for a more detailed account). However, because organisations as a special phenomenon have similar features some basic concepts are relevant to their analysis, regardless of the type of society they operate in.

Today there is a growing body of literature on Russian post-socialist enterprises, making attempts to define their behaviour in a new transition environment. The command system in its Soviet form is destroyed but the existing environment is not a market because of the lack of competition and the underdevelopment of market infrastructure. The major change in the environment is the loosening of state control and regulation, which gives Russian enterprises more independence and flexibility, but at the same time imposes more responsibilities and risk taking. The most important characteristic of the environment in which Russian enterprises perform is uncertainty and, hence, their main objective today is to survive. They have to develop new patterns of behaviour in order to stay alive in the changing world.

Two comments seem appropriate in this situation. First, it is not always clear what authors dwelling on the problem of survival of Russian enterprises do actually understand by it. Survival can mean either adaptation to the changing environment or preservation of some characteristics enterprises consider important. This, in fact, implies different behaviour on the part of an enterprise. Second, many researchers agree that the state is the major source of uncertainty for Russian enterprises: despite new trends in relations between enterprises and the state the latter still remains their main partner.

Research on Russian industrial enterprises shows that the weight of factors that are beyond direct control of an enterprise is quite significant. The two of

them are usually mentioned as influencing most the life of Russian enterprises: enterprise status at the beginning of reforms/restructuring ( equipment, product mix, etc.,) and macroeconomic policy of the state. In short, the concept of survival implies that at present short term objectives are more important for Russian enterprises, which find it difficult to develop a long-term strategy, as everyday fight to stay alive hampers their strategic vision.

### Organisations as social relations

The mainstream theory today conceptualise organisations as system of social relations:

"social relationship which is either closed or limits the admission of outsiders will be called organisation (Verband) when its regulations are enforced by specific individuals: a chief, and, possibly, an administrative staff which normally also has representative powers" (Weber,1978:48).

According to Stinchcombe (1965), organisation is a system of stable social relations, consciously aimed at attaining certain aims and objectives. It is generally acknowledged that organisational goals are continuously negotiated in the interactions between its members. Organisational outcomes are produced by the actions of individuals and groups within organisations. Therefore, analysis of formal and informal relations in organisation is significant.

Social relations have two major dimensions: power and conflict. Power involves the ability of particular groups to impose their definition of the situation and solution of it on other groups within the organisation. In discussion of power and conflict the important role is allocated to a notion of interest as each group within an organisation tries to promote its interests and seeks to reach its aims.

Perception of organisations as a system of social relations is valuable for understanding change. Functionalism and conflict theories despite their differences state that social structures determine the world. The change occurs because of the dynamics of the system. Functionalism, for example, views social change as evolutionary and adaptive when the system accommodates to new circumstances and, therefore, can hardly explain rapid changes. The

action approach suggesting that the power structure in an enterprise can be redefined admits the possibility of social change rather than systemic adjustments.

Silverman stressed that

" the action approach does not in itself provide a theory of organisations. It is instead best understood as a method of analysing social relations within organisations" (Silverman,1970: 51 ).

Action-based theory puts an emphasis on perceptions and actions of individuals and their groups, the goals people choose to pursue and the ways they use to reach these goals. Any explanation of human action has to take into account the meaning which individuals involved assign to their actions. Social reality does not just happen, it has to be made to happen.

For Weber (1978) it is important to understand attitudes that inform actions of various groups and individuals in organisations. It is often argued that there is no direct link between attitudes and behaviour as people fail to act as they believe they should because of constraints imposed on them. The action approach maintains that the notion of choice means that actions are not totally inhibited by environmental demands or structures but depend on objectives and values of the actors concerned. Social structures are the outcomes of such actions though existing social structures set certain restraints. Therefore, in order to understand why people make choices they do it is important to understand their attitudes that determine behaviour and serve as instruments of continuity and change in social life.

## ***2. Managers, as Members of Organization, in Society and Enterprise: Western and Russian Focus***

### **Managers in modern society: Western approaches**

In the Western research the role of managers in organisations and society is typically evaluated from the viewpoints of "social group" and "political actors". They do feature in the analysis of social stratification as a definitive social group, though different explanations of their position on the social ladder of society have been given. This means that, first, managers should share

certain common characteristics, and, second, they should demonstrate some common trends in attitudes, beliefs, etc., determined by their specific position in society.

The criteria used to define a social group can be broadly classified as economic (position as regards to the means of production and level of income) and social (social status and prestige, educational level, etc.).

a) Many authors of different schools tend to approach managers in terms of ownership and control. Managers are related to such classes as owners, on one hand, and workers, on the other hand. They are on a payroll but differ from workers in many other respects. As Saunders (1990) notes, managers may employ people, issue commands to workers and make decisions on the ways enterprises are run without owning the capital. They are well remunerated and enjoy quite high social prestige.

In this regard, Saunders (1990) mentions that the Marxist analysis based on the two-class division of society fails to incorporate managers. Marxism contends that managers express the interests of capitalists. But the socio-occupational approach seems to be more fruitful in defining the position of managers. Occupational position is often taken into account when constructing social strata regardless of the fact whether it is an outcome of other social relations or self-important. For example, Scase (1992) argues that class relations connected with the mode of production determine occupational structure of society. According to Bell (1973), occupations are relatively stable work activities determined by the objective requirements of organisation of the work systems and exist independently of other social relations at work.

In this context position in the labour market is more important than the relationship to property. Scase recognises that

"occupational order is a core dimension of any system of social stratification" (Scase, 1992:37).

Watson (1987) explicitly links class position to a position in the division of labour in society with implications it has for access to those experiences, goods and services that are scarce and valued in that society.

Goldthorpe's classification (1980) includes managers into the so-called service class on the basis of their work situation (the degree of authority they enjoy at work) and their sharing similar life chances and economic interests. This service class exercises power on behalf of the corporate authority but, at the same time, is employed selling its services in the market. But "service class" differs from the working class by having a relative security, prospects for material and status advancement and a certain professional code. Goldthorpe makes an important conclusion that this class is growing and acquires more social and political importance in society.

But the theory of social stratification defines not only special groups in the society but also their relations to other groups. Davis and Moore (1945) explain the functional importance of different positions based on two criteria: uniqueness (can not be easily substituted by other positions) and number of subordinate positions. In this context managers definitely occupy a high position in the social order of society.

The ideas of professionalism and managerial discretion have emerged with separation between ownership and control: managers run an enterprise but do not own it. Nowadays this distinction is gradually eroding because managers often become owners at the same time holding shares of their enterprises.

The managerial thesis is widely used in the Western theory. The managerial revolution is consistent with the trends of industrialisation in the developed countries. Berle and Means (1947) and Burnham (1945) argued that ownership had become dispersed among shareholders and control over large corporations had fallen into hands of professional managers. Baran and Sweezy (1968) suggested that as managers were among big shareholders there was no divorce between ownership and management. However, this does not change the essence of the idea: managers are not neutral, they are in many cases interested in the performance of their enterprises.

The development of management as occupation caused the growth of a distinct stratum in enterprises. But claims that management is a profession has serious implication for managers as professional ethics emphasise first of all the responsibilities occupations have towards society.

b). The important role that management plays within organisations is stressed by the theories of management and organisational behaviour that assume that management co-ordinate, direct and guide the efforts of the members of organisation towards the achievement of organisational goals.

Management is a group in organisation that usually articulate organisational goals. It is seen as a dominant coalition whose members have the power to decide how organisation operates (Child, 1969). The idea of managers balancing the interests of all groups concerned with an organisation seems to be attractive to explain their role in organisation. On one hand, managers have a stake in an enterprise, on the other hand, they have to take into account the interests of other stakeholders (shareholders, employees, customers, public at large) in order to secure a successful performance of an enterprise. The important function of managers is mediation between environment and organisation, inside and outside, trying to reach an acceptable compromise between internal and external interests.

Managers attempt to integrate all other elements of organisation - people, structure, and goals. The success of business is dependent on the knowledge and skills of managers (Drucker, 1979; Mullins, 1993).

The discussion on rational/irrational basis of decision-making has explicit consequences for managers. In the first case the capacity of managers to make rational decisions based on evaluation of various opportunities is praised. In the second one it is insisted that managers can hardly be expected to make rational decisions as they face a number of constraints, including the power of other groups within the organisation. But the formal / informal dichotomy is more important for the understanding of the position of managers in organisation. The formal relations in organisations have been recently underestimated, while the democratic nature tend to be overestimated. The importance of formal decisions proceeds from the fact that the system of remuneration is directly linked to the fulfilment of formal decisions. It is managers who take the formal decisions whatever the influence of other internal or external factors. If a certain degree of irrationality in a decision

making process is allowed than the importance of perceptions and attitudes of managers becomes evident.

Bearle and Means (1947) found out that managers had considerable discretion and, as a result, contributed to the broadening of corporate objectives. Due to separation of ownership and control the influence of owners can be weakened and managers may pursue objectives other than profit-maximisation including social goals. Managers can also follow strategies that first of all benefit them rather than the owners. Though reservations are expressed especially about the extent of managers' discretion the managerialist thesis still enjoys popularity.

Changes in industrial organisation in Germany, France and Britain, which occurred during the last twenty years and national variations within the general tendencies, enable Lane to conclude that the role of managers has increased and to suggest that

"trade unions have lost their influence both at the level of collective bargaining and in national politics" (Lane, 1989:120).

The power in industrial relations has shifted in favour of management though it is still unclear how it would affect national politics.

High technology production systems make management dependent on "responsible worker initiative and involvement" (Lane, 1989:143). As a result managers have to offer employees opportunities for participation, good employment conditions and career opportunities.

c) The incorporation of managers into middle class (Scase, 1992; Giddens, 1973) has important implications for the analysis of their role in contemporary society. The theory of social stratification not only explains the existence of different social groups but also addresses the issue of social stability. The latter is dependent on the size of the middle class: strong middle class helps to preserve stability in society. Incorporating managers into middle class implies that they are satisfied with their position in society, exercise a certain power and authority and, therefore, might be interested in preserving the status quo. Goldthorpe (1980) notes that though managers as the service class do not



necessarily have a preference for capitalism, they will support it as long as it enables them to maintain their position.

d) In the political arena managers are discussed as an interest group, which is fundamental to the democratic political process. As they form a distinct group it is suggested that managers must share common interests that they may try to promote via professional organisations, or other bodies, which may have similar concerns. As the role of interest groups depends to a large extent on the functions their members perform in the social division of labour, such associations may exercise a considerable power derived from their members' important position in the system of production.

#### Soviet managers: Western and Soviet Approaches

Defining position of Soviet managers in society Western scholars tend to consider them as a distinct social group. They were especially interested in the role managers had played during the two periods of the Soviet history, namely industrialisation and emergence of the so-called "red directors" and the 1965 reforms. These were the periods of serious changes in the "*khosiastvenny mechanism*", the way the Soviet economy in general and enterprises in particular were managed.

Western scholars adhered to sometimes apparently contradictory approaches to evaluating the role of Soviet managers. On one hand, Azrael (1966) and Bienstock and colleagues (1944) depicted them as obedient cogs in the totalitarian machine. On the other hand, Granick came to the conclusion that

" from the point of view of practical independence in making concrete decisions, the Soviet director may be conceived of as an entrepreneur" (Granick, 1974:285).

In his influential study he demonstrated that Soviet directors had considerable power and a large measure of autonomy. The necessity to implement guidelines of the Communist Party was the only serious restriction of their activities. Granick argued that, as the Soviet factory was the only stable

element in the often-reorganised industry, it amassed considerable decision-making power and enterprise directors enjoyed substantial autonomy.

Granick (1972) suggested that Soviet managers above all pursued the interests of their own enterprise. One of the reasons was a special bonus system dependent on fulfilment of certain performance indicators. It encouraged:

- attainment of short-term objectives;
- priority to problems of a unit for which a manager was responsible;
- negotiations with the state authorities for better terms and more subsidies.

Therefore, the necessity to reconcile interest of an enterprise, on one hand, and the national economy and society as a whole, on the other hand, was one of the most serious problems of the Soviet industrial management. This corresponds with the findings of some Russian researchers who point out that external pressures are important to understand the development of Soviet enterprises (Ilyin, 1996).

Analysing Soviet politics Western researchers often refer to industrial managers as an interest group stressing their important role as a source of influence on the state (Scilling and Griffiths, 1971). Though in the totalitarian systems interest groups are prohibited or non-existent it does not prevent certain interests from exerting influence. It should be remembered that Soviet managers were members of the Communist party and were dominated by it. The party organisations penetrated all levels of society, each enterprise having a party committee. It was hardly possible to articulate autonomous interests, but the important position of managers in the production process enabled them to express interests in issues directly related to production process.

However, reservations must be made on application of interest group approach to Soviet managers. They were not organised politically and did not participate in political life as an independent force. Therefore, it would be more precise to refer to Soviet managers as an opinion group.

Soviet theory is almost silent on managers. In the Soviet Union the two-classes division of society based on access to the means of production was

recognised to include the working class and the peasantry as basic groupings plus *intelligenza* as a social stratum. Nevertheless, as the public ownership of the means of production eliminated exploitation, unequal relations to the means of production led to the differentiation of the conditions of people's life. Especially in the late Soviet studies discussion definitely shifted to the analysis of socio-occupational division. Conditions and character of work (complexity, qualifications, autonomy, etc.) were the main criteria used to define a social stratum. But, in those studies, it is not always possible to distinguish managers who are often included into the so-called "specialists" (Роговин (Rogovin), 1984). One of the reasons is that the formation of a classless society and the elimination of the differences in the style of life of people belonging to different groups was one of the main objectives of the Soviet social policy.

Late Soviet research prioritised the study of specific interests of various social strata. Such interests were considered non antagonistic in socialist as opposed to capitalist society. But, in general, it was acknowledged that group interests were aimed at maintaining the position of the group in the social structure of society. Different groups had different stakes in reforms of management of the national economy undertaken in the Soviet Union. For example, Zaslavskaya and Rivkina (Заславская и Рывкина, 1989) came to the conclusion that decentralisation of economy was likely to benefit enterprise managers who could be considered as reform supporters.

#### Russian managers today: increasing powers

In the USSR managers used to be state employees. Their status was characterised by a high educational level; stable long-term tenure in office and a system of special bonuses. Party membership was desirable for promotion. Industrial management career could be a step to higher governmental and party posts with more privileges to come.

Now old enterprises became more independent from the state, a lot of enterprises were privatised and turned into joint stock companies as well as new private establishments emerged. The role of managers has been

fundamentally changing, they can and, in fact, some of them do own shares in their enterprises ensuing an interest in their success as owners.

Russian and foreign experts on the subject point out that management has considerable influence and power within Russian enterprises and have strengthened control over them in the course of privatisation (World Bank, 1996; Dolgopyatova, 1995). Empirical evidence shows that top management has very strong control over enterprises. For example, in order to find out the correlation between ownership and control the World Bank survey (1994) examined the influence of different groups within enterprises in the decision making process. It revealed that managers played the most important part in passing decisions on various issues; including hiring and firing of workers and provision of social benefits. In the light of other research, Rose's statement (1994) that, in shaping enterprise social plans supply side factors, including management attitudes, are more important than demand side — workers' preferences — is justified.

This strong belief in the power of managers results in the fact that behaviour of Russian enterprises is usually studied through managers. Most studies of occupational welfare in Russia are based on interviews with senior managers and focus on the range and volume of services provided, sometimes on their dynamics.

It should be noted that two other players in the field -- workers and trade unions were excluded from my analysis on the following grounds.

The role of workers in decision-making in enterprise is inconsiderable. Long delays in payment of wages are an indirect evidence of their weak position and inability to control the situation. There are data to suggest that, even if workers own a major package of shares, they have little influence over decision making (World Bank, 1996; Blasi and Shleifer, 1995).

Absence of powerful workers' organisations is one of the reasons for their poor participation in the life of enterprises. At present trade unions in Russia do not play any significant role and their influence on political and economic issues appears to be weak. Trade unionism in the Western sense has never been strong in Russia. It did not have a chance to develop in Imperial Russia as trade unions were made legal only ten years prior to the 1917 October

Revolution. In the Soviet Union trade unions were very closely affiliated with management of enterprises; in fact, a trade union leader was a member of management team. Both managers and workers were members of the same trade union. Nowadays when relations between capital and labour are changing this is not any more appropriate. Old trade unions have a dubious reputation among workers and are not taken seriously. Newly emerging ones are not strong at the moment and still have to establish themselves as independent bodies really concerned with the interests of their members and this, of course, will take some time.

But at present there is an evident lack of theoretical backing for the understanding of the role of Russian managers. Sociological studies typically focus on entrepreneurship as a distinctive phenomenon of the social life of modern Russia. A number of studies have been conducted recently to draw a social portrait of new entrepreneurs in Russia. Much less attention is paid to industrial managers whose position in society has been definitely changing. In order to fill in this gap it is necessary to discuss the relevant theories developed in the West and in the Soviet Union/Russia as a starting point of elaborating theoretically sound approaches to Russian managers.

### ***Conclusions***

As occupational welfare is incident to or arising out of employment and, thus, supplied through organisations of various kinds, including industrial establishments, exploration of organisations in a greater depth and setting a conceptual framework for issues related, in particular, to the place industrial managers occupy as members of organisation and society at large, are more than appropriate for the purposes of the present study.

The contents of this chapter indicates that:

- interaction of organisations and their environment is a natural precondition of their existence. The state and society are the major components of organisations' environment that influence their operations, occupational welfare among them, in many ways offering opportunities and shaping constraints;

- there is a consensus in the research that managers, being members of organisations, at the same time constitute a special social and political group in society with certain distinctive social characteristics that might pursue its own interests;
- managers play an important role in Russian organisations and have a great potential to shape their life. The available data indicate that in the course of transformation the powers of Russian managers have increased.
- as values of a market economy and democracy are now accepted in Russia the academic discussions of the Western scholars on organisations and managers will have more relevance to their Russian counterparts that, unfortunately, are still not well researched though the number of relevant studies is growing. But it should be remembered that in the absence of real market environment Russian enterprises might still retain some characteristics of Soviet ones.

All this leads to conclude that Russian managers are important players in the field of occupational welfare, who are likely to shape its organisation perspective influenced by their attitudes and perceptions.

## **Chapter 4**

### **Health Care as Component of Occupational Welfare**

Health care has been taken as a specific subject of the thesis because of its importance among many problems of occupational welfare. The choice was also prompted by the fact that health care is typically overlooked in the debates on the problem because of the difficulty to locate it as one of the elements of occupational welfare, especially in the absence of its general definition. Besides, my intention was to enlarge the discussion by introducing valuable experience of Soviet enterprises employees' health protection.

This chapter is dedicated to such principal matters pertaining to its research as the two perspectives of occupational welfare in health care, relation to pension/taxation issues, occupational disease versus general illness; definitions, principles and organisation of occupational health care and occupational health services.

#### ***1. Problems Pertaining to the Study of Health Care as Component of Occupational Welfare.***

##### **The two occupational welfare perspectives and health care**

Philosophy of workers' health protection ensues from social / quality of life and economic / productivity considerations and aims at maximising health gains for society and organisations. It justifies the necessity of application of the social policy perspective and the organisation perspective to occupational health care.

Society is concerned about public health as an important ingredient of living standards. Right to health care was one of the first social rights granted by the modern states and social security systems in many Western countries began with workmen's compensation and health insurance. Health policy is also closely related to economic policy: healthy population is crucially important for economic development. Therefore, health is of everybody's concern (See Figure 1 in Appendix A).

Picking out the employed as special health protection target group is stipulated by the following reasons. First, they represent a large section of population and, second, they are all subjected to the same aftermath of working environment, physical, chemical, biological, psychosocial and ergonomic which can be damaging to workers' health, not mentioning accidents at work. That is why workers must be classed as a group having specific needs in health protection determined by the risk of suffering occupational diseases and the necessity to eliminate bad influence of working conditions on health status in general.

Nowadays issues of workers' health and occupational health services (OHS) have been permanently on the political agenda of international community, for example the European Union (the EU). As early as in 1962 a special committee on industrial health and safety was established as a branch of the GDV (Directorate General Five). Since the late 1980 the EU activities in this field have intensified resulting in adopting the programme of action on safety, hygiene and health at work in 1988. The next year the EU Council took the decision on the introduction of measures to encourage improvements in the safety and health of workers at work. It is important to note, that the EU decisions on health and safety at work are adopted by the qualified majority rather than by reaching consensus as it is the case in the most other issues.

If the organisation perspective of occupational health care is discussed, employers look for healthy workforce because, first of all, ill health is costly for many reasons. If workers are sick or die prematurely it has a direct impact on the costs of hiring and training new workers, sick leave, terminal benefits, etc. Better health means reduction of absenteeism from work and increase in productivity and profits. According to the World Bank estimates, from 10 to 20 per cent of the GDP are lost every year due to bad health status of the employed (WHO, 1995).

This argument is well illustrated by the diagram that demonstrates the relationships between the healthy working environment, the health of the workers and the productivity and profitability of enterprises (Fig. 1, Appendix A).



But not only economic factors are important. Protection of the working people health is discussed today in the framework of the sustainable development. Needs of the present generation should be met in such a way that it does not damage people's health and environment, destroy resource base for human development and leave a chance to the future generations to satisfy their needs. Human beings with their right to healthy and productive life in harmony with nature are in the centre of this strategy. Occupational health is one of the basic elements in social and health dimensions of the principle of the sustainable development (WHO, 1995).

#### Health care and pensions / taxation issues of occupational welfare

In the West the problem of occupational welfare has been definitely dominated by pension issues. Esping-Andersen (1996) quite explicitly connected the development of occupational welfare with the establishment of pension rights. The recent works edited by Shalev (1996) and Rein (1997) focused on occupational pensions.

On the contrary, in the Soviet Union pensions had never been included into an enterprise domain. To be precise, enterprises had no right to provide pensions in addition to the state system. The state health and pension systems developed alongside: for example, there were no occupational pensions but enterprise health services in-kind did exist. Pensions were funded from the state budget while health care was an important element of occupational welfare. For Soviet enterprises health care for employees was always more important than pensions. The tradition has deep historical roots because employer provided health services were established in Russian industrial enterprises as early as the late nineteenth century while no pensions was paid at all.

Social funds in Soviet enterprises were never looked upon as financial assets that is usually the case for pension arrangements in the West. Occupational pension funds there can accumulate considerable sums of money and are often regarded as a means of personal savings and capital formation. Nowadays the state tries to involve enterprises more explicitly in solving

pension problems by incorporating occupational pensions as a second (together with the state and personal) tier in pension systems being created in many Western countries. Occupational pensions plans are intended to create additional financial resources for economy and show the way to lifetime redistribution of income.

It is also worth to mention that pension plans are perhaps the only occupational welfare arrangement on which enough statistical data is available that, of course, makes a task of the research much easier.

The principal difference between health plans and pension schemes is that health protection generally implies not only compensation for the loss of income but also provision of health services in-kind. Payment of benefits and provision of health services may either go together or be organisationally and financially separated. Occupational health plans, as a rule, cover only employees, sometimes their dependents, whereas occupational pensions are paid to people no more in employment.

There is one more issue that deserves to be mentioned in connection with organisation of occupational health care. Tax treatment is assumed to be one of the most effective instruments of affecting the development of occupational welfare. Comparison of taxation of occupational pension and health schemes in the OECD countries brings out a noteworthy pattern. While occupational health insurance plans are taxed in most countries (9 out of 13) occupational pensions, on the contrary, are levied in a few ones (4 out of 13) (OECD, 1988). According to Mitchel and Rojot (1993) it demonstrated that the state policy was aimed either to discourage occupational health plans or to promote first of all occupational pension schemes.

#### Occupational disease versus general illness

People's health is affected by quite a number of social and economic factors among which conditions and contents of work being most important. As working environment can cause illness and injuries employers must bear certain responsibilities for their employees' health. Whatever differences exist in

understanding of their scope and the ways they are to be fulfilled the working people should be protected against three types of health threats:

- injuries at work;
- occupational diseases;
- general illness.

The major question is whether employers should be held responsible only in the first two instances when influence of employment conditions can be easily traced or in case of general illness as well. The relative importance of the burden of injuries at work, occupational diseases and general illnesses should always be kept in mind. Officially recorded morbidity patterns show that in contemporary society the burden of general illnesses is heavier than that of injuries at work and occupational diseases caused directly by employment environment.

The principal distinction between an occupational disease and a general illness is that the former is definitely produced by working conditions while the latter is not related to the job, at least directly. But in practice it is difficult to find out whether a disease or an illness arose out of or in the course of employment. The matter is that many diseases result from both occupational and non-occupational causes and a number of work-related diseases tend to manifest themselves long after the period of a worker's exposure to the influence of health damaging working conditions has terminated.

If it is admitted that there is no difference in treatment of occupational disease and general illness then they can be easily integrated in and covered by one programme. But it is often argued that injuries at work and occupational diseases require specialised medical care as well as rehabilitation provided through appropriate programmes by specially trained personnel. In any case, integrated and separate health schemes have their advantages and disadvantages, the major trend, however, being promotion of the former.

### Role of enterprises in protection of the working people's health: principal approaches

The close link between health status of the employed and working conditions, that worries society and enterprises, implies employers' involvement in promotion of health of population through provision of care for workers. It could not but affect organisation of health care systems.

The role of employers in provision of health care for workers can be discussed from the following viewpoints:

- employers' contributions to the national health systems;
- occupational health and occupational health services.

If the latter are typically included into occupational welfare, the former are usually not considered as its element. Such an omission renders it important to discuss employers' part in the provision of health care in society in more detail. It is typically exercised:

in case of financing -- via general taxation, social or private insurance contributions or lump sum payments;

in case of management and control -- via state-administered, self-managed or privately-run plans.

In the latest analysis of health care systems the emphasis is placed on purchaser / provider relationships. For example, in the OECD report (1994) they are classified according to sources of financing and methods of paying providers while role of enterprise in health care is practically ignored. Roemer's study is among the few that discussing methods of health care financing explicitly introduce industry, or

"the provision of services at the expense of an enterprise, supported by its earnings" (Roemer, 1976 :15)

Maydell (1993) argued that every specific form of organisation of health care, first, was designed to achieve certain objectives, second, needed to fit into the social and political system that exists in a country. It is with this understanding that experiences of some countries are briefly surveyed below.

In the UK employers contribute to the National Health Service (NHS) through general taxation thus having minimum influence on the way it operates.

Provision of medical treatment is separated from payment of sick benefits by employers as the statutory sick pay. In order that employees can avoid waiting lists, enjoy more comfort and privacy, gain direct access to consultants occupational health care is provided via voluntary health insurance plans. Hogg Robinson Healthcare (Fletcher, 1997) estimated that employers privately insured about 1.8 million people in the UK.

Another way for employers to fulfil their obligations is health insurance, either voluntary or compulsory. In Germany, for example, they make contributions to compulsory health insurance administered by sickness funds. Main features of the German system are as follows:

- rates of contributions vary because sickness funds not only collect money but also fix rates that are on average about 13 per cent of payroll equally divided between employer and employees;

- both parties exercise considerable influence on administration of sickness funds ensuing from the principle of self-management carried out by employees and employers associations;

- sickness funds are engaged in payment of benefits and provision of health services.

Voluntary occupational health insurance in Europe, as a rule, is employer managed and limited in scope because nation-wide health care programmes exist in many countries. It is introduced to supplement mainstream health care when compulsory health coverage is deemed to be inadequate or it is necessary to defray the full cost of treatment. In this case the above-mentioned type of insurance allows having a greater choice of doctors or health services, better accommodation at hospitals, saving of time, etc. That is why it might be attractive even if there is compulsory insurance system in a country.

But voluntary health insurance may be the mainstream as it is, for example, the case of the USA. It is provided by employers, both employers and employees usually contribute to health insurance, be it voluntary or statutory, employers' share being mostly the same or larger than that of employees. There is no single nationwide system of health protection of population: two

governmental social security programmes, Medicare and Medicaid, cover only the elderly and the poor.

In the West insurance is the most widespread mechanism of provision of health services for workers. Its crucial problem today is raising costs of medical treatment. Limiting the scope of services covered or increasing contributions, including co-payments by the insured, can deal it with. However, either of solutions is unlikely to gain public support.

In these circumstances the role of an enterprise as responsible agent has been growing. One of the advantages is that organisation usually has greater bargaining power in negotiating with providers of health care than individual employees. Occupational health insurance arranged as group insurance programme guarantee better treatment for employees than in case of purchasing individual private health insurance. Good management of a health plan helps to find a way to reconcile higher costs of treatment and augmented expectations.

Taking into account the mentioned above and using the definition of occupational welfare, developed by the author, it is argued that employers participation in the national health schemes should be regarded as a component of occupational welfare in its part clearly linked to employment, first of all social and private insurance, organised on employment basis.

## ***2. Definitions, Principles and Organisation of Occupational Health Care***

### **Definitions of occupational health and occupational health services (OHS)**

Occupational health care dated back to the nineteenth century emerging as an answer to challenges of the new industrial society. But initial attempts to develop its conceptual foundation were undertaken at international level by the World Health Organisation (WHO) and International Labour Organisation (ILO) only after the Second World War.

The WHO Constitution stipulates prevention of accidental injuries and the promotion of improvement of working conditions as functions of WHO. It has had a specific programme of occupational health since 1950 and carried it out

in close coordination and collaboration with ILO. The Alma-Ata declaration (WHO, 1978) emphasised the necessity to organise primary health care services both preventive and curative as close as possible to where people lived and worked giving priority to the needy including the working people at high risk. The Health for All provided for improvement of health of the employed. International organisations, such as WHO and ILO, national authorities and professional bodies have been engaged in working out definitions of occupational health and occupational health services (OHS).

Occupational health as defined in the Global Strategy for Occupational Health for All is a multidisciplinary activity aiming at:

- protection and promotion of the health of workers by preventing and controlling occupational diseases and accidents and by eliminating occupational factors and conditions hazardous to health and safety at work;

- development and promotion of health and safe work, work environment and work organisation;

- enhancement of physical, mental and social well-being of workers and support for the development and maintenance of their working capacity, as well as professional and social development at work;

- enablement of workers to conduct socially and economically productive lives and to contribute positively to the sustainable development (WHO, 1995).

Therefore, three main aims of health protection of the working population include maintenance and strengthening of the health of workers and their ability to work; improvement of working conditions and safety at work; development of structures and cultures of every organisation in order to create a positive social climate, to secure increase in its effectiveness.

The Global Strategy for Occupational Health for All provides for the importance of OHS that are placed the fourth among the ten priorities set up by the WHO. Occupational health service was first understood as

"...a service established in or near a place of employment for the purposes of:

- a) protecting the workers against any health hazard that may arise out of their work or the conditions in which it is carried on;

b) contributing towards the workers' physical and mental adjustment, in particular by the adaptation of the work to the workers and their assignment to jobs for which they are suited; and

c) contributing to the establishment and maintenance of the highest possible degree of physical and mental well-being of the workers." (ILO,1959).

It was envisaged that if due to geographical or other reasons organisation of OHS in an enterprise was impossible then a contract with a local general practitioner (GP) or health service should be made on provision of the first aid in case of emergency, carrying out of medical screening, if required by the national legislation, hygiene control.

In 1985 the new ILO Convention modified the definition of OHS which now

"means services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking on

-- the requirements for establishing and maintaining a safe and healthy working environment that will facilitate optimal physical and mental health in relation to work;

-- the adaptation of work to capacities of workers in the light of their state of physical and mental health. "(ILO,1985). <sup>11</sup>

### Principles of functioning of OHS

The main principles, which underlie the idea of OHS, are as follows.

a) Working conditions influence people's health, therefore:

- diseases caused by the working conditions should be diagnosed, treated and compensated;
- it is a responsibility of employers to secure health and safety at work;
- employees should not bear any costs for organisation of OHS or pay for the services they provide.

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<sup>11</sup> Since 1950 ILO and WHO have had a common definition of OHS. It was adopted by the joint ILO/WHO Committee on Occupational Health at its first session in 1950 and revised at its 12th session in 1985.



b) OHS should be developed to cover all workers in all sectors of the economy and in all enterprises as well as the self-employed. Special attention should be paid to agricultural and migrant workers, employed in small enterprises and in the informal sector and the self-employed.

c) Modern OHS in practice integrating the efforts of diverse professionals disclose a comprehensive multidisciplinary approach securing workers' health by both influencing environment at work and workers themselves. That is why they are referred to as services aimed to protect health rather than just to provide medical treatment.

The medical approach dominated health care systems until recently. Situation has been changing under the influence of such factors as technological progress; new values (priority for primary care, workers' rights); stress on prevention (interdisciplinary character, safeguarding general health status of workers).

Prevention and health promotion are recognised as the most important functions of OHS. Cases of medical treatment of general illness are solved depending on circumstances. However, as protection of workers' health is understood comprehensively it must inevitably include specific measures to prevent occupational diseases as well as to establish some kind of control over workers' health status. It should be taken into account that it is difficult to separate occupational disease from general illness as in many cases it is hard to establish a link between working conditions and occurrence of illness. Therefore, though ILO accentuates OHS orientation towards prevention, the latter at the same time recommends that provision of general primary care, now an important trend in development of health care, should become one of OHS responsibilities. Thus, the fact that OHS have a potential to strengthen primary care leads to the growing attention to their activities.

#### Organisation of occupational health services

According to international standards OHS should develop on the following patterns:

- coverage of all workers by occupational health programmes;

- special emphasis on small enterprises and the self-employed, including agricultural workers;
- provision of primary care services where necessary;
- national health programmes aid in gradual development of OHS for all workers starting from those at the highest risk.

Organisation of OHS depends on the requirements of national legislation, health care system and traditions of a country. They can be established:

- in compliance with the legislation in force;
- in accordance with collective agreements or other agreements between employers and workers;
- in any other form as approved by the relevant authorities after consultations with employers and workers' organisations.

The ILO Convention (1985) stipulates that one of the major organisational features of OHS should be their easy accessibility to workers and therefore they must be provided within or near the place of employment. It specifies that services can be provided:

- by the undertaking or group of undertakings;
- public authorities;
- social security institutions;
- other bodies authorised by the competent authorities;
- combination of any of the above.

Researchers have elaborated on the spheres in which OHS work. For example, Rantanen (1989) enumerated the following functions:

- surveillance of the work environment;
- initiatives and advise on the control of hazards at work;
- surveillance of the health of employees;
- follow-up of the health of vulnerable groups;
- adaptation of work and the work environment to the worker;
- organisation of the first aid and emergency response;
- health education and health promotion;
- collection of information on workers' health;
- provision of curative services for occupational diseases;

- provision of general health care services.

Roemer (1976), in his turn, noted that OHS greatly varied and though they could be found in all countries they were nowhere the predominant method of provision of health care.

The scope of OHS activities, for example, in some European countries differs consisting of:

- prevention, visits to working places, provision of the first aid and medical screening (Belgium, France, Germany, the Netherlands);
- prevention and provision of some medical treatment (Austria, Finland, Italy, Sweden);
- prevention plus provision of full medical treatment (Iceland).

The size of enterprises is such an important factor of OHS provision that it is mandatory in some countries, for instance, OHS should be set up in enterprises employing more than 50 people in Belgium, over 100 people in Spain. However, as a rule, they are established in large enterprises.

Another matter of concern is the coverage of employees. OHS are opened either in enterprises where it is really necessary (Denmark, Sweden) or cover all workers (Belgium, France). First OHS were established in industrial enterprises only but later they spread to other organisations. In the majority of countries employers bear costs of OHS though in the rest they are financed by the state or via health insurance. If importance of economic incentives for employers are acknowledged they can get subsidies from the state to cover the costs incurred as in some Scandinavian states.

But despite all the efforts to develop OHS there still is a gap between the requirements of WHO and ILO and reality. According to available estimates only 20-50 per cent of workers in Europe have access to OHS that fully comply with WHO/ILO rules. It largely depends on:

first, the ways OHS are related to health care systems. In the West the latter varies from the National Health Service in the UK to the employment-based health insurance in the USA. Though Global Strategy for Occupational Health for All underlines the increasing role of health care systems in the development of OHS the latter are usually separated from the mainstream. In

health care systems emphasis is made on cure while OHS are intended to deal with prevention of health hazards although in some countries they may also diagnose and treat occupational diseases. The lack of coordination between the two systems often does not permit them to cooperate effectively;

second, interdepartmental relations. Traditionally labour ministries supervise issues of protection of health of the working people. But as OHS contribute to solving both health and labour problems, communication and coordination between health and labour authorities as well as other agencies concerned is required.<sup>12</sup>

#### Enterprise-based health services in the Soviet Union as a model of OHS

Enterprise health services in the Soviet Union are regarded by WHO (Rantanen, 1989) as a model of OHS. It had two distinct features:

- OHS were an integral part of the national health system and therefore they are often referred to as a national health service model;
- provision of primary and even secondary care was an important function of OHS.

OHS as a division of occupational welfare played much more substantial part in the Soviet Russia than in the Western countries. The belonging to the national health service and necessity to provide special medical treatment to employees influenced their development.

The principles laid down at the inception of the Soviet health care were:

- absence of financial barriers in access to medical services;
- universal coverage of the entire population;
- provision of full range of medical services;
- equal access to medical services of all people;
- integration of health services that ensured continuity in medical treatment including prevention and rehabilitation as well as the system of sanitary and epidemiological services;

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<sup>12</sup> In many countries responsibilities for protection of workers' health originally vested in ministries of labour are gradually transferred to ministries of health (see Roemer, 1976, for details).

- high quality medical education and, as a result, high standards of professional skills of medical personnel.

The national health service was founded on the integrity of the system -- one aim, one method, one approach to problems, one plan exclusively in the hands of health authorities.

The Soviet state was proclaimed to be the state of the working people which aspiration was to express and defend their interests. Health care system had first of all to maintain health status of the working people and their ability to work (Карибский (Karibsky), 1927). The class-industrial organisation of health services became one of the fundamental principles of the Soviet medicine.<sup>13</sup>

Workers were regarded a special category of patients because:

a) influence of employment environment on the health status of the working people was deemed important. Morbidity was to a great degree caused by working conditions and it was essential for medical personnel to have special training, skills and experience to diagnose and treat various occupational diseases;

b) accidents at work occurred quite often that required the first aid to be quickly provided;

c) such dangerous and infectious diseases as tuberculosis and sexually transmitted diseases were widespread among industrial workers;

d) treatment of workers had to result in as full as possible restoration of their ability to work rather than just curing of illness (Лукомский (Lukomsky), 1924; Штейнберг (Steinberg), 1926).

The purpose of the OHS was to overcome individualised approach that dominated mainstream health care systems in other countries and was intended to cure a particular illness of a particular person irrespective of conditions that caused it. Health services in enterprises, on the contrary, treated an employee as a part of particular environment rather than simply cured illness.

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<sup>13</sup> On organisation of the Soviet health care system, often referred to as Semashko model, see: Marree, J. and P. Groenewegen (1994).

Occupational health services were predestined to eliminate the negative affect of working conditions on workers health. It was acknowledged that

"though there are special occupational diseases, unfavourable industrial factors influence the general health status and contribute to the development of other, non-occupational diseases" (Фридлянд (Fridlyand), 1966: 45 ).

Health centres in enterprises became the main type of occupational health services in the Soviet Union. They were supervised by the state and financed jointly by the state and enterprises. In this way the significance of special treatment of workers, first of all in high-risk industries, was emphasised. Enterprise was taken as the nucleus of society through which preventive and curative health services could be promoted and health gains maximised for the purpose of advancing productivity and improving the health of population. Cost of illness made itself feel stronger in the Soviet Russia because of the direct link between operational costs of an enterprise and economic gains of society, enhancement of the national economy and an individual well-being.

It was recognised that if an occupational disease aggravated any other disease without explicit occupational causes, then the loss of ability to work was considered occupational. Health centres were not only engaged in preventive work in order to promote labour productivity, prolong time of employment, reduce absenteeism and offer the first aid in case of emergencies but in providing primary and sometimes even secondary care thus enabling employees to enjoy preferential access to health care facilities for treatment of general illness.

WHO admitted that such a model was effective in combining protective and broad curative services and secured comprehensive health treatment for workers but at the same time expressed concern that in this framework preventive function of OHS might be underestimated.

### ***Conclusions***

Occupational health care is one of the cornerstones in the structure of occupational welfare. It is intended and provided to protect the workers against

any health hazard at work and to contribute to the establishment and maintenance of the highest possible degree of physical and mental well-being of the workers.

International institutions such as WHO and ILO lay down principles of occupational health care but their enforcement is the prerogative of national legislation rooted in conditions, traditions and customs of a country.

The success or failure of occupational health services is determined by political, socio-economic and organisational factors and interrelations of the numerous stakeholders involved -- the state, industries, local communities, voluntary agencies, etc. Positive experiences of other countries irrespective of their ideology and regime may also prove useful.

For instance, international community admits that occupational health care in the Soviet Union can be a benchmark in some areas because as organisational model it

"effectively combines occupational with general health services, constituting a comprehensive workers' health service" (Rantanen,1989:28 ).

The Global Strategy on Occupational Health for All sets the objective to further develop high quality and effective occupational health care to cover all employees regardless of industry, organisation or occupation (WHO, 1995). As far as contemporary changing Russia is concerned it is still faced with two issues: whether this division of occupational welfare will survive and what place, in this case, occupational health care could have in a new society with the Soviet experience duly heeded.

## **PART 2**

### **HISTORICAL OVERVIEW OF OCCUPATIONAL WELFARE IN RUSSIA: A CASE OF HEALTH CARE**

This part of the thesis is intended to provide a historical overview of occupational welfare in Russia. Its objectives are to trace the origins and evolution of occupational welfare, identify factors that influenced its structure and functions with an emphasis on state regulations and show its role in the welfare system at different stages of development. The overview is focused on health care as an important component of occupational welfare: health services in industrial enterprises appeared to be one of the first provisions in that field.

Each chapter is accordingly divided into two parts: in the first one general issues of occupational welfare in the context of the state social policy are analysed (social policy perspective) whereas the second section is devoted to finding out how those issues featured in provision of health care for people in employment (organisation perspective).

To better understand the principal characteristics of occupational welfare the following historical societal settings with essentially different ideology and societal organisation are taken for analysis:

- The late Imperial Russia from 1860s onwards when industrialisation led to adoption of first measures aimed to establish a system of social protection of the working people;
- The Soviet Union of 1917 to late 1980s when a unique model of social policy and occupational welfare was created on the principles of socialist ideology and planned economy;
- The post-Soviet Russia since 1991 when Russia had to modify its welfare system in the course of social transformation of society.

The study of occupational welfare in the Imperial and Soviet Russia is a challenge in its way because I have not succeeded in discovering special research on the topic. Works on Imperial Russia's social history are dedicated to industrialisation, development of the working class, trade unionism and



introduction of social insurance. Social policy and social welfare in the Soviet Union are well studied but, unfortunately, little information is available on occupational welfare either in Russian or in English.

## **Chapter 5**

### **Occupational Welfare in the Imperial Russia: Factory Medicine and Compulsory Health Insurance**

Chapter 5 renders a brief account of social settings in which workers' welfare (in fact, the embryo of occupational welfare in its present meaning) and factory medicine came into being in Russia. Analysis is also focused on the Tsarist government and employers' attitudes to occupational welfare as a component of national system of social protection and on factory legislation especially in its part regulating factory medicine and compulsory health insurance.

#### ***1. Social Policy and Occupational Welfare: General Issues.***

##### **Social policy and welfare of workers**

The emergence of occupational welfare can be dated from the late Imperial Russia and considered as a principal factor of formation of social policy in the country.

Flora and Heidenheimer (1981) argued that for the development of the welfare states in the West two processes were of a major importance: the rise of capitalism, the emergence of national states and their transformation into mass democracies. This assertion can be attributed to Russia because only after the modernisation of the Russian Empire was started in the early 1860s by Alexander II the establishment of social protection system was put on the agenda.

The abolition of serfdom and the introduction of local self-government through elected bodies — *zemstvos* — had very important implications for the further social and economic development of the country. The subsequent

rapid development of industry led to disruption of traditional social relationships and, consequently, changes in the social structure of the Russian society.

The welfare of peasants who at that time constituted the majority of population primarily depended upon possession of land. It was assumed that having land a peasant would be able to secure the well being of his family. Therefore, the problem of land ownership dominated all other issues of social welfare (Pinker, 1981). The state social responsibilities towards peasants were vested into local authorities (*zemstvos*), which were supposed to organise social services for rural population including provision of public health and education.

The break-up of the old social structure and the emergence of new social classes inherent to industrial society -- industrialists and workers -- called for a necessity to formulate their social rights and responsibilities as well as to define social welfare functions of the state. Therefore, three main things should be taken into account in the analysis of occupational welfare before the 1917 October Revolution: the place occupied by industrial workers on social ladder; capitalist employers' attitude to their social responsibilities for workers and the Tsarist government position towards "division of welfare"<sup>1</sup> There is a

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<sup>1</sup> It would be appropriate to make brief remarks on the social policy role of the Russian Orthodox Church that was the most powerful religious body in the country. It was incoherent and the attitude of the church to the labour problem was passive. On the eve of the twentieth century there was neither Orthodox conception nor any important movement of social Christianity in Russia (Florovsky, 1974). The official role of the Russian Church was in fact limited to moral backing of government activities. It ensued from the position of the Russian Church which in the course of the historical development of the Russian state became what many observers described as "a department of the state" heavily regulated and controlled by the state. But of course there was a difference between the attitudes of various layers of the clergy. Pointing out to the lack of the comprehensive social concept does not mean ignoring the role the church traditionally played in social protection of the weak. It was always engaged in charity concentrated around local churches and monasteries and thus depended to a large extent on parish laymen rather than on general nationwide strategy.

The Russian Church failed to develop definite stand on such new phenomena as formation of new social strata, relations between capital and labour, social welfare of workers, etc., because it was not prepared to recognize the necessity of social change inevitable under new social and economic conditions. No innovation in pastoral work or doctrine followed.

As to the Catholic Church it promoted the subsidiarity principle implying that intervention of a higher unit of society was justified only in case the lower levels capacity to meet the needs of the destitute had been exhausted. In Russia "*sobornost*" ("*sobor*" is a gathering of people to discuss public matters) as the community idea meant an individual action coupled with collective responsibility. In relation to social

substantial body of evidence for suggesting that Baldwin's argument (1990) that by the end of the nineteenth century the urban working class in the European countries could not secure its welfare independently is true for Russia.

First, workers lived in poverty and their economic status was not sufficient to maintain their own welfare to say nothing about providing for a family in urban area.

Second, being a newly born class industrial workers had not yet taken a definite position in the social structure of the Russian society and their citizenship status was not clearly defined. Industrial workers formed a "hybrid class" (Strauss, 1941; McDaniel, 1988) as they were recruited mainly from peasants and still continued to maintain close ties with their villages while working at factories. As a rule they formally belonged to rural communities: only after the Stolypin's reforms in 1906 identity cards were issued to legalise a possibility for peasants to live outside their villages. Strong rural connections were the principal difference between Russian and West European workers (Pipes, 1990).<sup>2</sup> Coming from villages where the life style was quite different they often found it difficult to adjust to new environment and factory discipline.

Third, workers were helpless in defending welfare interests having no channels to express their views and to bring their problems to the political agenda as well as no possibility to promote self-help organisations. There were no formal communication links between factory owners and workers. Walkin (1963) stressed that the Russian Empire was a "state without society". Until the beginning of the twentieth century when the first elements of constitutional regime were introduced Russia was the classical absolutist monarchy.<sup>3</sup>

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welfare it implied close solidarity of the Orthodox Christian community (*pravoslavnye*) in securing the well-being of its members.

<sup>2</sup> Only about one half of workers in Russia was engaged in industrial establishments. The other half was employed in the so called *kustarnaya promishlennost* (small, often family size, craftsman units).

<sup>3</sup> After the 1905 Revolution the Tsarist state was forced to declare political reforms in the October Manifesto (1905) and the Fundamentals of Law (1906). The post of the Prime Minister was established in 1905; the first legislative body - *Duma* - was elected and trade unions and economic strikes were made legal in 1906. Legal political parties and voluntary organisations started to emerge, too.

But with the development of industry workers grew in numbers and gradually revealed distinct characteristics as a social group. Since strikes were usually treated by authorities as political or even criminal events (the breach of public order) the open expression of social and economic grievances made workers the most troublesome class in society. Unlike other groups of population workers turned out to be capable of becoming organised in order to further their demands for better living conditions. In a situation of workers' unrest provision for their welfare was the way the state embarked on in its attempts to prevent dissemination of the socialist ideas among workers.

The concept of citizenship and rights prominently figures in the Western research on historical development of the welfare states. Madison (1968) argued that in general welfare policies in the Imperial Russia were more of a charitable nature and the approach to social welfare was mainly assistencial. Necessity to establish contractual relations to oblige society to assist the needy on the basis of eligibility requirements was almost ignored in Russia as well as the right of an individual to any form of public assistance.<sup>4</sup>

In general, the state paternalistic attitude to workers ensued from an assumption that they were unable to manage their own problems successfully and, therefore, needed somebody to look after them. Such a philosophy, in fact, reflected the feudal tradition when the lord of the estate had a responsibility for the welfare of his subordinates that was very strong in Russia with its long history of serfdom. There was also a conviction in paternalistic duty of employers to take care for welfare of their employees (*noblesse oblige*). The state conception of employer's social responsibility required social services for workers to be provided by employers rather than central or local authorities. It was based on a rather negative attitude of the tsarist state towards capitalism as social organisation of labour. Its officials often stressed that employers should first and foremost be held responsible for workers'

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<sup>4</sup> The Soviet interpretation of the history of the Russian Empire is evidently dominated by the labour question approach with an emphasis laid on industrial workers' poor living conditions and inability of the Tsarist government to solve the problem of workers' welfare. Recent Russian studies reveal an increased interest in the role of local authorities in social development and the process of enactment of social insurance (Куприянова (Kupriyanova), 1996; Степанов (Stepanov), 1997).

poverty. Employers' preoccupation with their own profits and neglect of workers' interests were considered the main reasons for strikes disturbing social tranquillity.

#### Government and employers' attitudes to occupational welfare

It should be taken into account that there had never been consensus on welfare policies in the Tsarist government. On the contrary, the state departments authorised to deal with social matters had different approaches to the labour problem that often caused tensions between them. A considerable influence on the policy making process in that area was exerted by the police (Ministry of Internal Affairs) which main concern was to prevent labour unrest. Senior officials at the Ministry in question understood that the revolutionary movement could not be fought by repression alone. Acknowledging the necessity to improve social welfare of workers, they were prepared to infringe upon interests of industrialists in order to preserve peace in society.<sup>5</sup>

The two other ministries concerned (Ministry of Finance and, after 1905, Ministry of Trade and Industry) were mostly preoccupied with promotion of industrialisation, thus, considering social problems a secondary issue. Those governmental bodies would prefer to keep labour policy within the limits of the existing laws, modifying the latter insofar as that could not be helped and safeguarding the interests of employers as much as possible. Schwartz (1969) referred to that division within the government as bureaucratic-legalistic versus police tradition.<sup>6</sup>

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<sup>5</sup> It is worth noting that it was Ministry of Internal Affairs from which the idea came to initiate docile workers' organisations to exert influence on workers. The social experiment attempted under its auspices was later referred to as "police socialism" or *Zubatovschina* after the name of Zubatov, its main ideologist who organised several workers' societies in Moscow. Zubatov thought that workers needed moral and ideological guidance and should not be left alone in the hands of employers. The aim of the state was to defend the economic interests of workers contributing in that way to peace not only in factories but in society as well and tying workers to the autocratic state. Zubatov's concept was that of the social monarchy which would restrain the greed and power of industry bosses by coming to the aid of the insulted and oppressed (Rogger, 1983). The anti-capitalist ideology of Zubatov's scheme was obvious to liberal circles of society that strongly opposed his ideas as threatening the rights of private enterprise.

Zubatov failed to reach his goals. An outburst of strikes under the leadership of his followers which, in fact, was in contradiction with the intended aims of the movement, led to its end.

<sup>6</sup> With the election of the State Duma the situation became even more complicated because the conflict of interests of deputies and a complex parliamentary procedures.

But both those approaches had practically the same implications for the development of welfare system as employers were supposed to play a leading role in providing social benefits to workers. Because of the constant deficit of the state budget, the economic problems caused by the war with Japan and consequences of the 1905 Revolution the state was not prepared to accept any financial responsibilities for social welfare. As cost containment considerations were of a major importance at that time the Tsarist government favoured welfare policies that enabled it to introduce some social measures without incurring much additional expenditure or raising taxes.

Industrialists were dependent on the state because the legitimacy of capitalism was not clear-cut. Process of industrialisation started under the conditions of the absolute monarchy and expansion of industry was not spontaneous but to a large extent initiated and supported by the state. Quite a lot of factories depended on the state orders rather than on mass consumption.

Entrepreneurs were not well organised politically, their regional organisations often being stronger than nationwide ones. As a result, they failed to work out a unified proactive policy on labour and welfare problems to lobby it through the government. For example, the activities of the Society for the Promotion of Russian Industry and Trade (1867-1917) demonstrated that attempts of bourgeoisie to influence the Tsarist government in its own interests were "quite indecisive... and exclusively advisory in nature" (Куприянова (Kupriyanova), 1996: 61).

Employers' reaction to the government's social welfare proposals was mainly negative in a sense that they tried to defend their own interests at workers' expense. That, in turn, contributed to a further alienation of entrepreneurs from their employees.

Paradoxically, many industrialists favoured a political change first claiming that workers' unrest was caused by their political rather than economic infringement. Therefore, the problem could be solved by implementing political reforms first, by granting workers political rights and improving state

administration mechanisms. Employers blamed the state for concessions it made to workers in economic matters.

Workers could be divided into two groups depending on how employers participated in workers' welfare (Schiltze-Gavernitz, 1901). One group of workers practically was not dependent on employers in settling welfare problems. They relied either on support of relatives in rural areas or voluntary provisions to secure themselves and their families against consequences of illness, disability, unemployment and death. The voluntary provisions included, for example, *kassy vzaimopomoshchi* (mutual aid societies) or special funds contributions to which were made jointly by employer and employees. But such forms of welfare associations were not widely spread, especially in the regions of Central Russia (Walkin, 1963).

The second group of workers was more closely tied to employers through a wide range of occupational welfare arrangements. Employers often provided housing and other facilities for employees on factory grounds (schools, churches, shops, etc.). The truck system was used in many industrial enterprises. However, availability of most occupational benefits depended to a large extent on employers' good will and they could be considered as gifts, but not rights.

In 1913 employers' per annum expenditures on maintenance of schools, crèches, hospitals, etc. amounted to 3.7 per cent of annual payroll plus 4.5 per cent on workers' insurance, medical care, housing, that made over 8 per cent of payroll in total (Crisp, 1978). There were several reasons for employers to provide occupational benefits.

- Owners of some enterprises, especially large, prosperous and usually well managed ones, preferred to improve the living conditions of employees in order to prevent strikes which by interrupting the process of production caused serious damages to employer.

- Strong ties that most workers maintained with their native villages as well as attitude of the government and society to entrepreneurship in general made employers resort to welfare provision as a means of stabilisation of labour force. Crisp (1978) argued that seasonal employment was one of the factors

contributing to increase in expenditures of large firms on housing and various social security provisions in an effort to attract and hold labour which made for high labour unit cost.

► Provision of social services to employees was employers' pragmatic reaction in the absence of both mutual aid and community support (Russell, 1991).

► Some employers perceived improvement of workers' well being as their moral commitment. Such an attitude often originated from religion. For example, Old Believers and Jews traditionally lived in communities where the rich cared about the poor. In early Old Believers communities engaged in industrial production the hereditary principle was abandoned in favour of accumulation of wealth in the interests of the community (Blackwell, 1968).

It was characteristic of the Russian society that workers, as a rule, were not required or encouraged to contribute directly to voluntary occupational plans. However, the latter in fact were financed by workers indirectly through low wages. It can even be suggested that wages were set up taking into account that employers should provide social benefits as well.

It is worth noting that welfare provisions were not implemented in all industrial establishments. Some private enterprises were run on paternalistic lines providing various services and facilities for workers whereas many employers were indifferent to the poor working conditions and labour management. Quite a number of entrepreneurs considered Russian industry to be too weak to provide welfare for workers and advocated promotion of private initiative to enhance economic status of the country.

#### Factory legislation and social insurance

In the late nineteenth century the state began to directly intervene into activities of enterprises with a view of improving workers' life by legalising some welfare provisions, which had already been available in factories and were deemed important by general public. Thus, provision of medical treatment and payment of benefits out of fines levied on workers were made compulsory.



The 1885 Law provided for the establishment of a special fund to accumulate fines from which workers were to be paid in cases of temporary inability to work, pregnancy (not more than a half of earnings two weeks prior and two weeks after the delivery of a child), loss or damage to property due to fire, flood, etc. (up to two thirds of six-months wages) or in other cases subject to approval of factory inspectors. Those regulations can be regarded as the inception of compulsory occupational welfare.

The Tsarist state approached workers' welfare and labour problem first through the enactment of factory legislation. Rimlinger argued that

"traditional dependence and protection, whatever its meaning in practice, was never challenged by the liberal ideas of individual freedom and equality. The challenge to patriarchal subordination in Russia came from egalitarian ideas of the revolutionary socialist movement". (Rimlinger, 1971:168).

In contrast to this generally accepted view, von Laue (1962) suggested that as industrial development required cheap labour, caring for workers' welfare and promoting industrialisation turned out to be conflicting commitments. The state intervention in social affairs in the interests of workers' by means of regulating industrial relations and introducing factory legislation could be taken as a liberal break-through in the wake of the abolition of serfdom in order to ensure freedom of contract to encourage industrial development. On the other hand, protective labour legislation was a corollary of the still semi feudal nature of the Russian state because

"in feudal society protection against arbitrariness and oppression was more important than from the loss of income" (Rimlinger, 1971:175).

In the early 1880s the Factory Inspectorate was established to supervise employment environment in all industrial enterprises employing more than 50 workers. During industrial boom and peak of labour unrest in 1885-1887 the first factory laws were passed prohibiting night work for women and the minors and enacting employment and wages regulations. The Factory Inspectorate, in

fact, became the mediator between employers and employees in securing legal protection and prevention of abuses against workers.

At that time in its policy towards occupational welfare the state proceeds from employer's liabilities. The Accident and Death Compensation Law passed in 1903 was employer liability law to be executed through courts that made it a part of the civil rights. Employers were to pay cash benefits for accidents during the work hours amounting up to two thirds of previous earnings in case of total disability, though coverage was limited. Workers were no more responsible to prove the negligence on the part of employer but there was the provision on carelessness of worker at work that would free employer from his obligations.

The intensity of social welfare activities of the government was directly connected with outbursts of workers' strikes. The 1905 Revolution showed that something was to be done to calm workers down. A few state commissions were set up to inquire into the living and working conditions of industrial workers and to work out measures of their improvement. The Tsarist government was forced to introduce legislation on workers' organisations and social insurance (Степанов (Stepanov), 1997).

The necessity to launch social insurance was proclaimed in the Manifesto of December 12, 1904. A number of draft laws on health care, housing, pensions, etc, were worked out by the government but only two of them -- on health and accidents insurance -- were finally brought to the State Duma in June, 1908 while others four, including those on pensions and housing, had been declined.

In the late 1890s the idea of the state participation in social insurance became quite popular among employers. It can be explained by the fact that several projects, which envisaged individual employer's liability, were then under discussion. Employers' attitude was openly hostile: they claimed that it would put too much a burden on employers. Recommendations worked out by different employers' organisations during 1880-1905 reflected employers' willingness to vest the solution of social welfare issues in the state. The Congresses of Entrepreneurs of the Southern Russia openly declared that the

state had to participate financially in social insurance plans together with workers and employers.

Introduction of social insurance had enforcement, administration and financing dimensions. Flora and Heindenheimer (1981) argued that constitutional dualistic monarchies tended to be the first to introduce social insurance legislation because of the necessity to win support of the hostile working class; the existence of the developed bureaucratic machine to implement new arrangements and the wish to shift financial burden to urban classes.

The government expressed no intention to participate in social insurance programmes that probably would have been in natural accord with the alleged paternalistic claims of the Tsarist regime. Witte, one of the most influential finance ministers and ideologist of the reforms, which were aimed to improve social and economic situation in the country, strongly opposed the idea of the state supported social insurance.

Social insurance in Russia just as in many Western countries started with protection in case of industrial accidents. The law was passed in 1893 providing for protection against job-related illnesses, injuries and deaths though the coverage was limited to workers of only three occupations: mining, railroads and the navy. It required equal contribution from employers and workers to be administered through partnerships ("*tovarishchestvo*").

The government's intervention in social welfare had one more dimension. McDaniel (1988) commented that even those laws that did manage to be enacted were very unevenly enforced: laws on books did not always achieve practical significance both workers and employers showing little respect for law, often violating its provisions.

In his critique of Russian insurance legislation Lenin (Ленин, 1971) pointed out that laws had to envisage some build-in mechanisms enforcing their implementation, one of the most important being sanctions for non-compliance. All the legal acts mentioned above failed to incorporate the necessary provisions. Enforcement was usually executed by non-legal methods like police intervention in the time of industrial unrest. Besides,

factory inspectors who were supposed to control the implementation of laws and regulations were unable to do the job properly because their number was insufficient. There was no effective workers control, either; at least until sickness funds were established in 1912. It was yet another proof of inability or, probably, the lack of interest of the Tsarist government in the implementation of policy decisions that meant in practice leaving workers once again at good will of their employers.

The introduced social insurance regulations were incomplete in the part concerning coverage of risks. Insurance provisions for the old-aged, disability or unemployment were never seriously discussed.

The dramatic process of emergence of social welfare in the Russian Empire in the late nineteenth century -- the beginning of the twentieth century is indicative of failure of the Russian absolutist monarchy to accept new realities and comprehend the necessity of social change. McKean defined attempts of the last Tsarist governments to build up a social welfare system based on the German experience as "half-hearted, grudgingly conceded measures of social reform" (McKean, 1990:180). The Tsarist regime was unable to break

"a vicious circle, when calls for change led to greater repression which in turn led to further calls for change" (McCauley, 1988:130).

## ***2. Health Services for Workers: Factory Medicine and Compulsory Health Insurance***

### Organisation of health care for workers

The origin of enterprise-based health care in the Russian Empire can be traced back to the late nineteenth century when health care services for general public and for workers were separated. The latter were called "*fabritchnaya meditzina*" (hereinafter referred to as factory medicine). The term covers health care services in kind provided for workers by and at the expense of their employers.<sup>7</sup>

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<sup>7</sup> The other health services were:

- *zemskaya meditzina* - health care in rural areas provided by *zemstvo* (local self-government bodies), established in 1864;
- *gorodskaya meditzina* - health services provided by city authorities to urban population;
- private health services.

Dementiev (Дементьев, 1912) distinguished five types of health services for workers:

- factory hospitals where workers received comprehensive treatment (primary and secondary care, home visits). They operated in 6.8 per cent of factories covering 43.9 per cent of all industrial workers in the country;
- "*priemniy pokoy*" (a small hospital with up to four beds) where only primary care and emergency services were provided, other cases treated on agreement with local health agencies. 2.3 per cent of factories with 6.7 per cent of workers were covered by such arrangements;
- primary care services in 20.6 per cent of factories covering 25.4 per cent of workers;
- health services provided on agreements with *zemstvos*, city authorities or private health services (3.8 per cent of factories with 5.6 per cent of workers);
- health services, provided occasionally, for example, by doctors visiting a factory several times a week were available in 4.7 per cent of factories with 2.5 per cent of workers. Dementiev regarded them as unsatisfactory level of health provision.<sup>8</sup>

Thus, about 84 per cent of all industrial workers in 38 per cent of factories were covered by at least one type of health services.<sup>9</sup>

There was a direct correlation between the level of provision of health services and the size of a factory: as a rule, in large enterprises they were organised better than in smaller ones. For example, hospital services were provided in almost 70 per cent of enterprises with more than 1000 workers and only in about 6 per cent of enterprises with 50 to 100 workers (Заблудовский (Zabludovsky), 1956).

It is noteworthy that *the Tsarist government urged employers to provide at their expense health services for workers.*

Law "On the Establishment of Hospital Premises at Factories and Plants in the Moscow Region" was enacted in 1866 stipulating the opening of hospitals

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<sup>8</sup> The data are based on the Factory Inspectorate statistics. There were 14,247 factories reporting to it in 1907.

<sup>9</sup> The data are taken from Vigdorchik (Вигдорчик, 1912) and are consistent with figures cited by other authors. for example, Solov'ev (Соловьев, 1913).

in factory premises at the expense of employers. It ruled on the ratio of beds in such hospitals and the number of employees (approximately one bed per 100 workers).

The Industry Statute (clause 52) prohibited charging workers for medical treatment provided by employers in enterprises with more than 100 workers.

The 1866 Law was passed as a temporary measure to cope with the outburst of cholera in the central regions of Russia. It explains why it was formulated in general terms that caused difficulties in its interpretation. The law did not contain any stipulations on conditions of care, number of medical personnel to be employed, treatment of the dependents, comprehensiveness of treatment (primary and secondary care) and types of industrial undertakings (size and industry) where the Law was to be applied. But a Russian saying goes that no other arrangement lasts longer than a temporary one.

#### Factory medicine legislation and its consequences

The 1866 Law is the formal beginning of factory medicine in the Russian Empire.<sup>10</sup> Its enactment even before the adoption of factory laws in 1880s was undertaken by the state to involve employers in health protection of workers under the influence of two factors.

First, hygiene conditions in Russian factories, especially big ones with many people working in congestion, were very poor. There was a permanent threat of epidemic outbreaks dangerous to the whole society, including tuberculoses and sexually transmitted diseases. It especially became evident for authorities and general public in the late 1860s when the country had to cope with the epidemic of cholera.

Second, in general, the status of health services in the country was poor as well. Their administration in urban areas was in the hands of special state bodies (*Prikazi Obtchestvennogo Prizreniya*). But in the majority of towns they were virtually non-existent or of a poor quality. Health services for peasants, as it was already mentioned, were provided by *zemstvos* established in 1864.

In those circumstances the state tried to convert occupational health services into the channel of health care for workers.

In 13 towns where about 18 per cent of all factories (18.5 per cent of workers) supervised by the factory inspection were situated every person was levied with a special hospital due -- *bolnichniy sbor*. It was not abolished after the 1866 Law had been passed. The city authorities remained responsible for provision of health care free at the point of delivery for all groups of population, including workers. Employers were only liable for primary health services to their workers in cases of accidents and emergencies and not required to organise hospitals.<sup>11</sup>

Unfortunately, the data found by the author is not enough to appraise employers' attitude to health obligations imposed on them. But the fact that forty years after the enactment of the 1866 Law many employers failed to introduce health care services in their enterprises could serve as indirect evidence that their attitude to it was negative.<sup>12</sup> Financial considerations were apparently the most important for employers to take such a position as provision of health care required considerable spending on their part. The obligation to open hospitals was especially difficult to implement both financially and organisationally for small factories and even not necessary in those areas where the level of public health care was satisfactory. It was two times more expensive for an average employer to provide health services in his own hospital than to pay for workers' treatment elsewhere (seven and three roubles per worker a year, accordingly) (Данский (Dansky), 1914). Share of hospital expenses fell down from 66 per cent in 1897 to 59 percent in 1907, *priemny pokoy* -- from 16.4 per cent to 6.8 per cent while share of

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<sup>10</sup> The government's policy on factory medicine was quite inconsistent. In 1867, for example, the State Council decided that in spite of the 1866 Law being a temporary measure it had to remain in force without any amendments while in 1908 the Senate ruled exactly the opposite.

<sup>11</sup> The role of factory medicine should be evaluated with caution. According to Pogozev's estimates, only 1.8 million out of 10 million workers or about 18 percent were covered by factory inspection. Of the remaining 82 percent only railway men and minors were provided with some health care other workers being treated as population at large.

<sup>12</sup> According to the data of the Third State Duma, 19 per cent of the permanently employed workers and 28 per cent of the temporary employed in 1912 did not get any health care in their enterprises.

primary care increased from 11.7 per cent to 27.9 per cent, respectively (Астрахан (Astrahan), 1911).

But nevertheless factory medicine slowly developed. The number of factories, which had their own hospitals, increased from 710 (514.8 thousand workers) in 1897 to 964 (798.3 thousand workers) in 1907. By the end of the period health services of all types were provided at 5439 factories with 1,5 million workers covering 84 percent of factory workers -- 500 thousand workers more in comparison with the year of 1897. Expenses on health care also increased from 4 million roubles to 9.4 million roubles. Average annual expenses per worker rose from 3.91 roubles in 1897 to 6.13 roubles in 1907 (Астрахан (Astrakhan), 1911).

The significance of factory medicine for Russian society is emphasised by the fact that it was always in the centre of debates on the improvement of health services in the country. There was no consensus in the ruling elite on the problem and main propositions advanced were:

- to develop health services on the already established patterns;
- to transfer factory medicine under the auspices of *zemstvos*;
- to introduce insurance principle through *bol'nichnaya kassa* (sickness fund).

But whatever proposals for reforms were discussed they implied participation of employers in health care provision. In his letter to the Minister of Internal Affairs in May, 1866, the Moscow Governor stressed that employers' obligation to provide compulsory health services for workers was justified because factory owners got the major share of profits gained from employment of workers who often lived in very poor conditions (Деметьев (Dementiev), 1912). Some officials believed that joint efforts of *zemstvo* and employers could be a better solution (for example, establishment of one hospital in the locality to provide health services either for several factories or to workers and local people together).

*Zemstvo* leaders and some groups of doctors advocated creation of a national health service to be administered by *zemstvo* or city authorities. Employers would have to pay special contributions to run the service instead



of offering in-kind provisions. Factories where hospital conditions complied with the set standards might be exempt from paying contributions. Financial issues dominated debate as *zemstvo* supporters acknowledged that funds coming from employers could be used to raise the standards of health care offered to public at large. They insisted on free health services for population. One of the arguments against the establishment of sickness funds was that while health services developed as free for ordinary people workers would have to pay to sickness funds under insurance schemes.<sup>13</sup>

Workers' organisations, factory doctors, some factory inspectors and the socialist movement demanded that health care should be organised at factory level and managed by workers through self-governing sickness funds (Вигдорчик (Vigdortchik), 1912). In early 1900s trade unions suggested that health services for workers should be provided through trade unions and financed by their members.<sup>14</sup>

The idea of workers' right to preferential treatment was put forward to justify the importance of factory medicine. It was substantiated by statistical data on accidents and morbidity, which were higher among workers than in other groups of population. New health risks inherent in industrial employment – accidents and occupational diseases – required special attention to be paid to workers' health needs and to training doctors with necessary skills to treat workers.

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<sup>13</sup> These ideas were comprehensively expressed in the decision of the Moscow *Gubernskoye Zemskoye Sobranie* in 1887. In particular, it was proposed to levy a special tax on enterprises in manufacturing -- three rubles per worker for factories with more than 16 workers -- for organisation of health services for workers. Capital expenditures on hospitals providing medical treatment only to workers should be borne by employers.

The Health department of the Ministry of Internal Affairs declined the proposal. It ruled that if health services in factories were not satisfactory employers could come to agreements with *zemstvo* on a voluntary basis, the number of beds to be determined in accordance with the 1866 regulations. At the same time hospitals providing satisfactory care for workers were to remain under factories' authority.

<sup>14</sup> Bolsheviks were very active promoters of insurance principle. They controlled a special magazine "*Sotzial'noye Strakhovaniye*" (Social Insurance) published since 1913 that for a long time was the only Bolsheviks' legal mass media. The party programme on social insurance was comprehensive: to cover all workers in all industries; to provide protection from all risks; to give full compensation of lost income; to include the dependents; to be run on self-governance principle; all expenses to be covered by employers.

Employers failed to display any definite stand on future development of health services in the country showing the lack of evident interest in changes in health care. They were fully responsible for financing and administering factory health services without any strict control on the part of the state. At first, *zemstvo* had the right to interfere but in 1893 the Ministry of Internal Affairs issued the decree vesting all rights in connection with factory medicine in special Offices on Factory Matters (*Prisutstviya*), set up at regional level in 1886. Thus, employers could easily control their expenditures on health services.

Factory medicine was a very good example of dualism of occupational welfare as a halfway between charity and rights, public nature and private form of provision. Vigdorchik (Вигдорчик, 1912) noted that its public nature rested in:

- provision of health services free of charge;
- compulsory character;
- explicit state regulations.

He regarded factory medicine as a form of compulsory health insurance, concerned only with provision of health services for workers. The function of payment of sickness benefits was exercised through a limited range of compulsory and voluntary health insurance arrangements. For instance, compulsory sickness insurance was first introduced in 1861 for workers in state-owned factories and railways. Special partnership was to be established in every factory to accumulate up to three per cent of wages to pay out health benefits and pensions. According to incomplete data by the year 1902 about 600 thousand workers were covered by either voluntary or compulsory health insurance (Захаров (Zakharov), 1968).

The 1912 Health and Accident Act was the first social welfare law to be debated in the highest elected legislative body and attracting much public attention. It took the State *Duma* eight years to pass it.<sup>15</sup>

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<sup>15</sup> Two draft laws on compulsory health insurance were discussed in the State *Duma*. The one was worked out by the government, the other -- by a special committee set up by the State *Duma*. Both

The Act provided for cash benefits in case of sickness, maternity and death to be financed by both employers and workers. The latter's contributions amounted to up to two per cent of wages, those of employers constituting two thirds of workers' instalments. Thus, employer's individual responsibility was replaced by his collective liability with workers. Benefits compensated 50-66 per cent of wages for workers with families and 25-50 percent for the lone workers and were to be paid from twenty six to up to thirty weeks per year.<sup>16</sup>

Coverage was limited by enterprise size and industry and spread to enterprises with more than 20-30 workers in manufacturing, mining, foundries, and inland water transport. Special *bol'nichniya kassy* (sickness funds) were set up in factories to be administered by joint committees of labour and management. In that way workers gained the right to participate in administration of health insurance.

The Act regulated mainly payments of sickness benefits. It was acknowledged in general terms that members of sickness funds had the right to health care. But how they were to get medical treatment turned out to be much debated issue. In accordance with the government draft health services in-kind were to be provided by employers and only cash benefits to be paid by sickness funds. The idea of the State *Duma* was to transfer employer-owned health services to sickness funds and to increase employers' contributions to help funds to survive. But different parties represented in the State *Duma* failed to reach an agreement on dissenting views under the pressure of the government and the government draft was adopted with minor amendments (Степанов (Stepanov), 1997).

The Act stipulated for insurance of workers in case of temporary loss of income in the form of benefits to be paid by sickness funds and for provision of health services at the expense of employers.

Sickness funds got the right to organise a provision of health services for family members of the insured and some of them began to do so. They grew

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proposals provided for the establishment of sickness funds but with different coverage and level of benefits as well as the degree of workers' participation in management.

<sup>16</sup> All the indicators set by the Act were lower than in other European countries.

interested in using employer-owned health care facilities as they lacked resources to set up their own health services (Сольская (Sol'skaya), 1913).

Employers succeeded in reducing to minimum their obligations to workers and got considerable control over sickness funds. For example, they were granted the right to propose sickness funds draft statutes, which in many cases were finally imposed on workers.

The enactment of the 1912 Act undeniably worsened the terms of health care provision. For example, there used to be no official limitations for workers to get free medical treatment. In accordance with compulsory health insurance rules laid down by the Insurance Council workers could be treated at the expense of their employers only as members of sickness funds in case of illness without loss of ability to work and, in case illness caused loss of ability to work, for not more than four months.

In a number of regions *Prisutstviya* insisted that large enterprises employing over 500 workers should open their own hospitals. Though provision of secondary care was left to employers, the first aid and primary care were made compulsory. In other cases (secondary and maternity care) workers were supposed to use local health services on the same conditions as other local people, employer compensating treatment on *per diem* basis. Dansky (Данский, 1914) argued that such limitations threatened the development of factory medicine and in practice workers in areas with poorly organised health services would be denied any health care.

Employers' reaction to the 1912 Act was neither hostile nor uniform..<sup>17</sup> As the date of enforcement of the law was not directly stipulated employers had a room for manoeuvre. It was planned to establish 3198 sickness funds with 2.3 million members. The year after the law had been passed 484 funds were registered, but only 21 of them with 16.4 thousand members set forth to collect contributions and pay out benefits. 2167 sickness funds with 1.7 million members functioned by January 1st, 1915. The control over the enforcement

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<sup>17</sup> The detailed account of the debates around the adoption and enforcement of 1912 legislation (response of bureaucracy, industrialists and revolutionary movement as well as workers themselves) can be found in several studies (McKean, 1990; Степанов (Stepanov), 1997).

of the 1912 legislation was to be exercised by factory inspection but it must be kept in mind that there were only 230 factory inspectors in the whole Russian Empire.

The system, which emerged as a result of the 1912 legislation, though regulated by the state, was fairly independent of it in terms of financing and administration. Provision of health care was separated from payment of benefits and, therefore, compulsory health insurance covered only payment of benefits through sickness funds. Factory medicine survived as an independent division of health care.

Employers continued to play the main role in protection of workers' health contributing to compulsory health insurance and paying for medical treatment. But while the latter was both financed and provided by employers, sickness benefits were employer-subsidised because workers had to contribute as well.

### ***Conclusions***

Workers' welfare and factory medicine as its part came to the forefront in the mid XIX century after the abolition of serfdom and initiation of a series of reforms in the Imperial Russia.

Russian policy makers were evidently influenced by the Bismarckian ideas – as in Germany where bourgeoisie was weak and had to fight with aristocracy innovations in social policy in the Russian Empire came, as a rule, from the above, i.e. from the state. As soon as the Tsarist regime realised a need to establish national system of social protection it turned an eye on occupational welfare in an attempt to make it a significant component of emerging social welfare system. In the new social surroundings employers were urged to provide social services for their employees. It was one of the main reasons why occupational welfare was relatively well regulated by the Russian state: incremental voluntary occupational welfare provisions could not contribute to consistent social policy.

Making factory medicine compulsory was among first measures undertaken by the Tsarist government on the way of building up welfare system. The ideology justifying the existence of employer-provided health services was

derived from an assumption quite strong in society that employers were to be held responsible for health protection of their workers because of the nature of industrial process. Therefore, for more than half a century workers got medical treatment free of charge at employers' expense. The network of health care facilities was created in factories separated from other health services in the country. Factory medicine financed and administered by employers became an inherent feature of Russian society.

The way factory medicine developed and compulsory health insurance was introduced quite explicitly demonstrated that the Russian state was unwilling to participate in a new system neither financially nor organisationally and did its utmost to shift social responsibilities for workers' health to employers. The official authorities never promoted the idea of the state participation in social insurance.

## Chapter 6

### Occupational Welfare and Health Services in the Soviet Union

The emphasis in Chapter 6 is made on the specific properties of the Soviet social policy and occupational welfare -- ideologically conditioned public consumption funds, rigid state regulation, particular trends in development of occupational welfare, its main features and types. Formation and functioning of enterprise-based social funds are disclosed in detail. As to occupational health care, it is presented in its social, legislative and organisational outlooks.

#### ***1. Social Policy and Occupational Welfare: General Issues***

##### Evolution of the Soviet social protection system

The Soviet welfare state was extensively researched by many scholars in various aspects (Madison, 1968; Rimlinger, 1971; George and Manning, 1980; Dixon and Makarov, 1992).

The Soviet welfare system of 1980s was not established once and for all immediately after the 1917 October Revolution. It had a long history of development in coverage, types and value of benefits, organisation and financing. The Soviet social policy should not be looked at as something static. It was modified ideologically and organisationally though measures undertaken to adjust welfare system to new challenges were not always successful.

The formation of the social protection system began with introduction of unemployment and occupational sickness benefits for all employees (unemployment benefits were abolished in 1930 to be re-established in 1991) and then of non-occupational sickness benefits. Disability pensions for the elderly were instituted in 1922, old age pensions for workers in several industries in 1928, their coverage extended in the following decades to include even clerical staff. One of the major events was the 1956 pension reform aimed at raising pensions. In 1964 and 1970 peasants-members of collective farms were incorporated into the centralised social security system (pensions, sick leave, maternity benefits, etc.). The payments were rising as well. By

1980s a wide range of social benefits covering major social risks was granted to population.

The first social protection regulations enacted as early as December, 1917 were based on the Bolsheviks' comprehensive social insurance programme. Then the role of the state budget gradually increased and in the late 1930s social insurance funds were incorporated into the state budget. Since that time until the early 1990s social benefits were financed through the state budget in accordance with the centralised plans.

The public social funds were earmarked in the budget as *obschestvenniye fondi potrebleniya* – public consumption funds (PCF). Social benefits and services, first of all social security, education and health, used collectively and considered by the state most important, were financed from these funds. PCF accounted for about one third of people's income; the ratio between cash and in-kind benefits was approximately 50/50.

It was only in 1971 at the 24th Congress of the Communist Party of the Soviet Union (CPSU) that improvement of the well being of the Soviet people was officially declared the main priority of the state. But statistics showed the tendency for a gradual decrease in the share of the budget social expenditures. They fell from 36.2 per cent in 1970 to 32.5 per cent in 1985, including expenditures on health and sport – 6.1 per cent and 4.6 per cent, respectively, whereas appropriations on the national economy increased from 48.2 per cent to 56.8 per cent.

Deacon (1992) gave a plausible explanation why 1970s-1980s efforts to turn economy to attainment of social goals failed. Pointing at a link between the level of economic development and the scope of social policy he stressed that the Soviet state faced a need to balance between social equality and economic efficiency, personal freedom and state guaranties. It was essential in this context to distinguish between the Marxist and Leninist doctrine on the role of welfare and social policy objectives in the socialist society and the extent to which real developments, theoretical and practical, matched it. The theoretical assumption was that first it was necessary to create a solid economic foundation for social policy. But maintenance of the already created



economic system required more and more resources. In practice it happened that the task had not been fulfilled that could not but negatively affect the social protection system.

Kornai (1997) suggested that in the Soviet Union an attempt was made to implement social policy objectives, which were not adequately backed by economic resources. He referred to the phenomenon as "a premature welfare".

Occupational welfare including a wide range of social benefits was undoubtedly an integral part of the Soviet social policy. There are estimates suggesting that by 1980s social expenditures of enterprises amounted to about 20 per cent of public consumption funds (Антосенков (Antosenkov), 1987). But it has turned out to be quite difficult to evaluate its real scope. The only official data on the subject available are on social funds of enterprises. But they are incomplete because a part of expenditures on the maintenance of social assets were financed from sources other than social funds. Besides, there is even no official information on such an important indicator as the number of enterprises, which provided occupational benefits to their employees, probably because of substantial variations in the number of benefits in different establishments that reported to different ministries. At the same time surveys were not widely carried out until 1980s.

Another serious problem is that at present governmental agencies do not operate on long-term retrospective data basis and, therefore, are not interested in storing information concerning the Soviet Russia. That is why it is practically impossible to get any official data additional to already published in the official Soviet statistical sources.

#### Main features and types of occupational welfare

Occupational welfare in the Soviet Union had the following major characteristics.

a) Occupational welfare provisions in industrial enterprises were never a privilege of the managerial staff, at least formally. They were open to all employees. Though there was no formal discrimination certain criteria were

used to allocate benefits, as a rule a combination of need/achievement approaches and the length of service. Typically it was low-paid workers or workers with children who were target groups.

In this connection it should be mentioned that the scope and value of benefits in governmental bodies and party and ideological apparatus which officials formed the elite of society were bigger than in other places. That system was especially developed in Moscow.

b) Occupational benefits were usually provided in-kind through programmes directly financed and administered by enterprises and based on their social assets.

It had two significant implications:

- accent was made on collective rather than individual consumption;
- enterprises had social assets on their balance sheet.

c) Enterprises could also offer cash benefits to employees in the form of social assistance. They paid lump sums for workers on some occasions, for example, the birth of a child, but had no right to provide supplements to such monetary arrangements guaranteed by the state as pensions or sick pay.

d) Enterprises also paid social insurance payroll contributions. Their size depended on industry and was adjusted from time to time to economic conditions. These contributions were included into the state budget and amounted to about 5-6 per cent of its revenues. Workers did not pay anything to social insurance.

e) Apart from social benefits in-cash and in-kind enterprises administered a number of social security benefits (sickness and family benefits, maternity leave). It meant that the employed received their social benefits financed from public consumption funds via their enterprises.

Housing used to be one of the main components of occupational welfare. By 1980s the share of housing stock of industrial enterprises and other organisations amounted to 60 per cent of the total national housing stock. Enterprises built and maintained blocks of flats for their employees or gave them credits either to build housing individually or to join special construction co-operatives.

Measures to support families with children and to improve women's working conditions were another important element of occupational welfare. Enterprises spent substantial resources on children services developing a vast network of nurseries and kindergartens, summer camps and other leisure facilities for children. They could also pay maternity benefits additional to the state-provided ones.

Great attention was paid to health care, recreation and organisation of holidays. Some enterprises owned health centres or health stations, recreation and rest facilities or covered workers' expenses on holidays and recreation elsewhere, paid for additional vacations.

Quite widespread was provision of such services as canteens, laundry, dry cleaning, food shops, repairs, etc. on enterprise premises.

Enterprises were involved in provision of durable consumer goods and foodstuff either distributing them among employees free of charge or at wholesale prices. Some of them financed agricultural farms, which supplied foodstuff for canteens and individual consumption.

#### State regulation of occupational welfare

Occupational welfare was explicitly regulated by the Soviet state through financial and administrative mechanisms. Mishra (1981) pointed out that the state was to decide what type of benefits to provide and how much money could be spent on them. Social facilities were often a "part of the deal", maintained by an enterprise in accordance with decision of the state authorities. However, in many cases enterprises had a choice what social services exactly to provide. The composition of occupational welfare in a particular enterprise depended on social needs of its employees (housing, food supply, health care and recreation, etc.) In the framework of the state regulations enterprises had discretion to choose how they will follow state guidelines and what amount of money allocate for occupational welfare. As a result occupational benefits were quite unevenly distributed between enterprises and the package offered to employees varied (OECD, 1996).

In order to meet its social policy objectives the state regulated in the sphere of occupational welfare:

- amount of resources to be earmarked for it;
- its major components;
- its organisational forms.

The explicit connection of occupational welfare with the state social and economic policy is revealed in mechanisms of its financing.

Enterprise expenditures on occupational welfare were divided into capital investment and current expenditures. Capital investment included financing of construction and repairs of housing stock, kindergartens, health services and other social assets as well as purchase of equipment and instruments, fleet, etc. The emphasis on in-kind provision led to high share of capital expenditures: in 1970-1980s half of the Social and cultural measures and housing fund (hereinafter referred to as SCH fund) was spent on capital investment (Дегтярь (Degtyar), 1984). It reflected the state policy according to which enterprises were obliged to spend not less than 50 per cent of the SCH funds on construction of housing and other social assets. Lump sum payments and credits for employees engaged in individual or co-operative housing construction were included into current expenditures.

To have a full picture of the size of occupational welfare in Soviet industrial enterprises it is necessary to take into account the existing social infrastructure which major indicator was the value of fixed social assets accumulated in the past.

#### Occupational welfare and enterprise-based social funds

Funds specifically set up in enterprises to finance occupational welfare were called social funds. They accumulated financial resources for construction and maintenance of social assets and for other activities intended to meet various social needs of employees. These funds were used collectively to improve living standards of employees, to stimulate their active participation in production process in the interests of the development of the national

economy, to improve labour discipline and to contribute to the increase in labour productivity.

The system of social funds dated back to 1920s when widely spread after 1917 October Revolution remuneration in-kind was substituted by allotment of resources to special funds. They were created only in profit-making state (or with state participation) enterprises special rules being applied to the subsidised ones. Such social funds were not organised in private enterprises that still existed at that time on assumption that participating in distribution of profits even in the collective form, workers would become interested in development of the private sector against the nature of the dictatorship of proletariat.

Since 1923 various social funds were established in state enterprises until 1928 when a Decree "On Funds of Improvement of Working Conditions of Employees" was adopted by the Soviet government, which substituted all the previous legislation. New funds were financed from profit-after-tax and spent on a wide range of social benefits. Shares were fixed for housing -- between 75 and 85 per cent -- and recreation -- up to 5 per cent. Funds could also be spent on canteens, crèches, nurseries, laundries, libraries, etc.

To stimulate employees, directly or indirectly, social competition fund, remuneration fund and management rewards fund were established. In 1936 the director's fund was set up in industrial enterprises to replace all previously existing funds and to accumulate 4 per cent of net planned profit and 50 per cent of extra-profit (difference between gained and planned profits). The percentage was equal for all enterprises. The idea was to encourage employees to work better as well as to make the system simple and effectively manageable by consolidating all funds in one. Programme of spending, proposed by director, was subject to trade union committee's approval.

The list of activities to be financed from director's fund included: a) housing (50 per cent of the fund); b) improvement in the living conditions by providing social services (crèches, dining rooms, health services, etc.); c) payment of bonuses to best-performing workers; d) capital expenditures; e) encouragement of technical innovations.

During the World War II director's funds ceased to function because it was necessary to mobilise all resources for wartime needs. However, in 1946 they were restored subject to certain changes in regulation. For example, the share of resources allocated to funds was no more differentiated depending on industry. The size of fund was limited to 5 percent of industrial personnel payroll.

In 1955 director's fund was transformed into fund of improvement of social and cultural conditions and development of production.<sup>18</sup> It was to be established in enterprises which attained the planned targets for output, decrease in costs of production and profits. The major innovations included possibility of gradual increase in the share of profit apportioned to the fund and rising of the upper limit. For a long time resources to various funds had been allocated in accordance with enterprise belonging to a particular ministry. It resulted that the size of funds in enterprises of the same industry could have differed just because they reported to different ministries. Under new conditions the share was fixed for the whole industry regardless of ministry in charge.

The reforms of management of the national economy of 1965 affected the way social funds were formed. Three special "economic incentives" funds were created in industrial enterprises: production development fund, material rewards fund, social and cultural measures and housing fund (SCH fund). The two latter were aimed to finance the bonuses and enterprise social welfare initiatives. Mechanism of payments to these funds changed several times during the following decades but it always depended on indicators of enterprises economic performance. In 1966-1990 about 17 per cent of profit of state industrial enterprises on average were allotted to the three funds mentioned above.

In 1970 resources of economic incentive funds amounted to 84.4 per cent of all funds in industrial enterprises rising up to 92.6 per cent in 1985. The share of improvement fund which still existed in enterprises that had not

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<sup>18</sup> It should be noted that each of the funds mentioned was first created in industrial enterprises and later on introduced in other organisations.

established economic incentives funds decreased from 0.9 per cent to 0.17 per cent, accordingly. In 1985 the share of material rewards fund in economic incentives funds amounted to 41.8 per cent, SCH fund – 15.8 per cent, slightly decreasing as compared with 1970 (42.9 per cent and 18.6 per cent, accordingly). (Центральное статистическое управление (Central Statistical Agency), 1990).

Financing of occupational welfare from enterprise-based social funds differed in a number of ways. Some of them were included into the cost of production, others financed from profit.

The size of social funds depended mainly on an enterprise efficiency. One of the major concerns always was to secure a right correlation between enterprise input into the national economy and the amount of its social expenditures. Though the scope of some spending, for example, on the maintenance of the social assets and agricultural farms, was determined by the size of social assets rather than performance indicators.

There were other than social funds sources of financing occupational welfare that were not, for accounting purposes, directly named as social expenditures, for example, on construction and maintenance of social assets in enterprises which had their own construction or repairs branches. In that case resources actually spent on social assets would be calculated as a part of other planned activities but unrelated to occupational welfare.

Enterprises could specifically allocate some money from profit on maintenance of social assets (housing stock, kindergartens, etc.) or agricultural farms; and, at last, resources of trade unions that have their own social budget.

It should also be noted that enterprises social expenditures could be divided into current spending and capital investments in social infrastructure that amounted to about 20 percent of the total social spending of enterprises. Therefore, they were not counted as a part of public consumption funds that covered only current expenditures.

### SCH fund.

SCH fund was the most important of all funds for occupational welfare covering approximately 90 per cent of the total social spending of an enterprise. Sometimes social expenditures of enterprises were even equated with the amount of SCH fund.

It was formed from profit as a fixed percentage of material rewards fund and originally financed construction of housing and other social assets only. Since 1986 some other expenditures previously covered from the budget (costs of maintenance of housing, kindergartens and other health and educational facilities, compensation of the difference between wholesale and retail prices for agricultural products produced by farms, belonging to enterprises, etc.) were also paid from SCH fund. Approximate structure of its expenditures is given in Table 6.1.

Table 6.1

#### **The structure of SCH fund expenditures, %.**

SCH fund	1975	1980
Total	100	100
including		
capital investment	50.5	43.9
culture and education	18.8	14.3
health care and recreation	14.2	21.7
customer services	8.4	12.6
other social and cultural activities	8.1	7.5

Source: adapted from Загорулькин и Колесников (Zagorul'kin and Kolesnikov), 1983, p.29.

For a long time in the bulk of enterprises SCH funds amounted to about 30-50 percent of material rewards fund. The latter, in turn, was formed from profits on the basis of several performance indicators, which were defined for each industry (increase in labour productivity, share of high quality products in the total output, level of efficiency, etc). Two or three indicators were usually used at a time including target on the growth of labour productivity. In early



1980s an attempt was made to directly link the size of SCH fund to one indicator such as, for example, productivity of labour or profit. It was suggested that for each one percent increase of a selected indicator the fund would grow by 2-4 per cent<sup>19</sup>.

The size of SCH fund mainly depended on the fulfilment of plan targets: if plan was overfulfilled/underfulfilled SCH fund would increase/decrease accordingly. The stimulating role of SCH fund featured in its connection with the material rewards fund, or, to put it other way, with final results of an enterprise performance. In fact, it undermined to a certain extent its social function as no limits were set to secure means enough to meet social needs of employees (for example, per capita social expenditures).

A part of SCH funds was amalgamated in *ob'edineniya* (Soviet equivalent of a corporation) and ministries got the right to finance some of their social activities: construction of social assets important from the point of view of the whole industry, supporting social expenditures in enterprises which suffered temporary losses in the process of development of new technologies, additional remuneration of well-working enterprises.

Other funds used for social purposes were small and insignificant. For enterprises, which were called «planned inefficient enterprises», the amount of social expenditures was set in absolute figures by the ministries concerned.

### Main trends of development

The general tendency in development of occupational welfare was determined by ever increasing attention to social function of enterprises and was reflected in the following processes:

► The growth of the total enterprise expenditures on occupational welfare. During the period of 1971-1985 the size of SCH funds in industry, which

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<sup>19</sup> The ratios for each industry were set by the government but ministries concerned got certain discretion to change them depending on social needs of employees of a particular enterprise. But it often happened that norms failed to be keeping with changes in economic situation when, for example, the share of profit allocated to finance expenditures on maintenance of social assets was not adjusted to gradually growing size of social assets. As a result, enterprises were forced to spend SCH funds on purposes which diverted means from fulfilment of their statutory objectives (Полозов (Polozov), 1978).

played the most important part in enterprise social spending, doubled (Антосенков (Antosenkov), 1987).

► The search for more efficient ways of utilisation of means spared for social purposes. The major trend was to develop services to meet social needs of workers of a particular enterprise; to concentrate efforts on needs which could either be solved by an enterprise only or enterprise could do it more effectively than public agencies. In order to reach those objectives the rights of enterprise in management of social programmes had been gradually extended.

► The cooperation with local authorities in solving social problems in an attempt to overcome negative aspects of industrial approach to social services. Its major drawback was that local authorities had practically no say in control over enterprise-based social benefits. For example, they could not send children to enterprise kindergartens even if there were free places there unless their parents worked at the enterprise in question.

Thus, the aim of cooperation between enterprises and local authorities was fully to utilise social assets of enterprises; to bring together interests of enterprises and communities. Its most widespread form was the pulling together of funds of enterprises and local authorities for housing and social services construction followed by their joint use. In case of housing the flats were distributed proportionally between participants.

## ***2. Health Services for Workers and the Soviet System of Health Care***

### **Outline of development of occupational health care**

As it has been shown in the previous chapter prior to the 1917 October Revolution industrial enterprises played a significant part in provision of health care for workers. Factory medicine survived in the Soviet Union though its organisation and financing was drastically modified. In the course of transformation of enterprise-based health services were integrated into the national health service.

Health care for workers in the USSR developed along the following lines:

- integration of factory medicine into the national health system;

- special treatment of workers;
- preferential treatment of workers.

Two basic options were available after the 1917 October Revolution: either to develop insurance medicine further, that would mean preserving separation of health services for workers from health authorities, or to organise special provision of medical treatment to workers within the unified system of health care.

Formation of the National health service with the state assuming responsibility for people's health was the principal tendency. After the 1917 October Revolution for a brief period employer-provided health services were transferred without indemnity to sickness funds, but in February 1919 they were placed under the auspices of the People's Commissariat of Health (the then ministry) established in late 1918. It was the logic outcome of economic development when process of nationalisation of industry was underway causing dramatic increase in the number of people, employed in the state sector.

In early 1920s insurance contributions were introduced as a source of funds supplementary to the state budget. The intention was to finance provision of health services for workers under the auspices of the health authorities. It happened during *NEP* (New economic policy), the period in the Soviet history when the state allowed private business to develop, and brought major changes -- financial and administrative -- in health care.

a) In accordance with the decree "On Social Insurance in Case of Illness" (December, 1921) a share of the unified social insurance fund was apportioned to a special fund to be spent on health services for the insured only (the so-called Social insurance fund for health / Fund D). State industrial enterprises were to contribute 4.5 per cent of payroll, state departments - 3 per cent of payroll, all other enterprises and organisations - from 5.5 per cent to 7 per cent of payroll. Social insurance administration got the right to introduce stimulating and penalising rates depending on enterprise efforts in improvement of working conditions.

b) Sections of health services for the insured (*rabmed*) and workers' insurance councils were established in the People's Commissariat of Health and local health departments.

The emerging system of organisation and financing of health care was a combination of National health service and compulsory health insurance models. Health services for the insured were provided by the health authorities in agreement with the insurance bodies and trade unions and financed from the state and local budgets and insurance funds. The latter were considered supplementary to the budget and were charged to a special bank account to be spent on the insured only. Special councils were set up to coordinate the activities of the health authorities, insurance agencies and trade unions.

At that time belonging to labour force was the main eligibility criterion for free health care. It was provided to: those working on labour contract and members of their families, the disabled due to labour, families of survivors. Family members included parents, children, brothers and sisters aged up to 16 or 18 if they studied; disabled children regardless of age if they became disabled before the age of 16 and were fully supported by the insured.

Health services rendered via insurance system included first aid in acute cases and accidents; primary care; maternity care; hospital care with full board; home visits and rehabilitation. Medical treatment was provided either in separate or local clynics. In the first case health services were financed exclusively from insurance funds directly via sections of health services for the insured (*rabmed*). In the latter case insurance funds covered only expenses incurred by the insured to be treated first in the waiting lists.

But in practice those arrangements failed to fulfil their main aim -- to secure better treatment of the insured. Insurance funds were supposed to be supplementary to the state and local budget allotments and intended to improve health services for the insured, first of all, working in heavy industry. However, as state financing was insufficient insurance money, in fact, played a more significant part as the main financial source for health services and were often spent on those not insured.

In 1927 sections of health services for the insured (*rabmed*) were closed as duplicating the work of other departments and failing to pay enough attention on prevention. Later Social insurance fund for health (Fund D) was put under the auspices of the health authorities and incorporated into the state health budget to unify the supervision of health care system. It was actually a formal establishment of the National health service financed from the budget and organised by the state bodies.

It meant that insurance mechanisms in-built into the health system were regarded inappropriate for the unified health system and guaranteeing preferential treatment of workers. That was where enterprise-based health services stepped in again.

Factory medicine had managed to survive through all these years. Employer-provided health services in many cases were not closed immediately as

"it is very risky to destroy immediately old, bad organisation of health services before a new system is fully established -- it may cause dissatisfaction of the wide masses of the working" (Штейнберг (Shteinberg), 1926: 34).

Because of lack of funds local health authorities were often forced to make agreements with enterprises to draw money to finance health services for workers. Sometimes they even moved their health services to enterprises or introduced payment for medical treatment of workers in local health services.

During *NEP* many enterprises initiated the organisation of health services for their workers at social insurance expense on agreement with health departments. For example, by 1923 there were 200 health services in Moscow factories, though it was claimed that only 20 of them were well equipped whereas 180 failed to comply with standards (Шахгельдянец (Shakhgel'diantz), 1978).

Table 6.2

**Network of Occupational Health Services in Soviet Industrial  
Enterprises\* (numbers)**

	1940	1950	1965	1970	1975	1976
<b>Health centres total</b>	479	675	1,196	1,445	1,353	1,348
including those with hospitals	--	472	960	1058	933	925
Number of beds	--	38,063	147,327	186,567	202,875	209,769
Average capacity	--	--	153	176	217	227
<b>Health stations total including</b>	8,261	11,290	29,257	32,262	34,290	34,609
doctor' s	3,206	5,435	5,425	3,268	2,529	2,485
paramedic' s	5,055	5,855	23,832	28,994	31,761	32,124

\* The data is for the USSR.

Source: Захаров и Хотько (Zakharov and Khot'ko), 1963; Шахгельдянец (Shakhgel'diantz), 1978.

The data of Table 6.2 show rapid development of the network of health services for workers. During the period of 1940-1976 the number of health centres in the USSR increased almost threefold while the number of beds in enterprise hospitals grew by the factor of 5.5. According to Kudriavtzev (Кудрявцев, 1998), by the late 1980s of 1,348 health centres 935 provided secondary care.

### State intervention in occupational health services

Enterprise health services underwent many changes but *explicit state intervention into provision of health services in-kind by enterprises* always remained. The state regulated the following issues:

- a) industries where health services were to be opened, usually heavy industry undertakings (steel, coal, mining, and chemicals);
- b) size of enterprises in which setting up of health services was compulsory;
- c) type of health service and, consequently, the range of medical treatment provided to workers.

The first regulations on enterprise health services were issued as early as in 1921. One of the government decrees stipulated the necessity to establish first aid stations and organise recreation facilities for workers. Next year the People's Commissariat of Health ruled that such stations were to be organised in any enterprise employing more than 100 workers. The purpose was to develop a system of health services as prevention centres promoting health education providing medical treatment in case of emergency rather than primary care units. According to Zakharov (Закхаров, 1968) there were 1,064 first aid stations in the country by 1927.

In 1924 legislation allowed for a special form of organisation of health services for the insured.<sup>20</sup> Enterprises could contribute to maintenance of local health services that provided medical treatment to their workers on agreement with local health departments concluded with participation of trade union representatives.

The following services could be opened in enterprises depending on the number of employees: first aid stations -- more than 100 workers; *ambulatoriya*<sup>21</sup> -- more than 500 workers; hospitals -- more than 3,000 workers (one bed for 100 workers, or one bed for 75 workers if working conditions were judged unhealthy).

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<sup>20</sup> *The statute "On Participation of Trade Unions and Enterprises in Health Protection of Workers"* (1924)

<sup>21</sup> A small polyclinic providing a limited range of primary care services.

Local health department with approval of trade union committee and enterprise management appointed medical personnel. A supervision of day-to-day management was vested in a special council consisting of a director of a health service, representatives of the trade union and management.

Expenses additional to those approved by the People' Commissariat of Health were incurred by an enterprise. However, there was a possibility to finance enterprise health services from health insurance fund subject to a preliminary agreement with local health department. Health authorities could also transfer health services to enterprises on agreement; in this case 85 per cent of health insurance funds went to those enterprises.

Eventually, the range of services provided by the first aid stations had increased and they were transformed into health stations with more functions to fulfil. According to the statutes adopted by the People' Commissariat of Health in 1930, their main objective was primary care and prevention. The next step was the establishment of enterprise health centres often referred to as *medsantchast*, which, in fact, became one of the most widespread types of health services in Soviet industrial enterprises.<sup>22</sup> The aim was to have health services closer to workers to provide high quality medical treatment, to undertake preventive measures with a view of bringing down morbidity levels and fighting occupational and infectious diseases, to improve working conditions (Шихова (Shikhova), 1979). Therefore, occupational health services developed from the first aid and health stations to health centres which could be complex establishments including polyclinic, hospital, health stations and even recreation facilities.

It should be noted that medical treatment for workers were not only rendered by enterprise health services. In order to meet workers' needs enterprises co-operated with local health authorities. Subject to the degree of the latter's involvement it could be:

-- polyclinic or doctor's health stations opened in an enterprise as branches of the local health services;

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<sup>22</sup> Activities of health centres were regulated by the special statutes of the People's Commissariat of Health "On Health and Sanitary Department" adopted in 1938 and then amended several times.



-- doctor (*tzekhovoy terapevt*) specifically employed by a local polyclinic to treat workers of industrial enterprises situated in the area.

-- beds reserved for workers in a local hospital in case enterprise health centre provided only primary health care services.

All these arrangements were aimed to ensure preferential and high quality treatment of workers of enterprises situated in local health services catchment area. Medical personnel, especially in local polyclinics situated in town industrial areas, was supposed to undergo special training as well as to know well labour conditions in the near-by enterprises.

Interaction between the state and enterprise in occupational health care had several aspects.

The state-regulated types of health services to be established in an enterprise mostly depended on the number of employees and industry. The 1934 state regulations specified that health services for workers should be provided in:

- *ambulatoriyas* offering services of consultants of main specialities in enterprises with 6,000-9,000 workers;
- doctor's health stations organised in enterprises with 1,000-6,000 workers employing up to three doctors depending on industry;
- first aid stations employing nurses in enterprises with 400-1,000 workers or in branches of large enterprises if they were situated far enough from enterprise polyclinic or doctors' health station.<sup>23</sup>

The 1968 Ministry of Health regulations required enterprises to open a special section in health services (*tzekhovoy uchastok*) to cover 2,000 workers (or 1,000 workers in chemicals, oil refinery, coal and mining) in enterprises employing more than 10,000 workers.

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<sup>23</sup> It was a recommendation of the All-Russian conference of representatives of local health departments in August, 1934, later approved by the People's Commissariat of Health, that was reorganised into Ministry of Health in 1946.

Enterprise-based health services had dual lines of accountability: they reported directly to local health department, first of all on medical issues, and coordinated their activities with local polyclinics. On the other hand, they reported to the management of an enterprise, especially on financial issues.

Enterprises were responsible for provision of premises and maintenance of equipment, furniture, etc. of health stations, *ambulatoriyas* and health centres. They paid for fuel, electricity, telephone, transportation of patients in acute cases, etc.

The state contributed to financing of enterprises health services: local health departments paid salaries to medical staff, purchased high technology medical equipment and soft materials. Technical staff (cleaners, hospital attendants, etc.) was on an enterprise payroll.

#### Main features of occupational health care

Occupational health care can be classified according to three main criteria.

a) People whom services were supplied to:

- employees only in the so called *zakritiye* health centres (inaccessible to dependents and patients from outside);
- dependents and local population.

b) Scope of services provided:

- comprehensive (as in polyclinic or hospital) in health centres ;
- limited, usually first aid and nurses, in health stations.

c) Geographical location:

- inside an enterprise territory;
- close to an enterprise but outside its territory.

The following were the main features of the system of enterprise health services.

a) Occupational health services functioned first of all in enterprises, which were obliged to supply health care for their workers. Other enterprises financed and provided medical treatment for their workers at their own discretion. Only about 20-25 per cent of workers in the USSR were covered by such provision (Архипов и Покровская (Arkhipov and Pokrovskaya), 1966).

b) Health care was provided in-kind mostly through health centres or health stations, sometimes hospitals.

c) The functions of health centres were not limited to prevention and first aid but typically included curative treatment as well.

d) Occupational health services were supplementary to the national health service because workers still remained eligible for medical treatment through it (local polyclinics, hospitals, and tertiary care services).

Moreover, enterprise health services usually provided a limited range of medical treatment to include mostly primary care and first aid. As a rule, enterprises had no capacity to organise specialised treatment with the help of consultants, doctors typically made home visits from local polyclinics. Thus, the majority of workers intensively used the National health service that, as a result, was the combination of industrial and regional organisation. Implementation of the principle of preferential treatment of workers would be impossible without involvement of the whole network of health services.

The major trend in development of the system of occupational health services in Soviet industrial enterprises was extension of:

range of services provided to workers. For this purpose in 1970s some small enterprise health centres were merged (see Table 6.2).

coverage as the size of enterprises obliged to establish health services gradually decreased. For example, if according to 1934 regulations health centres were opened in enterprises employing more than 10,000 workers, in 1968 that indicator dropped down to 4,000 workers.

### ***Conclusions***

The unprecedented model of people's welfare was built up in the Soviet Union in compliance with the Marxist-Leninist doctrine. Whatever its peculiarities, positive or negative, it will take quite a specific place in history. But it would be utterly wrong to think that this model was isolated from the past and has nothing to bear upon the future.

The state regulation of everything in the country could not but pertain to occupational welfare. It was intended to combine social welfare (meeting

social needs of employees) and economic (giving enterprises a room for manoeuvre to stimulate labour force productivity) purposes. That would entwine the social policy and the organisation perspectives of occupational welfare.

The way that it worked was demonstrated by occupational health services, which found themselves at the crossroad of both perspectives belonging to enterprise and the National health service at the same time.

First, they were a joint venture financed by the state and an enterprise and, second, provided preventive as well as curative services to workers reporting to local health authorities on medical issues.

In the times of dramatic social changes in the post-Soviet Russia similarities of the Soviet model with the Western practices mentioned in Chapter 1 are another reason to believe in the future of occupational welfare in Russia. It is a phenomenon inherent in the Russian society rather than merely an undertaking of the Soviet power.

Occupational welfare outlived two political regimes so different in ideology and organisation because it was embedded in the texture of society and, in one way or the other, supported by the state.

Though it should be mentioned that the Soviet Russia made much more systematic use of occupational welfare and was more heavily involved in its financing and regulation. But both the Tsarist and the Soviet regimes attached big importance to occupational welfare in social protection of population. It led to some common characteristics of occupational welfare in the Imperial Russia and the Soviet Union:

- ▶ occupational welfare was initiated from below, from the depth of society, taking advantages of enterprises in providing social services over other forms of social organisation;
- ▶ occupational welfare was to contribute to solve labour market problems in the course of industrialisation;
- ▶ the state institutionalised the emerging forms of satisfying social needs of working people;

► occupational welfare was free of charge for employees and all parties involved were used to it.

The mentioned above implies that changes in ideology or political regime in Russia had not dramatically affected occupational welfare. It had demonstrated an ability to adjust to new situations. Therefore, there is no reason to suggest that occupational welfare should go away with the Soviet times as it definitely has a potential to survive in a new environment.

## **Chapter 7**

### **Occupational Welfare in the Post-Soviet Russia**

The purpose of Chapter 7 is to examine the status of occupational welfare and its health care component against the background of social policy and liberal reforms in the post Soviet Russia. It deals with the new social insurance system and enterprise social insurance contributions, types of occupational welfare, divestiture of enterprise social assets,

Occupational health care is explored in the three main dimensions -- compulsory health insurance contributions, enterprise-based health centres and other provisions (voluntary health insurance, medical treatment in the national health service).

#### ***1. Social Policy and Occupational Welfare in the Post-Soviet Russia:*** ***General Issues***

##### Social policy and market-oriented reforms

The era of post-Soviet Russia formally began with the cessation of the Russian Federation from the USSR and the declaration of the independent Russian state in December, 1991.

It had been preceded by the decade of political attempts to modify the existed system using the potential of socialist ideology and planned economy and preserving the leading role of the Communist party.

Intention was to increase the rate of growth of national economy and to overcome the so-called "zastoy" (stagnation) when indicators of economic development and labour productivity traditionally exploited to demonstrate the advantages of socialism were gradually worsening. For example, an annual growth rate of labour productivity decreased from 5.4 per cent in 1961-1970 to 3.2 per cent in 1981-1985 (Центральное статистическое управление (Central Statistical Agency), 1990).

In social policy the increasing importance of human factor of production in accelerating development of the national economy was stressed. Improvements in the living standards were to contribute to enhancing

economic potential of society and vice versa. As it meant stimulating, first of all, the working people the role of occupational welfare had to be more substantial. In accordance with the 1989 Law on Enterprises their competence in setting up and disposing of social funds was enlarged to encourage enterprises to spend more on social welfare. Workers were given more rights in social funds management.

In the early 1990s two major events in political and economic life radically influenced social situation:

- rapid disintegration of the Soviet Union and the emerging of the Russian Federation as an independent state; and
- introduction of liberal economic reforms often referred to as the Gaydar reforms after the name of the then Acting Prime Minister. Their ideology was based on strong belief in the advantages of market economy.<sup>24</sup>

Contemporary social problems flew from two circumstances. First, indications of mounting social tensions could be found long before transformation had started. Social programmes adopted in the 1970-1980s failed to bring significant positive results, for example, to eliminate shortages of consumer goods. Second, contrary to bright expectations, the first outcomes of the 1990s market-oriented economic reforms were very poor. Price liberalisation, restrictive income policies and privatisation led to dramatic social changes in the Russian society:

- the fall of birth rates and increase of mortality rates resulted in reduction of population. The rate of natural growth dropped from 2.2 to -6.4 per 1000 of population for the period of 1990-1999. As a result, population of the Russian Federation decreased from 148.0 to 146.6 million people;
- morbidity rates increased and epidemic situation worsened;
- the number of people living in poverty grew and, even according to the official statistics, reached about one third of population;

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<sup>24</sup> When the reforms started, the Soviet ideology came into conflict with market principles, at least as they were understood by Russian policy-makers: almost anything opposite to the Soviet practices was automatically regarded acceptable.

- the number of unemployed increased from 6,712 thousand people in 1995 to 9,094 thousand people in 1999, their share in economically active population grew for the same period from 9.5 per cent to 12.8 per cent;

Instead of improving individual capacity to secure the personal well being the reforms brought on a substantial increase of people in need of social protection to include not only the disabled, pensioners or unemployed but often the employed, too. In 1995 minimum wage was about 13 per cent of the subsistence minimum. Many people were unable to maintain their traditional standards of living and it caused feeling of uncertainty and pessimism. High income inequalities, producing concentration of wealth and poverty were characteristic features of Russian society.

The system of social benefits formally covering almost all risks that had survived the Soviet times with minor modifications was not backed by adequate material resources. Benefits were very small and could not secure decent living for their recipients. For instance, survivor's pensions amounted to about 16 per cent of subsistence minimum in 1995. Though the state promised to maintain the rights to free education and health care their scope and quality fell substantially.

Measures undertaken in the field of social welfare failed not only to improve living standards but also to keep them on the pre-reform level. It is difficult to argue with some foreign experts who pointed out at the three crucial problems in the social sector reforms in Russia:

- lack of comprehensive reform concept and clear priorities (social issues were often solved in an ad hoc manner);
- unclear responsibilities (lack of collaboration between federal and local authorities and different agencies dealing with social matters);
- lack of financial and economic planning (the reforms were carried out without thorough financial and economic feasibility analysis) (ILO, 1995).

After ten years of the market-oriented reforms Russia still faces the problem of working out of a new social policy that would take the modern realities into account. New ideology has acquired special significance in the process of



revision of social policy concepts. Social values accepted by society, understanding of such notions as equality and equity; attitude to private property have been changing. Promotion of the principle of personal social responsibility influences labour motivation and individual consumption behaviour.

Economic and financial considerations begin to play the paramount role in adopting social policy decisions.

The state expenditures on social welfare have been constantly decreasing. The so called residual principle of financing so severely criticised in the late Soviet times meant that social sector was allocated resources left after funding other branches of the national economy. If the Soviet principle is believed to be "residual" then the new principle can be referred to as "minimal": the share of social expenditures in both federal and local budgets amounted to 8.1 per cent of GDP in 1999.<sup>25</sup>

Apart from the budget, social measures are financed from four extra budgetary social funds (Pension fund, Employment fund, Social Insurance fund, funds of compulsory health insurance) established in the early 1990s to increase and better target social welfare spending<sup>26</sup>.

Organisational and administrative mechanisms have become much more complicated with development of the mixed economy of welfare and gradual emergence of voluntary and private agencies alongside the state institutions. Tendencies to decentralisation and shifting social welfare activities to a local level have been strengthening. The greater scope of social obligations is vested in the local authorities on the assumption that people's needs are better known locally and, therefore, not only resources can be targeted more efficiently, but additional funds raised to satisfy local needs. This development and the rise of political status of local authorities (the heads of regional

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<sup>25</sup> They slightly grew from the beginning to the mid 1990 (10 per cent of GDP in 1995) and then dropped again by the end of 1990s.

<sup>26</sup> Since 1993 budget system in Russia has changed. In the Soviet Union budgets of lower levels of the state power were included into those of higher levels. Now regional and local budgets, including Moscow and St.Petersburg as special regions, are autonomous and excluded from budgets of higher level. Thus, local administrations have more flexibility in their budget policy. Social expenditures in federal and local budgets as well as by social funds should be summed up to have the full picture.

administrations (governors) are now elected) have given them much more power to set social policy priorities.

An emerging new model of social policy is evidently designed to increase the role of market in satisfying social needs of people^ to overcome state paternalistic ideology and centralised distribution and provision of social services, to level negative social consequences of market relations by creating safety nets for disadvantaged and to put social welfare spending in line with the economic status of the country. But apart from prospective vision of the situation by policy makers, it should be well thought out in terms of practical measures to be undertaken to reach planned goals.

#### Enterprises and new state social insurance

Enterprises have always played an important part in social policy through provision of occupational welfare to the working people who constitute a great part of population. Now they have also been affected by changes in social policy *per se* and in their place in contemporary Russian society. Many state enterprises have been privatised and, thus, become independent from the state authorities -- regional and ministerial -- having got more competence in managing and handling their financial resources.

Enterprises are presently involved in social policy via occupational welfare arrangements consisting of:

- compulsory contributions to the state social insurance;
- voluntary welfare provisions in-kind and in-cash to their employees.

The network of social insurance funds to which enterprises pay contributions is given in Table 7.1. It shows that the federal government evidently tries to get more resources from enterprises to finance national social programmes. It is proved by the ratio of compulsory to voluntary occupational welfare, which is definitely in favour of the compulsory one. Employers' compulsory social input makes nearly a half of payroll. In such a situation it is difficult to speak about liberal economic incentives for industry. Labour cost survey of about 3,000 enterprises in 1998 disclosed that

compulsory contributions to the state social insurance funds reached about 90 per cent of their total social spending (see Table A.3 in Appendix A).

Table 7.1

**Social insurance funds**

Fund	Supervision	Coverage	Funding
Pension fund	The Ministry of Labour and Social Development*	Retirement, disability and social pensions	28 per cent of payroll, 1 per cent of individual earnings
Employment fund	The Ministry of Labour and Social Development*	Unemployment benefits, re-training and job placement	2 per cent of payroll
Social Insurance fund	The Ministry of Labour and Social Development*	Maternity benefits, sick pay, recreation.	5.4 per cent of payroll
Compulsory health insurance funds	The Ministry of Health	Provision of health care services	3.6 per cent of payroll

\* Until 1996 Pension fund and Social Insurance fund were supervised by the Ministry of Social Protection when it merged with the Ministry of Labour and the Federal Employment Service to form the Ministry of Labour and Social Development.

Source: adapted from OECD, 1995.

It urges enterprises to find ways and means to lessen their payments that are calculated as a percentage of payroll. Illegal way to achieve it is to lower payroll. There are accounting techniques used by enterprises, including "double accounting" or employing people without official labour contracts. Private organisations often try to escape registration with social funds in spite of the threat to suffer penalties for failing to comply with regulations.

It has taken almost a decade before first signs of economic stabilisation appeared. Naturally it is early to speak about influence of these developments of the social sector that still finds itself in a quandary.

It was originally assumed that the shock therapy measures undertaken in 1991, despite of the first negative effects, would soon lead to improvement of economic situation, enterprises would prosper and pay to social funds. But the level of industrial output fell dramatically -- in 1995 it was merely a half of the 1991 level. The tendency of the number of the economically active population to decrease (falling from about 75 million people in 1992 to 70.4 million people in 1999. (Госкомстат (*Goskomstat*), 2000) should be also taken into account. As a result, the share of wages and salaries in household income has diminished. Delays in payment of wages and salaries are quite common. Enterprises often fail to pay compulsory contributions in time and funds constantly experience financial difficulties.

#### Occupational welfare and its types

The attitude of enterprises to new developments in the social sector is not clear though they have no option, for instance, whether to participate in compulsory social insurance or not: employers' contributions to social funds are deducted from the payroll simultaneously with payment of wages and salaries. Besides, no research is yet available to evaluate their point of view on new social insurance obligations. Together with the lack of official data on the subject it leads to the fact that Information from the field is of a conflicting character

The scope of occupational provisions has been gradually shrinking.

There are still enterprises providing social benefits in- cash and in- kind to their employees that are now voluntary: according to the 1989 Law on Enterprises they can allocate resources for social purposes independently. Those involved in two kinds of social schemes - compulsory and voluntary -- have additional headache of how to balance them and to cope with both paying considerable compulsory contributions and carrying out their own social plans.

Nothing has been undertaken by the state so far to encourage enterprises to maintain or develop occupational plans. On the contrary, the state policy implicitly provides for diminishing role of enterprises in organisation of social

services in-kind. For example, the 1994 programme of the development of industry stipulated that enterprises be freed from social assets. The federal government started with its own enterprises: social assets of some federal-owned enterprises were transferred to the local authorities by special decrees.

However, Dolgopyatova (Долгопятова, 1995) mentioned that when in 1991 her group conducted the first round of interviews with directors of industrial enterprises the feeling was in the air that enterprises would start quickly to get rid of social assets. But during the second round of interviews in 1994 researchers were surprised to find out that many enterprises despite financial difficulties continued to maintain quite a number of social services for their employees. These findings are supported by other surveys carried out by such bodies as the Ministry of Economy (Министерство экономики, 1995) and the World Bank (1996) that revealed that Russian enterprises provided several social benefits.

Table 7.2

**Industrial enterprises providing social benefits, % of the sample**

	mid 1994	1990/1991
child care / childcare subsidy	66	79
health care facilities	70	71
food subsidy / canteens	78	83
foodstuff / consumer goods	60	52
construction of new housing	50	73
housing/housing subsidy	55	59
holiday resort/holiday subsidy	45	57
transportation / subsidy	57	57
other	21	17
Number of benefits		
more than three	72	79
more than four	58	67

Source: adopted from: the World Bank, 1996:56.

Analysis of other studies highlights the following issues.

The average share of non-wage items of labour costs such as housing, social protection, culture, etc. in industry was relatively stable during the 1990s

making about 40 per cent of the total labour costs as average (see table A.2 in Appendix A).

The study on divestiture of social assets by Russian industrial enterprises carried out by one of the TACIS (Technical Assistance to CIS) projects (Kotova (Kotova)1999) found out that that the majority of respondents:

- failed to express unconditional intention to divest social assets;
- thought that it was unlikely to improve the financial status of enterprises (only 15 per cent of them said that divestiture did influence positively economic status of their enterprises).<sup>27</sup>

The World Bank survey (1996) explicitly demonstrated that Russian industrial enterprises were not only inclined to continue to provide occupational services and to maintain their social assets but occupational welfare objectives still appeared to be among their main priorities.

Table 7.3 shows that, first, workers welfare is one of the main concerns for enterprises and, second, the number of managers who think this objective is important even increased -- from 60 per cent of respondents in 1990/1991 to 69 per cent in 1994.

Table 7.3

**Main objectives of industrial enterprises,**  
**% of respondents.**

	1990/1991			1994		
	Not important	Of some importance	Important	Not important	Of some importance	Important
Sales	15	15	70	8	13	79
Employment	30	30	40	30	33	37
Workers income/ welfare	12	28	60	7	23	69
Profit	17	22	61	7	13	80
Privatisation	61	10	29	45	17	38
Shareholders' dividends	81	9	10	32	29	39

Source: adapted from World Bank, 1996:: 35.

<sup>27</sup> Expert Institute study (Набиуллина (Nabiullina), 1993) suggested that an average amount of enterprise profit spent on social programmes was 21 per cent (compared, for example, with 36 per cent as the share of investment in production and 6 per cent as payment of dividends).

There is a difference in the way benefits in- cash and in- kind can be got rid of. The former are easily cancelled enterprises just stopping to pay them. In the latter case discontinuance is more problematic as it involves closing down social assets when enterprises have to decide what to do with social assets in which so much has already been invested.

Importance of different occupational welfare services in meeting employees' needs varies (Commander and Jackman, 1994; Shalev, 1996). Some of them, if not provided by an enterprise, can be more or less easily obtained elsewhere. But others can be in short supply in community and, therefore, their cancellation is likely to affect employees in a much more fundamental way.

Surprisingly little seems to have been done about restructuring of enterprise social assets despite the fact that now enterprises have more options in organisation of occupational welfare:

- in the absence of the state explicit regulations enterprises, in fact, can provide any social benefits they deem important for their employees, including those, which were not traditionally included into their domain, for example, occupational pensions;

- new mechanisms such as insurance, especially voluntary health and pension insurance, are available. In the long run it may be more suitable for enterprises as it allows for more flexibility than other options. But existing statistical data show that new methods are not used well -- for instance, occupational pensions amounted to 0.3 percent of enterprises social spending in 1998 (see table A.3 in Appendix A);

- commercialisation of social assets when they supply services for fee to local population might be promising. Unfortunately, there are no data on how widespread it is. But it may be assumed that -- apart from other reasons hampering divestiture -- purchasing power of population limits possibilities of using enterprise social assets in this way.

### Divestiture of enterprise social assets

At present one of the key issues of occupational welfare is the fate of enterprise social assets.

Privatisation rules contain only general guidelines on what can be done with them. The principal piece of legislation on the matter is the Presidential Decree No 168 signed in 1993 and setting up a differentiated approach to social assets of privatised enterprises.

In accordance with the mentioned above Decree social assets can be privatised subject to approval of employees. They should continue to provide services that they originally used to supply. Enterprise social assets important for general public are not subject to privatisation and should be passed on to local authorities. The two parties can also conclude voluntary agreements on joint operation and financing of social facilities of enterprises.

Some enterprises disposed of their social assets. It is not a surprise as many of them are badly affected by economic crisis and experience serious financial problems. The obvious way to solve them seems to be to get rid of social assets and to transfer them over to local authorities. According to Leksins and Shvetzov (Лексин и Швецов, 1998), in 1993-1997 80 per cent of housing, 76 per cent of kindergartens and crèches; 82 per cent of health facilities that had belonged to industrial enterprises were passed to local administrations. It should be noted that some facilities are easier to divest than others both for technical (difficulty of access to facilities situated in enterprise territory; poor state and, thus, need for investment) and social reasons (different relative importance for employees).

The task was to ensure that social assets would continue to operate and remain available to workers and local population. But it has turned out to be not an easy thing. In many regions authorities have no financial resources to take on responsibilities for new social facilities. On the other hand, they sometimes object to enterprises intentions to sell these assets in case the buyer wants to use them for purposes, inconsistent with their original function. It, thus creates additional demand for municipal social services and especially concerns the so-called "company towns".



In order to prevent a conflict between social policy and enterprise restructuring objectives the federal authorities may render financial support to local administrations in divestiture process by paying them special subsidies from the federal budget. But due to financial difficulties the federal government often fails to fulfil its obligations. Another problem is that financial mechanism of such transaction is *vzaimny rastchet* (mutual settling of accounts), which means reduction by the federal government of the amount of a region's debt to the federal budget by the sum necessary to maintain newly acquired assets.

It may be added in conclusion, that if an enterprise already has developed social infrastructure, it becomes an objective factor of its life. An enterprise can face administrative difficulties in disposing of its social facilities, moreover, the divestiture may cause social tensions because it is unlikely that workers would appreciate such step.

## ***2. Health Services for Workers and the 1990s Health Reforms***

In the modern Russia health care as a part of occupational welfare includes:

- compulsory health insurance contributions;
- provision of health services in-kind by enterprise health centres/health stations;
- other provisions (voluntary health insurance; organisation of mandated periodical screening of employees, payment for medical treatment elsewhere).

### **Legislation on health insurance and compulsory health insurance contributions (CHI)**

Health insurance in Russia was enacted by the 1991 Law on health insurance of citizens of the Russian Federation. It was mainly necessitated by financial reasons: the state budget was simply unable to adequately support health care system and an urgent need arose to find other sources of funding. It was assumed that whereas the state financing at least remained steady CHI contributions from enterprises would be a vital supplement to the budget

appropriations<sup>28</sup>. Thus, CHI contributions became a new important element of occupational welfare in Russia.

The Law of 1991 stated that the aim of CHI was to guarantee that people would receive health services subject to occurrence of insurance risk. It provided for the following fundamental innovations:

- introduction of CHI with universal coverage;
- setting up of health insurance organisations (HIC) as independent non-profit bodies to accumulate CHI contributions from enterprises and local authorities and reimburse health services (hospitals, polyclinics) for provision of medical treatment. They were also supposed to defend interests of the insured and to control the quality of health care;
- liability of enterprises and organisations to make contributions for the employed in the amount stipulated by legislation, local administrations paying for those not employed;
- adoption of a basic federal programme of CHI covering a minimum set of services provided by the CHI system as well as regional programmes that could not be less in their scope than the federal one;
- introduction of voluntary health insurance for individuals and organisations.

Under this law enterprises were granted the rights:

- to participate in all kinds of health insurance;
- to choose a health insurance company;
- to control the fulfilment of CHI contracts.

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<sup>28</sup> Ideological and political reasons were also important. Health insurance seemed to conform best with the spirit of market economy which the Russian leadership was committed to develop. There were two major political circumstances that influenced the decision in favor of health insurance:

- The 1991 Law was passed by the Supreme Soviet of the Russian Federation at a time when the USSR still existed. It reflected the intention of the Russian Federation to do things in its own way and insurance model was chosen as opposite to budget medicine.

- It so happened that health care issues in the Russian high legislative bodies (first the Supreme Soviet and later in the State Duma) were in the hands of strong proponents of market economy and health became one of the first areas of "marketisation".

Though the Russian authorities couldn't ignore social objectives of the reforms and all documents on CHI were full of social rhetoric. It looked like all other reasons advanced in the course of health care reforms in different countries and so well analysed in the OECD Report (1994) and other papers had only marginal importance in Russia.

- to apply for reduction in the size of their CHI contributions if their workers' morbidity stabilised or dropped for three subsequent years <sup>29</sup>.

At the same time enterprises were obliged:

- to conclude compulsory health insurance agreements;
- to pay CHI contributions;
- to undertake measures to improve working conditions harmful to health;
- to give information on health status of the insured.

If introduced such a system would enable enterprises to control use of their money and influence activities on health insurance companies. But in 1993 the Law was amended and the model of relationships in health care system was modified by the establishment of CHI Federal and regional funds as special state financial bodies for accumulation of contributions from employers and local authorities and ensuring CHI financial stability. They were vested the right to conclude contracts with HICs or act as insurers themselves establishing direct links with health services.

Motives for such a turn in policy were not clearly articulated. It was asserted that in many regions the process of setting up HICs was too slow to meet the needs of the new system. It may be also admitted that such a change was an attempt of health care authorities at federal and local levels to establish control over CHI system, especially in the distribution of financial resources.

As a result there are now five main players in health care: Ministry of Health; local health authorities, CHI funds, health insurance companies and health services. <sup>30</sup> It is very significant that despite the fact that enterprises pay considerable CHI contributions they have never been referred to as players in the field though sometimes even patients are mentioned among them. It means that enterprises are practically devoid of a voice in the CHI system and have no control over the quantity and quality of health services. Only two representatives of employers out of thirteen members are on the Boards of federal and each regional fund in compliance with their statutes. Employees do not have any special treatment in the system.

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<sup>29</sup> Unfortunately, the author has failed to find any evidence that this clause has ever been implemented.

The position of the five players in health insurance issues are not identical; sometimes they even clash with each other. For instance, much attention has been drawn to relations between CHI funds and health authorities be it at federal or local level <sup>31</sup>.

Local authorities are bound to contribute from their budgets to CHI funds for economically inactive people having the right to determine their quota depending on the size of population and its health status. It gives them a possibility to substantially change their payments whereas the federal law fixes the level of employers' contributions. Besides, local authorities have proved to be inaccurate payers: 25 regions failed to contribute to CHI in 1995 (Гришин (Grishin), 1996).

In many regions local authorities make CHI payments from regional health budget, thus simply redistributing health expenditures between the two systems. These payments constituted merely 31 per cent of employers' contributions, which in 1997 amounted to about 60 per cent of CHI money. Enterprises are, thus, cross-subsidising local authorities and actually finance to a large extent provision of health services for non- employees.

Since the late 1993 enterprises have paid 3.6 per cent of their payroll for CHI separately to the Federal CHI fund and to regional funds: 3.4 per cent -- to the regional fund and 0.2 per cent -- to Federal fund the payments covering employees exclusively but not dependents. The rate is a political compromise rather than economically justified calculation. Even more so because these contributions were discussed in one package with contributions to the Pension fund which were reduced accordingly to exactly the same percentage.

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<sup>30</sup> Under local health authorities relevant departments of local administrations are understood. They are responsible to both local administrations (directly) and Ministry of Health (indirectly).

<sup>31</sup> After the establishment of CHI funds local health authorities lost direct control over considerable financial resources. The funds, in turn, have their own interests which do not always coincide with those of health authorities. Observers underline the conflicting nature of their relations as both groups have been fighting for leadership in the system that makes it difficult to find a compromise.

The situation is aggravated by the fact that the federal legislation does not clearly stipulate the division of powers between the state health authorities and CHI funds leaving this task to regions. As they actually decide many issues concerning CHI system in their territory it resulted in substantial variations in speed and scope of reforms in various regions.

Financial considerations prominently feature in CHI matters. There is general consensus that enterprises should continue to pay CHI contributions but their present level is regarded inadequate by many experts. The size of contributions proposed by CHI funds, Ministry of Health and independent experts ranges from 6 to 10 per cent of payroll. Some experts suggest that dependents should be covered by employers' contributions, others think that health services for pensioners and the unemployed should be financed by Pension fund and Employment fund, accordingly.

In 1994 the Federal CHI fund suggested to divide the flow of funds in health care system. CHI bodies would collect contributions from employers only and cover services for the working. Provision of medical treatment for other groups of population would be a responsibility of local authorities. But there is no evidence whatsoever on any reaction by the health authorities to this proposal that is practically ignored. It is quite understandable in the view of financial embarrassments of the state.

In 1998 CHI contributions covered approximately 35 per cent of total health spending the rest born by federal and regional budgets. They were enough to finance current expenditures on provision of medical treatment while capital investments had to be made from the budget. In general, the level of health expenditures is very low (about 3.5 per cent of the GDP in the mid 1990s). It turned out that CHI contributions from enterprises were used to sustain health care system rather than to be supplementary to the budget.<sup>32</sup>

It is usually ignored that the 1993 amendments to the CHI legislation substantially affected the role of enterprises initially envisaged by the 1991 law which stipulated for the establishment of health insurance companies (HIC). Under the 1991 law enterprises were to contribute directly to HIC.

Health insurance was aimed to promote an individual responsibility for health, medical personnel responsibility for quality of services and employer's responsibilities for protecting working environment (Введенская

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<sup>32</sup> It is a paradox that almost every textbook on health insurance says that introduction of CHI as a measure to mobilize additional financial resources is premature: at the early stages of transition a potential contribution base is shrinking because of a rising unemployment and a growing informal sector. Besides, no efficient mechanism to collect contributions is available (Barr, 1993).

(Vvedenskaya), 1991). To great regret, these goals have hardly been achieved, yet.

#### Provision of health services in-kind by enterprise health centres

The problem of enterprise-based health centres as traditionally an integral part of the national health care is very acute. Preker and Feachem (1994) were right to note that potential collapse of these services would require massive and expensive restructuring being a time bomb, which few governments had adequate steps to defuse.

Emphasis in health policy is usually made on health services of various governmental bodies financed from the state budget. For instance, at present nearly 20 federal ministries have their own health services. Starodubrovsky (1995) holds quite a negative view on such services claiming that they consume a major share of federal health expenditures, contributing to deepening health inequalities. At the same time health services in industrial enterprises are almost fully ignored in health policy and are touched upon only when restructuring is discussed.

Prospects of occupational health services are determined by the three main options: to keep them, to hand them over to local health authorities or commercialise their activities. The last two are, in fact, dictated by the same motive -- to improve enterprise financial status by reducing health expenditures. The role of health centres in enhancement of health status of the employed is typically not taken into account at all. Therefore, it is implicitly assumed that local health services have enough capacities to take responsibilities over from enterprise health centres.

But statistics for 1990s are alarming: the health status of the working people who make about 50 per cent of population has been steadily deteriorating. During 1990s mortality rates in working ages (20 to 50) doubled and the level of morbidity increased as well.<sup>33</sup>

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<sup>33</sup> The statistics on the health status and employment conditions come from Statistical Yearbook (respective years), published by the State Statistical Committee (*Goskomstat*).

Conditions of employment are among the main factors that negatively influence health status of people in employment. In the mid 1990s about 5 million people, including 2 million women, or about 20 per cent of industrial workforce, worked in conditions that failed to comply with sanitary regulations. In the majority of enterprises the programmes of improvement of working conditions were cancelled.

Worsening economic situation caused deterioration of working conditions in almost all industries. Process of technological modernisation is almost halted, no new equipment is installed while about 60 per cent of equipment in industry is out of date. Supply of special clothes and means of individual protection is limited as well.

Deterioration of safety at work has led to an increase in the number of injuries at work and occupational diseases. Injuries and poisoning take the first place in mortality patterns. The share of occupational injuries amounts to 23 per cent of the total injury and poisoning cases. Approximately 10,000-11,000 cases of occupational diseases and poisoning are registered every year. It means that as average 6.3 per 1000 workers suffered from industrial injuries. In 1995 there were 55 cases per 10,000, over 6,700 people died.

Average age of contracting occupational diseases is 40-45 years. In almost 95 per cent of cases workers become chronically ill and often lose ability to work. According to Ministry of Health data, by the end of 1990s there were about 200,000 people suffering from occupational diseases.<sup>34</sup>

Since 1989 there has been an annual increase in average length of sickness absence from work. In 1993 it amounted to 71 days, or 987 cases per 100 workers.

Another factor that is detrimental to the health status of the employed people is a decline in the quality of health care. Introduction of CHI has not brought positive changes into health care provision: the quality of health services has been falling. Russia has re-discovered such diseases as polio and tuberculosis, practically non-existent in the Soviet Union. People still face

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<sup>34</sup> Even official sources acknowledge that real figures are likely to be higher because not all cases of occupational diseases or injuries are reported.

problems of access to and quality of treatment and visit the same policlinics and hospitals with the same facilities that are very often out-of-date. Health services suffer from the lack of equipment and medication, many of them are in need of major renovation. There are regions where a patient will not be admitted to hospital without his/her own medication, food and sometimes even bed linen. Due to widespread poverty the majority of population cannot afford to pay for private medical treatment. Mandatory periodical screening is not carried out.

The latest available official data on occupational health centres is for the end of 1993. At that time there were 757 health centres, 791 doctor's stations and 17,000 paramedic's stations with about 70,000 doctors working in them.

The 1993 Presidential decree and relevant decisions of the Ministry of Health drew a line between health centres open to local population and those inaccessible to it. "Open" health centres are not subject to privatisation and should be transferred to local health authorities. "Closed" health centres providing health services for the employed only can be privatised with the approval of employees.

One of the decisions of the Ministry of Health was aimed to adjust the system of enterprise health centres to the environment. Their main objectives remained as they were before: to provide specialised medical care to patients, to control working conditions, to decrease the level of general and occupational illness and occupational injuries, to reduce absenteeism due to illness and injuries. The four options as to their status stipulated in the decision are given in Table 7.4.



Table 7.4

**Status of health centres**

Current status	Privatisation options	Clientele	Source of financing
Under federal government or industry ((ministerial) authority	No	employees	state budget, CHI funds, enterprises
Transformed into local polyclinic -- on the balance sheet of local authorities	not specified	local population	local budget, CHI funds
Transformed into local polyclinic -- on the balance sheet of a state-owned enterprise	No	employees and local population	local budget, CHI funds, enterprises
Owned by a non-public enterprise	Yes	employees	enterprise

Source: the Decision of Ministry of Health N 131 "On health centres", March, 1994.

No official data are available on the option that is the most widespread. It is officially recognised that enterprise-based health services decrease in numbers (according to the Ministry of Health by 162 for the period 1991-1993). They were mostly transformed into local polyclinics, but more details are provided. It shows that implementation of governmental decisions is not well monitored by the public and, supposedly, is likely to remain on paper.

In my opinion, the findings of Ministry of Economy survey are very helpful in clarifying the real situation. They enable to make an important conclusion that the majority of enterprises in the sample continue to operate their health care facilities.

Table 7.5

**Changes in the status of enterprise health services,**

% of enterprises in the sample

conveyed to other enterprises	taken over from other enterprises	transformed into independent legal entities	no changes
8.72	2.68	2.68	85.91

Source: Ministry of Economy, 1995: 44

Some of the surveyed enterprises even increased spending on health care: for one enterprise which reduced its health expenditures 5.2 enterprises increased them (see Table 7.6).

Table 7.6

**Expenditures of enterprises on health care facilities,**  
**% of enterprises in the sample**

	increased	remain the same	decreased
Enterprises whose expenditures on health care facilities	64.90	22.5 2	12.58

Source: Ministry of Economy, 1995:46

Enterprises usually cover expenses of their health services on:

- capital investment;
- maintenance of premises (security, cleaning, repairs,).
- doctors and paramedics at health stations organisation of which is not required by legislation and is optional for an enterprise.

The state budget pays health centres for carrying out special federal and regional programmes and funds salaries of doctors and paramedics working in health stations required by law. As to other staff, their salaries funding depends on the policy of local health authorities, doctors' salaries are paid either by local authorities (in case they want to control employer provided health care) or enterprise.

The two sources of health centres financing have survived with minor changes since the Soviet times; the new ones that emerged in the course of health reforms are CHI, voluntary health insurance and fees for services. An enterprise might choose to enter CHI system. Then it should conclude contract with regional CHI fund or HIC, depending on the model accepted in the region.<sup>35</sup> In this case health centre will be reimbursed for the health services

<sup>35</sup> The CHI has been developing fast-- in 1999 it incorporated 90 regional funds with 1170 branches and 415 health insurance companies. There are several CHI models in Russia. Only in 12 regions out of 89 reform was introduced in full compliance with legislation: regional funds accumulate money and conclude agreements with HIC which in turn act as insurers and deal directly with health services. In other models either funds or their branches may be insurers. In 18 regions no HICs were established.

provided for employees in accordance with regional CHI programme. Possibilities to raise funds by attracting local people will also increase: CHI legislation permits a person who has CHI policy to apply for treatment in any of health services operating in the system.

This option suits local authorities, too, as an enterprise will have to cover other expenditures which, in case health centres are transformed into local policlinics, would be born by regional budgets.

However, capacities of CHI system should not be overestimated. In regions it differs organisationally and by coverage provided. For example, in 20 per cent of regions only the working population is covered either fully or partially (hospital or primary care). In 34 per cent some groups of population are insured for some services. In some regions CHI funds compensate all health services for certain expenses incurred by providing treatment to the whole population. By the end of the 1990s only about 30 per cent of health services, mostly hospitals were included into CHI system.

To join CHI health services must have a license. Under licensing procedure an enterprise based health centre should supply quite a wide range of health services. It means that small health centres will not be able to get a license or, in order to do so, will have to expand the number of services.

### Other provisions

There are possibilities for enterprises today to improve the health status of their employees by means other than health services in kind. They may conclude agreements with local health services on provision of employees with medical treatment, additional to this in the national health service; or to buy equipment for a local policlinic or a hospital in exchange for health care for employees. A group of enterprises can unite their efforts in health protection of their employees.

According to health and safety regulations, employers must ensure that their workers undergo mandated screening before entering employment and in case they are influenced by dangerous factors at work listed in the Ministry of Health regulations.

Enterprises are allowed to pay for voluntary health insurance of their employees. Some of them practice group health insurance when employees make payments themselves getting the group premium.

Scarce data on this kind of insurance come not from health authorities but from insurance bodies. It has not yet been well developed: in 1994 only 0.4 per cent of enterprise social expenditures were spent on voluntary health insurance. To a great extent it is hampered by 28 per cent payment to Pension fund levied on voluntary health insurance contributions.

Enterprises might be interested in providing voluntary health insurance for its employees for purely financial reasons. First, they are entitled to include into production costs social expenses amounting to up to one percent of the profit from sales. Second, in accordance with voluntary health insurance agreements enterprises usually can retrieve the balance left by the end of the year (not spent on provision of medical treatment) and even to receive interest on their contributions.

As a rule, managerial staff is fully covered in the first instance while other employees may be eligible only for some services. Voluntary health insurance is popular with foreign firms or joint ventures that evidently resort to it out of habit. With the help of voluntary health insurance policy it is easier to get access to the best health facilities, which is especially attractive for areas nearby Moscow. Enterprises typically pay an annual sum that enables employees to receive certain health services in a polyclinic and/or hospital. Concern about employees' welfare is placed the last not because it is insignificant but as it is probably the most difficult thing to measure of all the mentioned above.

### ***Conclusions***

Social policy in post-Soviet Russia has acquired new dimensions. In these circumstances occupational welfare at present is characterised by the following developments.

First, composition of occupational welfare is now different. It includes compulsory contributions to the social funds while occupational services may

*de facto* be considered as voluntary. It should be noted that these changes failed to contribute to the improvement of the well being of people in employment.

Compulsory contributions are administered through the state bodies and are often looked upon in purely taxation terms enterprises having no influence in running the social funds. Nevertheless the state in Russia relies heavily on compulsory occupational welfare to finance its social policy. But the system is very likely to encounter all the problems, which typically arise out of the funded schemes.

Second, there is an evidence to suggest that despite of the evident lack of support from the state enterprises continue to provide social benefits to their employees in a new social and economic environment. Occupational welfare managed to survive, though it should be admitted that the real picture is somewhat sketchy because of the difficulty for an independent researcher to find information on the subject.

Occupational benefits are discussed in the framework of enterprise restructuring and their social policy identity features only when so called "social pillars" are discussed. The state policy towards employer-provided social services is evidently informed by the idea that enterprises should divest them. Local authorities whose role in provision of social services, according to the state plan, should increase are the first claimants. However, it is quite clear that on average they lack sufficient economic resources to secure the maintenance of divested enterprise social assets.

The recent developments in health care, such as introduction of compulsory health insurance and divestiture of occupational health services have done little to improve the health status of the working people. Enterprise-based services transformed into territorial polyclinics lost potential to treat occupational diseases. If general illness can be still cured in the local health network, it is practically impossible to get specialised treatment of occupational diseases there. The health centres that stay with enterprises -- especially privatised ones -- have almost lost all the connections with the National health service and, thus, taken out of the context of the health policy.

In such a situation the fate of occupational welfare, especially its voluntary component, depends to a large extent on the position of enterprises. Decision to be taken is not an easy one, especially when the state or independent experts fail to offer positive technologies how to properly manage new occupational plans.

### **PART 3**

#### **EMPIRICAL PART OF THE RESEARCH PROJECT**

Part 3 presents the empirical component of the thesis. It contains outcomes of the fieldwork conducted in Russia during the period of 1995-1997 with the view of finding out what occupational welfare was like, particularly health protection of the employed.

The issues of research methodology are specifically dealt with in this Part. It envisaged the use of a number of research instruments ranging from interviews to case studies. Explanations are provided why a particular approach is considered to be appropriate for investigation of the research topics listed below and what advantages and limitations such a choice entails. It is with this basic position in mind that a final judgement on the merits and weaknesses of the present study should be made.

A new environment of occupational welfare is explored. Its predominant distinctive feature is introduction of compulsory health insurance, the mainstream of health care reforms in Russia. The influence of liberal ideology, both in economy and social welfare, with its ideas of a free profit-making enterprise and an individual social responsibility which are promoted by the state as well as many constraints, in the first place, financial that industrial enterprises encounter should be also taken into account.

Despite factors mitigating against occupational services there are non the less enterprises that are going on to ensure health protection of employees and maintain their own health centres, especially the ones that used to do so in the Soviet times. This evident tendency of continuity in the height of transformation shows that occupational welfare is an established social institution in Russian society. Having more than a century long tradition it is, in principle, compatible with a market economy.

To better understand motivation of Moscow industrial enterprises in favour of provision of occupational health services two Moscow industrial enterprises were selected for case studies, making up a special chapter. As a follow up of

he field research some reflection ensuing from empirical evidence are suggested for consideration and further examination.

It is presumed that the contents of this Part may be regarded as a testimony that my problematic research on occupational welfare has been confirmed, on the whole, by empirical studies.



## Chapter 8

### Field Research Project and Its Design

Chapter 8 is dedicated to explaining the design of the field research. It clarifies the aim and methods of fieldwork. Ways and means of collecting information as cornerstones of any scientific inquiry are discussed in detail (interview, case study, etc.).

#### ***1. Aim of the Fieldwork***

The aim of the field research was to operationalise empirically the evolving role of occupational welfare in the Russian welfare state in connection with the private-public welfare mix. The study addressed the issues related to health protection of the working people. Individual decisions about self-provision were not discussed in the thesis, only the supply of health services was analysed.<sup>1</sup>

The present sample is focused on senior managers of Russian industrial enterprises within the broad context of social relations between enterprises and the state. Today the mix of the organisation and the social policy perspectives as well as the ratio of voluntary and compulsory occupational welfare has been undergoing major changes. By relaxing occupational welfare regulations the state, in fact, has stopped providing any incentives for enterprises to develop occupational welfare. This position is more or less clearly articulated in legislation and practical measures undertaken by the federal and regional governments and local authorities. As a result, enterprises now have more flexibility to decide whether to provide health services in-kind to their employees or not. In such a situation management attitudes are crucial for the formulation of enterprise strategy on health centres.

Three fundamental questions determine the general contours of the study. The original questions are:

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<sup>1</sup> Income loss due to illness was compensated from the Social Insurance Fund to which enterprises contributed separately (See Chapter 7 for details).

- what influence Russian industrial managers' attitudes to their responsibility for the protection of workers' health, including provision of health services in enterprise-based health centres?
- what motivates them to maintain health centres in a changing environment?
- what are the implications of the study of industrial managers' attitudes regarding enterprise health centres for evaluating the role of occupational welfare in contemporary Russia.

The first two questions are central in the study. They are quite complex and presuppose a whole array of explanatory hypotheses rather than a simple answer.

The first question was formulated to test managers' attitudes to their responsibility in health care protection of employees in changing national health service eroded by an introduction of compulsory health insurance. For a number of reasons health care is a good case of the state-enterprise interaction in the provision of health services for the employed.

a) Health is quasi-public good, so health services can be provided in a number of ways and the state-private mix, including occupational welfare, can vary greatly;

b) Health care reforms pioneered a change in the social sector: compulsory health insurance (CHI) was introduced in Russia in 1991-1993. Therefore, by the time the research project started in 1995 the health reform had already been implemented for two years;

c) System of CHI funds differs from other social funds established in the early 1990s:

regional CHI funds are set up by regional authorities and, therefore, quite independent of Federal CHI fund;

regional authorities are required to share contributions to CHI with enterprises by paying for those not working.

As a result, CHI contributions are among the most important external factors that might influence managers' perception of enterprise role in

employees' health protection, in general, and maintenance of health centres, in particular. Their attitude to the part enterprises play in health care mix is measured by their approach to the state-promoted compulsory health insurance.

The second question puts more emphasis on the organisation perspective. Managers are seen as influential stakeholders who may have certain interests of their own in provision of occupational health services. It is generally accepted that top managers have wide discretion in determining how their enterprises function and may pursue not only the goal of profit maximisation and implement strategies benefiting management rather than owners. However, there are still significant uncertainties about what exactly motivates, encourages or constrains managers.

The third question concerns evaluation of the prospects for development of occupational welfare and enterprise-based health centres in Russia. Judgements of this sort are always tentative but they may serve as important guidelines for channelling efforts in a right direction.

To be able to answer these questions in a manner substantiated by empirical investigation they should be broken down into more specific research topics used as focal points for building appropriate data collecting procedures, namely

- socio-demographic characteristics of respondents;
- managers' attitudes towards introduction of CHI and health reforms, in general;
- their view on enterprise health obligations towards employees and on how CHI contributions influence managers attitudes towards their health responsibilities, namely, provision of health services in-kind;
- managers' perception of the role the state should play in health care;
- their views on the place of enterprises in CHI system;

- managers' opinion about the ways enterprises could be incorporated into the national health care system;
- their understanding of the role of health centres in the life of enterprises;
- managers' motives for keeping health centres.

## **2. Methods of the Field Research**

The data were collected by means of the following methods the choice being determined by possibilities of obtaining information:

- *Interview;*
- *Case study;*
- *Additional sources of information.*

### ***Interviews.***

Two types of interviews were used: clarification interviews and structured interviews. Interviews were selected from a variety of social research methods available because of the following reasons.

a) There was an evident deficit of information on the subject, including a lack of documentary sources or statistics. Available information was fragmentary, and several recent surveys relevant to the subject under the study did not even address specifically occupational health services.

b) The policy area evolved rapidly as the consequence of the volatility of political and economic situation.

c) For similar reasons the position of enterprise changed as well. They became more entrepreneurial and acquired greater flexibility in their performance.

### **Clarification interviews**

Clarification interviews at the preliminary stage of the fieldwork were conducted with people from the health care and industry networks (see figure 3 in Appendix A). Qualitative free structured in-depth interviews facilitated the construction of an overarching picture of the subject of the research,

discussion being carried around a flexible number of questions asked. They permitted the disclosure of the main problems in the field and helped to understand the modern situation and formulate questions and response options for the questionnaire.

### Structured interviews

On the basis of preliminary stage results, a special structured questionnaire was developed (See Appendix B). It included mainly closed questions, so respondents only needed to choose from a given set of response options. Such a format was selected to fit the characteristics of respondents.

First, they were not used to participate in such kind of research. Closed questions were easy to answer as a respondent only had to select one of the options. It ensured a higher response rate, as those interviewed were more likely to be able to answer effectively. Respondents were also busy at work, so the problem of finding time for interviews had to be taken into account. Nowadays Russian managers have to value their time high and, therefore, shorter interviews were likely to be much more feasible than unstructured lengthy discussions.

Second, closed questions were more efficient and culturally acceptable, convenient to code and analyse than open, unstructured ones, as they produced less variable answers that could be reliably compared. It was important for an individual project limited in time. In order not to constrain respondents too much an option "other, please, specify" was included into response options. It ensured that respondents could express their opinion even if it was not reflected in any of the options suggested. Another response option used in some questions was "don't know -- hard to say" to accommodate those respondents who found it difficult to formulate their opinions. Jargon words were avoided, so questions were easy to understand.

The questionnaire consisted of qualitative questions on managers' attitudes towards:

- current health reform;

- employer-provided health services;
- enterprise health responsibilities.

The six point Likert scales were used to measure attitudes. A filter question (Q.1) was included to check the level of respondents' expertise and the intensity of their opinions. In order to identify the strength of their attitude towards the topic in question the ranking procedure was applied (Q.23) when respondents were asked to indicate their first, second and third choices.

Data were collected in face-to-face interviews, each questionnaire taking about an hour to complete. It allowed me to make observation notes in the course of the interviews and to use my impressions and respondents' informal comments to interpret the results. The purpose of the research project and definitions of the terms used were verbally explained to respondents if necessary. Face-to-face interviews helped to insure that all respondents understood each question in more or less the same way. Personal contacts with respondents helped to avoid misunderstanding and to lessen problems associated with recording responses.

One person per enterprise was questioned. In some enterprises I also had an opportunity to talk to the head of the health centre which helped to better understand what was happening in the enterprises in respect of health protection of employees, what was the situation concerning the health centres and how their roles had changed.

The data collected was coded and analysed with the help of SPSS that is clearly the most popular professional programme used in social and behavioural sciences.<sup>2</sup>

### Characteristics of the sample

The sample included 50 senior managers of Moscow industrial enterprises. About 25 per cent of the economically active population in Russia

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<sup>2</sup> In presenting correlation and factor analyses the following abbreviations are used

\*\* correlation is significant at the 0.01 level (2-tailed);

\* correlation is significant at the 0.05 level (2-tailed).

is employed in such establishments. The latter were selected on the following criteria.

a) The sample covered only managers of industrial enterprises. Governmental agencies and other organisations were excluded from the study on the grounds that their activities in health protection of employees remained heavily regulated by the state.

Table 8.1.

**Enterprises in the sample by number of employees and industry**

Branch of industry	Number of enterprises		Number of employees			
	number	%	100 -- 500	501-- 1,000	1,001-- 5,000	5,001 +
Textile/sewing/Shoes	12	24	3	3	6	-
Machine building	11	22	1	3	7	-
Food processing	10	20	2	4	3	1
Electrotechnics	9	18	2	-	7	-
Automobile	3	6	-	-	1	2
Watches	2	4	-	-	2	-
Metallurgy	2	4	-	-	-	2
Chemicals	1	2	-	-	1	
Total	50	100	8	10	27	5

Source: compiled by the author

In Moscow there are many so called *vedomstvennye* health services belonging to various governmental bodies and non-industrial organisations, including the state owned ones. For example, according to the data of 1995 survey of the Moscow statistical committee that started to record information on health centres in the mid 1990s, among 70 respondents 25 were

governmental agencies of federal and Moscow level; 33 were educational, academic and other organisations operating and only 12 -- industrial enterprises.

Enterprises in the sample belong to such basic branches of industry as textiles, food, machine building, automobile (see Table 8.1). The majority of enterprises operate in heavy industry, and many of them are relatively large in terms of the number of employees: 27 enterprises employ between 1,001 to 5,000 people.

b) The survey was focused on enterprises which at the time of the study provided health services in kind for their workers via health centres (*medsanchast*) or health stations: 24 of sample enterprises had health stations and 26 - health centres. The difference between the two is in the range of services provided and the number of staff employed. Health centres operate as polyclinics supplying a wide range of services, while health stations are small, sometimes one-room medical facilities usually staffed with one doctor and several nurses. Whereas the former can treat patients independently, the latter only provide first aid and contact doctors at local polyclinics specifically responsible for the treatment of workers in the polyclinic's catchment area.

It was suggested that availability of health care arrangements other than payment of CHI contributions influenced managers' attitude to their health responsibilities. The ones that still operated health centres after several years of market-oriented reforms were more likely to be sensitive to health care issues reflecting the interplay between compulsory and voluntary health obligations, as enterprise-based health centres in industrial enterprises, in fact, became a voluntary arrangement. They had to react to the changing environment and make decisions about what to do with health facilities. Besides, their experience might influence the attitude of other enterprises towards health plans.

The majority of the health centres in the surveyed enterprises provided services only to employees of that particular enterprise and sometimes their dependents and retired. Health stations typically served only employees.



It turned out to be much easier to obtain information about enterprises having in-kind provisions for their employees. They at least had some statistical records as well as there were several other surveys available for analysis.

c) The chosen enterprises were located in Moscow, the capital of the Russian Federation with a population of over 9 million people and about the same number of people coming to the city everyday to work. Though some authors comment that Moscow among other metropolis is "atypical for many reasons" (Gough and McMyllor, 1995), for the purpose of this study it is suitable for the following reasons.

Moscow is among the first regions where CHI was introduced while in some regions its development faced a lot of difficulties. In general, it is a city of dynamic social and economic transformations, including privatisation. But despite the fact that this is a place where many innovations were introduced, quite a number of Moscow industrial enterprises still continue to maintain their health centres.

Moscow is not only the seat of the Russian government with all its ministries and agencies; it is also the biggest industrial centre. Moscow enterprises belong to most branches of industry and experience the same problems as their counterparts in other Russian regions, the main one being decline in production.

Moscow industrial enterprises are situated within the developed urban infrastructure. This is not the case of the so-called "company town" where social welfare of population of the whole town depends on the fortune of the town-forming establishment. It typically means close links with local authorities, whereas in Moscow, as well as in other "multi-enterprise" cities, those relations are not so strong.

d) The form of ownership was not specifically taken into account. Though it is worth mentioning that the majority of enterprises in the sample were joint stock companies (32 public limited companies and 9 partnerships). Six enterprises were state-owned, one was a municipal property. However, the form of ownership has not proven an important factor that influences the

provision of health services by Russian industrial enterprises. For example, the Ministry of Economy study (Министерство экономики, 1995) failed to reveal significant relationships between the form of ownership and industry, on one hand, and social developments, on the other. The very existence of health care facilities in an enterprise implies that it is either state owned or has just been privatised.

There is no consensus among researchers about whether privatisation affected significantly the behaviour of the former state-owned enterprises. The subject is widely debated both in Russia and abroad. According to some commentators, the impact of privatisation should not be overestimated. Dolgopyatova (Долгопятова, 1995), for example, points out that old industrial firms which were converted into joint stock companies in the early 1990s were very likely to demonstrate for a long time the behaviour similar to that of the state-owned enterprises.

On the other hand, the size of an enterprise proved to be of more importance: the bigger the enterprise the more likely it is to supply a variety of social benefits. One of the surveys of Russian enterprises (OECD, 1995) discloses quite explicitly that size and industry branch is the most important factors that influence the development of enterprise-based health services. However, Green and colleagues (1986) came to the opposite conclusion that there was no evident relationship between these indicators.

Correlation discussed above is valid for voluntary arrangements only. In Russia the casual link between the availability of enterprise-based health centres, on the one hand, and size of enterprise and branch of industry it belongs to, on the other hand, is as follows. If an enterprise is large and operates in the priority branch of the national economy, where working conditions are typically harmful for the workers' health, it usually has a health centre, as well as provides other social services. Such a situation is a consequence of the state policy rather than an individual enterprise choice. In the Soviet Union occupational health centres were supported by the state in accordance with policy favouring large enterprises in heavy industry. Size and

industry were interrelated and high concentration in priority industries was a dominant tendency.

Therefore, if existence of health centres is taken as a starting point it is almost certain that enterprises operating health centres will conform to these characteristics. The only problem could be to define what is meant by a "large size".

Sampling was carried out according to the official data on organisations, which have health centres and health stations. A list containing 70 organisations was obtained from the Moscow Statistics Committee. The second list of 80 organisations was compiled on the basis of information published in special reference publications. The Moscow health committee provided the third one. The data were crosschecked to exclude double counting. As a result, 156 organisations in Moscow that had health centres were identified; included 56 industrial enterprises. The number of people employed by the sample enterprises amounted to about 160,000 people.

Those enterprises were first approached where I managed to find personal contacts or which were selected for their known interest in health care. The snowballing technique of sampling was very useful. Typically, a respondent that felt positive towards the interview was ready to help me to arrange a meeting with his acquaintance in another enterprise (of the same branch or situated near by).

To ensure that the interviewed really had information, which addressed my specific problematic, senior managers dealing with personnel and social welfare were targeted. They were directly involved in the provision of health services and knew the situation better than anybody else in the enterprise. Occupying high positions in the management hierarchy, they had knowledge of the general enterprise policy as well. Finally, their attitudes were important, as those actors were in a position to influence decisions on health services.

### Pilot study

The pilot study preceded wide-scale interviewing and was intended to:

► test the content of the questionnaire and its layout. Pilot interviews revealed some shortcomings. Several questions proved to be difficult to respondents to understand and, thus, their wording had to be altered to give the interviewed a clearer idea about what was being asked;

► check how long the interview would last. It turned out that the original questionnaire was too long and it took much time for respondents to fill it in. Thus, it was shortened to 31 questions to be completed within an hour.

► probe some administrative issues, especially how to approach potential respondents. The most efficient way was to phone and explain the purpose of an interview and the aegis of interviewer. To ensure respondents' co-operation and understanding of the project, they were given information about the aims and objectives of the interviews.

#### Limitations of the study

The available time-money-labour force limited the scale of the study. Interviews were conducted by one person; no extra money was available to employ additional staff or to cover travelling expenses.

Managers are unlikely to allow access to their organisations unless they can see some commercial or personal advantage to be derived from it. That means that access to fieldwork was very difficult and may be hedged by many conditions about confidentiality. Therefore, the contents of the research questions were to a large extent determined by reality rather than by purely academic considerations.

The sample was relatively small and geographically homogeneous, embracing 50 Moscow industrial enterprises. While the results of the research were often preliminary and exploratory, they nonetheless highlighted certain important trends in occupational welfare in Russia.

The composition of the workforce in the sample enterprises was not considered. It definitely requires investigation since it might be, for example, suggested that enterprises have to address specifically to the health needs of women employees.

Interviewed were asked if they would consent to being taped. Unfortunately, as no one agreed and it was difficult to put down informal comments of respondents in the course of interviews.

Only qualitative questions were included primarily aimed at discovering managers' attitudes rather than at analysing concrete figures. The original intention was to ask a few factual questions within the main questionnaire. But during pilot interviews it became clear that when respondents were asked to provide detailed information they felt uncomfortable and the degree of cooperation declined. The problem was that in answering qualitative questions respondents could express their own attitudes quite freely whereas it was necessary for them to consult someone else to complete a section on enterprise social expenditure. This required more cooperation on the part of managers, as they had to be well prepared for interviews. It was also evident that respondents were not always sure what type of information they could disclose to an outsider without permission of a higher authority.<sup>3</sup>

At the inception of the project the objective was to include both enterprises with health services and those providing voluntary health insurance (VHI). But the clarification interviews made it clear that enterprises providing VHI could not be included into the survey because of the following reasons.

First, the information available to the public on VHI, including official statistics was scarce. Voluntary health insurance companies were reluctant to disclose information about their activities, as competition in the health insurance market was intensifying. I failed to find any systematic data on the problem, to say nothing about a complete list of industrial enterprises that had VHI plans; although in clarification interviews some of the representatives of VHI companies mentioned that they had agreements with industrial enterprises.

Second, the situation in the field was very unstable. It was quite easy for an enterprise to cancel VHI agreement or to change insurance company.

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<sup>3</sup> The World Bank survey faced the same problem. As Lee (1996) noted, in general, the response rate for the qualitative section of the survey was better than the quantitative section, the most sensitive questions being financial detail, costs and profit structure.

There was an association of voluntary health insurance companies but it refused to participate in my study.

Third, from the clarification interviews with voluntary health insurance companies' employees (5 altogether) it became apparent that VHI was more likely to be purchased by new organisations such as Russian banks and foreign firms. They usually had a healthy financial status and, therefore, could afford VHI. Thus, the impulse to buy VHI for employees came from the top with no real pressure from the rank and file. Russian management in foreign companies typically did not have much say in decision-making as everything was done along the external corporate headquarters' guidelines.

In the end, taking all these factors into consideration interviews were conducted only in those enterprises that had health care facilities.

#### The problem of bias

One positive thing to be mentioned is that there was a very low probability for bias in answers. In Russia the issue of CHI is not politically sensitive and respondents had no restrictions or fears of any sanction that might have been imposed on them. They could freely express their own points of view without being constrained as, first, the problem was acknowledged to be controversial and different views were tolerated, and, second, the interviewer did her best not to express her own attitude. There were no loyalty or status barriers between the interviewer and informants since all of them had university degrees and were equal professionally.

#### ***Case Studies***

Two case studies supplement the survey results by going beyond the confines of a structured interview and probing more in-depth analysis. It permitted me to obtain a greater feel for the dynamics involved in decisions to supply health care at enterprise level.

Originally, I had no plans to use methods other than interviews. The fact that it was difficult for me as an independent researcher to get access to enterprises prompted me to make use of case studies. I also turned to a case

study as a method of social investigation that has the following advantages compared with the survey.

In a survey a researcher must at a certain point commit oneself to a questionnaire, which limits the type of information that he/she can collect while the case studies allow to modify the research design in the process of work. Survey research seldom deals with the context of social life or helps to develop the real feel for the life situation in which respondents think and act. Whilst the questionnaire based on one enterprise -- one respondent approach is very useful in obtaining a substantial body of information which is comparable, such method limits a fuller understanding of all the aspects of the functioning of an individual enterprises and deeper explanations of propensity to supply occupational welfare provisions. The case study is a widely used tool of exploratory research that gives a greater flexibility in data collection and analysis. Closer observation enables the investigator to study nuances in attitudes and behaviour.

Accordingly, two enterprises were studied in greater detail. The selected enterprises were different in many respects, including history of health services provision. One enterprise is well known for its health arrangements; the other started to build up health services in the early 1990s. The only evident common factor was that they both did provide health services for employees. This permitted me to look for similarities and differences and to discover what managers of the chosen enterprises shared in terms of behaviour patterns. They were ready to provide more information and afford me more time and demonstrated a high degree of co-operation.

The case studies used various methods of data gathering: direct observation, interviews with managers at different levels of authority, interviews with managerial staff at the enterprises health services (doctors and nurses), analysis of documentary sources made available through enterprises and press. Intensive examination of the selected enterprises helped to better understand the current situation concerning their health centres as managers' beliefs and attitudes were expressed within a more closely examined social context. The findings of the case studies might not be universally applicable,

but they do contribute to a deeper understanding of the real social relations within enterprises.

### ***Additional sources of information***

In order to verify the data collected during the field research findings of several other surveys relevant to the subject have been used as valuable supplementary contextual material.

No special survey of enterprise health or social services in Russia had been discovered. Among many studies of industrial enterprises focused on their economic behaviour in the new environment, only two incorporated substantial sections on occupational welfare:

- ▶ survey carried out in 1991-1992 and in 1993-1994, outcomes being reported by Dolgopyatova (Долгопятава, 1995).

- ▶ "Monitoring of Status and Behaviour of Enterprises", a survey of 433 industrial enterprises conducted by the Ministry of Economy (Министерство экономики, 1995) to monitor the status and behaviour of Russian industrial establishments.

One of its objectives was to collect information on enterprise social facilities such as kindergartens, housing, leisure, health care and education. Only about half of respondents answered "social" questions, 149 of them reported having health centres.

However, the research team acknowledged some methodological shortcomings. First, the data were sporadic and did not allow revealing any long-term tendencies in the development of social plans. Second, the volume of information on social issues received in the course of the survey proved insufficient to analyse economic and financial aspects of the functioning of enterprise social assets.

The surveys conducted by researchers on foreign companies like, for example, the one by Green and colleagues (1986) were studied as well. Though having no direct relevance to the Russian reality they, nevertheless, demonstrated general trends in the development of occupational welfare in a market economy.

Besides, the following surveys were especially valuable.



1. The World Bank survey of 435 Russian industrial enterprises conducted in 1994 (Commander, Fan and Schaffer, 1996). Its aim was to study how enterprises adjusted to the shocks of economic transition. The sample was stratified by form of ownership, regions and industries. 50 of the sample enterprises belonged to the so-called *de novo* firms-- newly- established ones. The questionnaire consisted of 39 quantitative and 89 qualitative questions.

2. Survey carried out by a team headed by I.Tratch, M.Rein and A.Worgotter in 1995 (Tratch and colleagues, 1996). The interview team visited 97 enterprises in Russian regions and was focused on investigating the role of social assets between 1989 and 1995.

3. TACIS (Technical Assistance to Commonwealth of Independent States) survey covering 92 enterprises in five regions was conducted in 1998 by the team of TACIS experts as a part of the project "Social consequences of economic reforms and privatisation in Russia" (Виноградова (Vinogradova), 1998 (a), 1998 (b)).

Though these surveys were not centred on health care, exploring, in the first instance, housing and child care facilities, they proved to be very helpful in formulating hypothesis to be tested through field studies and conceptualising evidence from the field.

### **Conclusions**

Formulation of the field research project and its design was not as easy task. The study addresses quite specific topics that guided the actual collection and analysis of the available data: novelty of the subject itself for Russian researcher; scarcity, fragmentation or lack of Russian literature, information on enterprises and official statistics were main impediments. For financial and organisational reasons the project was limited to Moscow industrial establishments.

The overarching aim of the empirical investigation was to get a better understanding of what is happening in the field of occupational welfare in contemporary Russia. In collecting the data the focus was made on attitudes of senior managers' of industrial enterprises to recent health reforms and

employers' health responsibilities, their motives for keeping enterprise-based health centres. For this purpose qualitative analysis is believed to represent the most suitable research strategy.

Interviews and case studies were main research instruments used. Each of them is focused on a specific data source and represents a certain facet of the subject investigated. On one hand, survey in general has advantages in terms of economy and the amount as well as standardisation of data to be collected. Moreover, fewer incomplete questionnaires and fewer misunderstood questions, generally higher return rates and greater flexibility in terms of sampling and special observations represent special strength of interviews. On the other hand, case study gives an opportunity to gain a full sense of social processes in their natural settings. It is argued that, taken together, they give a representative picture of the role of enterprise health centres in the protection of the workers' health in contemporary Russia.

Realisation of the project had its own difficulties. It was a one-person endeavour with all ensuing consequences. To make up a sample of enterprises, to establish contacts with a great number of busy people some of whom were, moreover, not very eager to cooperate or disclose information needed, to process quite a bulk of material and to do technical work required time and efforts. But regardless of all that and a lot of drawbacks, I hope to have made an unpretentious contribution to achievement of rather an ambitious, as I see now; aim to pioneer the study of occupational welfare in Russia to introduce my country into academic turnover on the subject. Readers of the thesis when forming an opinion about it will have to keep the abovementioned in mind.

## **Chapter 9**

### **Compulsory Health Insurance, Enterprises and Their Health Centres: Managers' Attitude**

Chapter 9 presents empirical evidence collected during the survey carried out in 1995-1997 in 50 Moscow enterprises providing health services in-kind for employees. Its aim was to examine health services in industrial establishments in the context of social and health policy and present status of occupational welfare in Russia with due account taken of changing aims and methods of health policy and enterprise behaviour. It discloses managers' attitude to compulsory health insurance as an important element of environment in which workers' health protection develops, the role of enterprises in the national health care system and place of employer-based health services.

#### ***1. Managers in the sample***

##### General remarks.

Senior personnel and social welfare managers were selected for interviews on the following grounds. First, as a part of senior management they had a real chance to participate in taking decisions on enterprise health policy. Second, they were directly involved in personnel and social welfare matters and knew situation around health centres better than other senior members of the staff. This part of managerial staff had influence in the field both as decision makers and opinion formers.

In all enterprises in the sample personnel/ social welfare work was established as a separate specialist function, but to define exactly the activities of personnel department was not easy. The scope of responsibilities as well as the status and title of the head of personnel / social welfare department and his / her position in the management structure varied in different enterprises. There was no common standard applicable throughout an industry. Organisation and size of enterprise affected the way personnel/

social welfare department fitted into policy and decision making process of an enterprise.

According to their position in enterprises the interviewed were divided into two groups. One group was comprised of deputy directors on personnel and social welfare who are the second level from top in enterprise hierarchy. The second group consisted of heads of personnel/ social welfare departments. Though their status was lower than in the first case they reported directly to directors of enterprises and were among five or ten key administrators forming a group of senior managers.

The objectives of personnel officers' activities were to ensure the adequate supply of labour in terms of quantity and skills; to develop and maintain a level of morale and human relationships, which would evoke willing and full cooperation of employees in attaining optimum operational performance.

To fulfil their task personnel / social welfare departments in Moscow industrial enterprises were typically responsible for:

- salary and wage administration;
- education and training;
- staffing;
- full observance of legislation relating to employment;
- employees' welfare.

Personnel / social welfare is generally identified as an element of support function as opposed to the task function. Task function is basic performance related to the actual completion of the productive process or directed towards specific and definable results. Support function underpins the former and does not normally have any direct accountability for achieving a specific task end.

The personnel/ social welfare element in Russian industrial enterprises has some special characteristics. Industrial occupations are not prestigious: working conditions in industry are often bad. At the same time the level of unemployment is high. Therefore, recruitment of workers is not a big problem especially in a situation when many of the surveyed enterprises have cut labour force in recent years. No sophisticated procedures are applied to hire a

worker. Managerial positions seem to be more attractive but very often mechanisms of "personal connections" are used rather than objective criteria are used to get the job.

#### Age, gender and education

Three personal characteristics of managers were examined in the survey: gender, age and education.

Table 9.1.

**Managers in the sample by age, gender and education, number of respondents, N=50**

Gender	30 – female	20 – male	
Age	10 – 31-40 years old	30 – 41-50 years old	10 – 51-60 years old
Educational backgrounds	35 – polytechnic	15 – social science	

Table 9.1 shows the composition of the sample by these characteristics. 60 per cent of respondents were women and 40 per cent men, or just the opposite ratio to gender distribution of manpower in Russian industry where the share of women is 40 per cent compared to about 60 per cent of men.

Gender issues were not addressed specifically in the study as in Russia gender problems until recently has never been included in mainstream research. And not only in this country. Mullins (1993), for example, noted that in the West women had tended to be overlooked within many classical studies on organisations and motivation, which either focused on men or avoided interpretation of gender divisions.

The number of women in workforce was traditionally high in Russia, but they rarely occupied high managerial positions and men dominated in the administrative hierarchy. From this point of view women in the sample were quite successful in professional career.

Managers in the sample were well educated: 70 per cent graduated from polytechnic universities and 30 per cent had degrees in social sciences. It is an unusual situation: one of the studies of personnel departments conducted in 1989 found out that only 58.7 per cent of their heads had graduate degrees (Маслов (Maslov), 1995).

The fact can be explained by several reasons. First, the majority of respondents were women. Employment statistics disclosed that the share of the employed with university degrees among women in Russia is higher than among men – 15.6 per cent and 18.5 percent, respectively, in 1995 (Госкомстат (Goskomstat), 1996). Second, Moscow is a big educational centre and the level of education of its population is higher than the country average. Finally, positions of personnel/social welfare managers are attractive to many people with graduate degrees who worked in organisations either closed down due to economic crisis, or paying low wages.

The study revealed no significant influence of gender on education (see Table 9.2). It arises from the fact that men and women in Russia have equal rights to education and there is no discrimination between them, except in some occupations perceived to be typically male ones (military, police, etc.).

Table 9.2.

**Composition of the sample by gender and education,**  
% of respondents, N=50

Gender	Education		Total
	polytechnic	humanities	
<i>Men -- count</i>	15	5	20
% within men	75	25	100
% within education	42.9	33.3	
<i>Women -- count</i>	20	10	30
% within women	66.7	33.3	100
% within education	57.1	66.7	
<b>Total</b>	35	15	50
% within education	70	30	100

However, the study yielded an important result. Many respondents acknowledged that holding senior managerial positions in personnel and social welfare field they did not undergo special training and were recruited for their jobs from a wide variety of other professions. For example, one of the respondents had been a personal assistant to a very high official in a relevant ministry. Another one -- deputy director on personnel and social issues -- had taken a post of a director of one of the Moscow industrial enterprises.

Respondents on the whole felt that they lacked necessary qualifications. Some of them were uncomfortable about it as they recognised a need for enterprise to adequately respond to new challenges in the changing environment. Personnel departments, which responsibilities were traditionally restricted to record keeping and payroll monitoring, set about playing multidimensional role in the development of strategies of addressing the change.

Respondents were aware of new approaches to personnel management and would like to know and apply them. For example, a few interviewed admitted that they did not have enough skills for interviewing and using this technique effectively.

The curricula of managers in the Soviet educational system -- the overwhelming majority of respondents graduated in those times -- did not pay much attention to employees welfare management in enterprises. Human resources management as a new specialisation began to be taught in the mid 1990s when importance of involvement and commitment of staff to aims of organisation was acknowledged. About the same time professional journals appeared, too.

Respondents formed three age groups (see Table 9.3). The biggest group -- 30 people -- included managers of 41 to 50 years old, the rest -- 20 people -- were equally divided between 31-40 and 51-60 years of age.

Table 9.3.

**Composition of the sample by age and education,****N=50**

Education	Age			Total
	31-40	41-50	51-60	
polytechnic -- count	5	25	5	35
% within polytechnic	14.3	71.4	14.3	100
% within age	50	83.3	50	
humanities -- count	5	5	5	15
% within humanities	33.3	33.3	33.3	100
% within age	50	16.7	50	
Total	10	30	10	50
% within age	20	60	20	100

The first and third age groups were equally divided according to education -- 50 per cent had polytechnic and 50 per cent-- social sciences degrees. More than 80 per cent of managers belonging to the second group-- those between 41 and 50 years old --were graduated from polytechnic universities.

Therefore, the majority of managers in the sample were educated and started working in the Soviet times and were mostly industrial engineers by education.

Managers in charge of health care were not specifically trained and came from different educational backgrounds. Predominance of women in the job might be taken as an indirect evidence of its relatively low status in top management. As social issues were of a marginal importance that was quite understandable -- they were never expected to be the main concern of enterprises -- social welfare function is considered the secondary one.

The well described "vicious circle" in social services (Hasenfeild, 1992) led to the situation when relatively low status of personnel and social welfare managers among management could be explained by the lack of qualifications that, in turn, failed to help to strengthen their role in enterprises.



Analysis of data indicates that such personal characteristics of respondents like age, gender and educational backgrounds in general had little influence on their opinions. There were divergences in answers to some questions between managers of different age, gender and education but they did not enable to define any strong correlation: correlation coefficients suggested that predictable influence of these characteristics remained rather weak.

#### Managers' role in decision making on health issues

One of the objectives of the study was to define the role of personnel/social welfare managers in decision-making on health issues. Respondents were asked to evaluate methods of participation in working out enterprise health policy and style of behaviour in decision-making process (see Table 9.4).

Table 9.4

#### **Methods of participation and style of behaviour,**

N=50

	Methods of participation	number of respondents	% of respondents		Style of behaviour	number of respondents	% of respondents
1	Concept developer	15	30	9	Centrist	20	40
2	Expert-consultant	10	20	10	Diplomat	15	30
3	Head of development team	10	20	11	Conservative (tradition)	10	20
4	Generator of ideas	5	10	12	Reformer	-	-
5	Critic-opponent	5	10	13	Observer	-	-
6	Analyst	-	-	14	Difficult to say	5	10
7	Project manager	-	-				
8	Difficult to define	5	10				

Respondents fall into three groups according to the way they participated in forming enterprise health policy. 15 respondents saw themselves as concept developers who -- unlike generators of new ideas -- worked to advance already agreed policies. The roles of experts-consultants or heads of development teams neutral in terms of initiative and responsibilities were taken by 20 (40 percent) managers totally. Of them 20 per cent perceived themselves experts-consultants. They were asked to analyse issues relating to employees' health protection and to make recommendations on their possible solutions. Those acting as heads of development teams worked to implement already adopted decisions.

The rest 20 per cent held an active position either generating new ideas or acting as opponents to enterprise health policy. It is worth noting that all critics/opponents did not consider the role of enterprise director in working out enterprise health policy equally important to that of the board of directors. Therefore, they were not constrained by influence of their bosses and could openly express their concerns. This method of participation in decision-making was tightly correlated with young managers (0.527\*\*) and men (0.408\*\*).

The interviewed did not see themselves as analysts or project managers. In the role of analyst personnel manager acts on his own initiative diagnosing problems and difficulties. Under project manager a head of a separate unit set up on a temporary basis for attainment of a particular task was meant. The survey demonstrated that such activities were not carried out in Russian industrial enterprises in the field of health protection.

In decision-making process respondents' behaviour in general can be regarded as neutral. They evidently avoided radical options: no one considered himself / herself a reformer, that was a person who wanted to seek far going solutions of existing problems. At the same time no one thought that he / she was only an observer passively watching what happened in enterprise with health services having no active role at all. 10 respondents deemed they were conservative. They wished to follow traditions of their enterprises favouring no principal changes. Correlation coefficients suggested that such behaviour is likely to be demonstrated by women (0.408\*\*).

The majority of managers regarded themselves as diplomats or centrists. Diplomats – 15 respondents -- negotiated and mediated between various interests in enterprises. They would support decisions suitable for all parties concerned since avoiding conflicts was most important for them, the style of behaviour rather strongly associated with elder managers (0.345\*).

Centrists – 20 respondents-- accepted that changes were necessary, though not too radical. They were open to new ideas but believed that problems related to employees' health protection should be settled within the existing system.

Managers in the sample had a real possibility to affect enterprise policy on health centres because of their unique position in enterprises. They acted as specialist advisers on personnel and social welfare matters and implementation of respective policies through other departments of organisation. On one hand, they worked in close contact with other senior managers, in some enterprises sat on enterprise boards advising fellow directors on health issues. Thus, personnel and social welfare managers maintained a unique perspective in organisational decision-making as bearers of social conscience, reminding senior management of their social responsibilities.

On the other hand, they provided specialist knowledge and services for line managers to support them in performing their jobs. Personnel and social welfare manager was an executor of enterprise policies acting in consultation with and taking advice from line managers. Their concern was exclusively management of human assets while line managers were also involved in management of physical assets. To what extent line managers in surveyed enterprises were supported by personnel and social welfare staff was typically decided by the top management depending on the nature and characteristic features of a particular industry.

There were two groups of factors that influenced the development of health centres: subjective, including attitude/influence of major stakeholders, and objective (availability of health care provisions in-kind and financial status of enterprise being the most important)(see Table 9.5).

Table 9.5.

**Factors influencing development of health plans, N=50**

		number of respondents	% of respondent s
1	Personal attitude of director	35	70
2	Financial status of your enterprise	25	50
3	Decision of shareholders' meeting	10	20
4	Existence of health care facilities	10	20
5	Decision of the Board	5	10
6	Pressure from employees (through collective agreement)	0	0

Respondents definitely considered subjective factors the most important in shaping enterprise policy towards health matters – only four respondents did not choose one of them at all.

The majority of managers acknowledged the leading role of directors in developing health services. They admitted that health policy was very much influenced by philosophy of the top management, or, in fact, originated from the top of enterprises. Whatever was the scope of their responsibilities personnel / social welfare managers acted by consent by delegated authority dependent upon the standpoint of top management on duties personnel / social welfare managers should perform.

Ten and five respondents mentioned the important role of shareholders and the Boards, respectively. It is worth noting that all the respondents ignored the influence of employees.

As to objective factors, I expected that financial issues would be crucial in shaping enterprise health policy taking into account the present difficult financial status of an average Moscow industrial enterprise. Therefore, 50 per cent response rate was not as high as expected. Another interesting finding

was that only ten respondents considered the very fact of existence of health centres or health stations as a factor influencing health policy in enterprises. The majority of managers did not feel bound by the arrangement to the extent that it would force them to continue health care provision.

Answering the question managers could choose several options and the analysis of combinations of responses gave the following results.

Nineteen managers selected only one factor, with 15 choosing only subjective factors (ten and five choose director and shareholders, respectively) versus four respondents who preferred objective factors.

Other respondents opted for two or three factors, with half of sample mentioning two options. The most popular combination was that of personal attitude of Director and financial status of enterprise (15 respondents) that was not at all surprising as it in principle supported the findings of other relevant surveys.

Analysis of responses revealed a zero correlation between gender and managers' attitude to the role of financial constraints in decision-making on health centres. It meant that gender did not influence respondents' opinions on the problem at all.

The mentioned above leads to the conclusion that non-economic subjective reasons were more important for respondents in issues of occupational health care than purely financial considerations.

In 30 enterprises decisions on health issues were taken by reaching agreement between senior managers. In turn, health problems were decided by those in charge, namely by directors and personnel and social welfare managers, in 20 enterprises in the sample. Voting procedures either at managerial, shareholders or employees meetings were not used at all.

Though all interviewed said that senior managers discussed among themselves problems related to workers health care, in the majority of enterprises -- 60 per cent -- it happened rarely (less than once a month) while in 40 per cent of enterprises health issues were included in top management agenda on a regular basis (more than once a month).

Therefore, only in 17 enterprises where decisions on health care were taken by reaching agreement between senior management health matters were discussed regularly. It could mean that either top managers made a team of people with similar viewpoints, or the stand of director was agreed to unconditionally managers and workers having little influence on decision-making in this field. Health centres were an area where line managers did not have much to say unlike other aspects of personnel and social welfare issues and health care problems were likely to be resolved by top management.

It is worth noting that respondents mentioned two more officials in enterprises influential in shaping health policy -- a head of health centre or health station and a trade union leader (in industries that still had strong unions) -- both working in close cooperation with personnel and social affairs managers.

## ***2. Industrial managers and compulsory health insurance (CHI) in Russia***

The data in Table 9.6 shows that there is a strong belief among managers in the leading role of the state in health care protection. 30 respondents think that development of a new health system should not lead to the decrease in the level of the state financing. Half of the interviewed considers the state to be the major financier of health care meaning, first of all, the federal government. Managers are aware of the fact that regional authorities may encounter difficulties in funding health care services and do not think that CHI should be organised on regional basis and financed mainly by local budgets.

However, it is generally understood that other institutions in society should also support health care system and help the government. 25 managers, or 50 per cent of the sample, suppose that though the state should guarantee provision of at least minimum of health services financial resources of regions, enterprises and population are also to be used in health care. At the same time only one fifth of respondents (ten people) explicitly acknowledged that enterprise CHI contributions are one of the major resources of the health care

system. In fact, they support the present CHI scheme financed by both local authorities and employers.

Table 9.6

**Managers' attitude to CHI, N=50**

		number of respondents	% of respondents
1	Introduction of CHI should not be accompanied by decrease in the level of the state financing.	30	60
2	The aim of CHI is to make access to health services easier for people.	30	60
3	Minimum health services should be guaranteed by the state; at that health care system should be built depending on financial resources of regions, enterprises, population.	25	50
4	CHI should level regional differences in health care.	15	30
5	CHI should be financed from local budgets and contributions of enterprises.	10	20
6	People should contribute to CHI.	5	10
7	CHI should be organised on a regional basis and financed mainly through local budgets.	0	0

As to personal contributions to CHI, only five respondents agree that people should pay for health care. The majority of managers believe that at present poverty is so widespread in the country that many people just cannot afford to spend money on health care. Thirty managers think CHI can help to solve the problem of access to medical treatment while 15 believe that CHI should eliminate regional variations in health care.

Correlation analysis reveals several interesting associations. There is a strong negative correlation between the two roles of the state in health care -- managers either speak in favour of keeping the level of budget financing, or advocate guaranteeing at least minimum health services (-.816\*\*). Besides, the first one is also negatively associated with a possibility of people contributing to CHI (-.408\*\*). Managers who believe that introduction of CHI should not lead to decrease in the state appropriations on health care do not think that individual contributions on CHI should be introduced. At the same

time they are likely to assume that the aim of CHI is to level the regional differences in health care (.535\*\*).

Better access to health care is associated with the state guarantees of the provision of minimum of health services plus attracting other resources into health care system (.408\*\*).

Table 9.7.

**Managers on the aims of introduction of CHI, N=50**

		number of respondents	% of respondents
1	To change the structure of health care financing using contributions from enterprises to compensate for decrease in the state financing	25	50
2	To increase efficiency of health care system	20	40
3	To introduce enterprise contributions by as a supplementary source of health care financing	15	30
4	To improve the quality of health care	15	30
5	To give patients more choice	15	30
6	To make the first step towards privatisation of health services.	0	0

Managers think that introduction of CHI was caused mainly by financial reasons though other matters were not neglected, either. It ought to be remembered that official debate on CHI introduction has been focused on issues other than financial. The overwhelming majority of managers (40 people) believe that the main aim of the recent health reforms is to attract more resources into the health care system by levying contributions on enterprises, though evaluation of the role of such contribution varies. Among them 25 respondents (making 50 per cent of all interviewed) are of the opinion that the state wants to use money paid by employers to decrease the level of the state financing while the remaining 15 respondents, seem to believe the



official policy statements considering CHI contributions to be a supplementary source of health care financing.

Twenty managers think that the government intends first of all to increase efficiency of the health care system, 15 mention improving quality of health care and giving patient more choice as targets of introducing CHI.

Table 9.8

**Correlation matrix among managers' opinions on the aims of  
introduction of CHI**

	Enterprise contributions as supplementary source	Change the structure of health care financing	Improve quality of health care	Give patients more choice.	Increase efficiency
Enterprise contributions as supplementary source	1.000				
Change the structure of health care financing		1.000			
Improve quality of health care	-.429**		1.000		
Give patients more choice.	-.429**		.524**	1.000	
Increase efficiency	-.535**	-.408**	.802**	.802**	1.000

\*\* Correlation is significant at the 0.01 level (2-tailed)

Table 9.8 presents a simple correlation matrix of managers' opinion on the aims of introduction of CHI. Regarding efficiency as the main reason for CHI is very strongly correlated with improving quality of care and giving patients more choice. At the same time it is negatively associated with changing the structure of health care financing and using enterprise contributions as a supplementary source of funds. The latter is, in turn, negatively correlated with giving patients more choice and improving quality of care.

This indicates that managers, according to their opinions on the aims of introduction of CHI, fall into two groups. One is definitely more concerned with financial aspects of CHI reforms and the role of enterprise in their financing;

that is with factors, directly affecting the life of their organisations. Members of the second group pay much more attention to other, non-financial issues, related to actual functioning of the health care system.

Managers regard it inconceivable that the state may go so far as to privatise health services. They consider privatisation to be an equivalent to commercialisation and, thus, introduction of fees for services. It once again stresses the fact that the state is still viewed as the main provider of health services.

Table 9.9

**Managers' view on the role of CHI bodies, N=50**

		number of respondents	% of respondents
1	These are one of the many bureaucratic structures	20	40
2	Health insurance companies use CHI for their own purposes, they hardly serve the interests of society	20	40
3	This is a reliable system, useful for people	10	20
4	Have not yet got any particular opinion	0	0

The general impressions managers have got about CHI bodies are quite negative (see table 9.9). They seem to be suspicious of the activities of CHI funds and health insurance companies. Twenty interviewees are sure that they are yet another bunch of bureaucratic structures caring about their own interests first. In managers' opinion, these bodies serve their own purpose ignoring interests of society. Only ten respondents believe that CHI bodies can be trusted and can help to improve the present status of health care system in the interests of population.

Table 9.10

**Managers on health insurance companies, N = 50**

		number of respondents	% of respondents
1	The right to carry out compulsory health insurance should be given only to state or municipal-owned firms.	30	60
2	Private health insurance companies are more interested in money turnover, their activities should be under the strict scrutiny.	15	30
3	Establishment of private companies only will allow at the first stage to overcome a residual principle of health care financing and to create favourable conditions for CHI development	5	10

Evaluating the role of health insurance companies managers believe that private ones are more interested in gaining profit than caring about people's needs. Therefore, the state should control the activities of CHI agencies. As table 9.10 shows, the majority of respondents suggest that CHI should be run by either the state or municipally owned organisations. Five managers think that only setting up private health insurance companies will enable the new system to reach its aims.

Table 9.11.

**Managers' evaluation of the activities of various bodies in health care reform, number of respondents; N=50**

	Positive	Rather positive	Rather negative	Negative	Can't say	Have no information
President	-	-	10	15	--	25
Federal Assembly	-	-	-	15	5	25
Ministry of Health	10	5		5	10	20
Federal CHI fund	-	5	5	5	10	25
Local authorities	-	5	-	5	35	5
Moscow CHI fund	-	10	5	-	35	-
Local employers	5	10	-	-	30	5

Assessment of performance of various actors in reforming health care system in Russia, including federal and local authorities, turned out to be a difficult task for managers. Many of them acknowledge having no sufficient information to make competent conclusions (see Table 9.11). Thirty five respondents have no opinion on the role of the Moscow CHI fund and local authorities in promoting health reforms. Five managers do not seem to know anything about the activities of Federal Assembly -- they just skip the relevant option. It means that the state bodies do not communicate their decisions to employers who are not considered by the state as players in the field of occupational welfare.

The higher the level of authorities the more negatively respondents evaluate their activities. Ministry of Health and local employers are the only two bodies that get rather strong positive evaluations, though by the minority of the respondents. It is evidently perceived that since the Ministry of Health is responsible for health care then it should perform a positive role in protection of population health. Besides, almost no exchange of information between employers on health issues is carried out and managers typically do not know what other employers in their locality are doing in health care provision. As a result, 30 managers cannot evaluate the role of other employers in their area. Fifteen respondents who assess employers' role in positive terms seem to judge by their own activities in the field.

Table 9.12

**Managers on the state of CHI in Moscow,**

number of respondents; N=50

1	Formation of CHI system has been completed	5	2	Formation of CHI system has not yet been completed	30
3	Regional financing mechanism has been established	-	4	Regional financing mechanism is not yet working	20
5	CHI covers only those employed	20	6	CHI covers the majority of population	10
7	CHI compensate for only some treatment	15	8	CHI compensate for almost all types of medical treatment.	10
9	Only few health services joined CHI	-	10	The majority of health services joined CHI	25
11	Have no idea about the organisation of CHI system in Moscow	-			

Many respondents found it difficult to comment on the stage of development of CHI in Moscow. Two polar options covering such major issues in the field as coverage and financing have been offered. The response rate is low compared to other questions and answers clearly indicated that in general managers do not know much on what exactly is going on in the Moscow health system. For example, only 20 of them risk answering the question on the regional mechanism of CHI financing mechanism. Their perceptions about the stage of CHI development in Moscow are quite vague and sometimes even wrong. For example, half of managers are sure that the majority of health services in Moscow have joined CHI that is not exactly the case. Twenty respondents believe that CHI covers only the employed while in Moscow the whole population is insured. It can be suggested that managers understanding of CHI functioning in Moscow is influenced by enterprise relations with CHI. when their real participation in CHI is limited to paying regular contributions.

Table 9.13

**Managers on factors hampering introduction of CHI, N=50.**

		number of respondents	% of respondents
1	Decrease in enterprises' profits	40	80
2	Incompetence of Moscow authorities.	10	20
3	Political instability	10	20
4	Lack of legislative regulations.	10	20
5	Lack of interest on the part of Moscow authorities.	5	10
6	Nothing hampers.	5	10
7	Hard to say.	5	10

The responses summarised in Table 9.13 can be grouped around three issues. First, the majority of managers consider financial problems, especially decrease in enterprise profit, the most important among the reasons hampering CHI development in Moscow. It should also be noted, that 20 managers, or 40 per cent, selected this answer as the only one option.

This is the major problem for industrial enterprises as poor financial status not simply impedes the operation of health programmes but threatens their very existence. The state of Moscow industry has declined and the level of industrial output decreases. In 1997 for the industry as a whole it amounted to only 33 per cent of the 1992 level. In fact, the crisis in Moscow industry is worse than in the country in general. Heavy industry suffered most -- the level of output in 1997 reached only 9.35 per cent of the 1992 level. On the contrary, food-processing industry turned out to be less hit by the crisis. As a result the structure of industry in Moscow changed. For the period of 1992-1997 the share of machine building and metallurgy decreased almost twofold - from 43 per cent in 1992 to 22 per cent in 1997 while the share of food-processing industry increased from 15 per cent to 30 per cent.

Second, unexpectedly, political instability, another important feature of modern Russian life, has been mentioned by only 10 respondents. Besides, it always goes in a package: all the managers who consider it as a factor running against CHI also mention lack of legislative regulations and financial status of enterprises. Third, 13 managers choose the activities of local authorities as main impediments of CHI reform linking their incompetence with the lack of interest in introducing CHI.

### **3. Role of enterprise in health care with reference to the recent health care reforms**

One of the aims of the interviews was to find out what managers thought about division of health responsibilities in society.

Table 9.14

**Managers on division of health responsibilities. N=50**

		number of respondents	% of respondents
1	The state should assume the whole responsibility for health care of its citizens	30	60
2	Employers should contribute to health care of employees; it is their social responsibility.	25	50
3	Employers could take part in health protection of employees, but only in case they have financial resources.	20	40
4	Every person should take care about his/her own health.	10	20
5	Expenses on health protection of employees are additional non-productive expenditures.	5	10
6	Issues related to employees' health protection are beyond employer's responsibilities.	0	0

According to data in Table 9.14 there are two institutions in society, which, in managers' opinion, should bear responsibility for the health of the

employed. The state comes the first with 30 respondents saying that it should assume the whole responsibility for health care. Enterprises are the second – 25 managers believe that it is employers' social responsibility to contribute to health protection of employees. Twenty respondents think that employers should participate in health programmes only if they have financial means while no one explicitly acknowledges that employers should not be concerned with employees' health at all.

Perhaps most significant is the combination of opinions. Managers typically agree with two statements – 38 people all together – of them 24 mention the state and employers, 9 – individual and employers and 5 – only employers.

It is important to note that these five respondents (or 10 per cent of the sample) that exclude employers select only one option. Four managers think that the state is the most important protector of health status of the working, and one manager believes that it is an individual who should care about his/her own health. On the other hand, 10 managers, who selected two options, do not mention the state. Five of them think about the significant role of individuals and social obligation of employers while the other five mention only employers but stress the importance of the financial dimension. Here five more managers should be added who agree with only one statement, that employers should provide health protection only if they have finances.

It should be noted that financial resources and unproductive expenses are tightly correlated (.408\*\*). Those who think that health protection expenses are not productive -- 10 per cent of managers -- nevertheless agree that if employers have financial resources they should participate in workers' health protection

It is not surprising that there is quite strong negative correlation between the role of the state and individual in health protection (-.612\*\*), meaning that managers are likely to favour either the state, or an individual.

Managers who think of employers' participation in health protection as a social obligation do not typically have any financial considerations in mind (.816\*\*). In fact, they agree that employers should try to carry on their health



responsibility regardless of the financial status of enterprises. On the other hand, managers that are concerned with financial issues seem to be more practical and do not approach their role in health care in terms of health/social responsibility. There are also significant negative correlations between the role of the state, on one hand, and importance of enterprise financial status (-.583\*\*) and productivity considerations (-.408\*\*) on the other hand. Managers in these cases are likely to be more inside oriented, relying first of all on capacities of their enterprises rather than appealing for support from other institutions in society.

Table 9.15.

**Degree of enterprise participation in health protection of employees.**

number of respondents, N=50.

Fully	Considerably	Partially	To some extent	Not at all	Hard to say
0	0	35	10	0	5

Table 9.15 shows that most managers do not think that participating in CHI as it is organised now they fulfil their responsibilities as employers in health protection of employees in full measure meaning, in fact, that more can be done. In general, respondents are very cautious in evaluating their role: no one agreed with the extreme options answers concentrating around neutral ones.

Introduction of CHI contributions have influenced the attitude of 40 respondents towards the role of employers in health protection of employees. But the extent of such influence is not significant as only 15 managers evaluate it as "considerable" with about the same number saying "very little"; twenty of them choose neutral opinions (see Table 9.16)

Table 9.16.

**Managers on influence of CHI on their attitude towards employees' health protection,**

number of respondents; N=50

To a great extent	To a considerable extent	To some extent	Very little	Not at all	Hard to say
0	15	20	15	0	0

Therefore, introduction of CHI seems to bring little changes into managers' attitudes towards enterprise health care responsibilities. If there is any change it is evidently in favour of an additional effort to be undertaken to protect employees' health as certified by data in Table 9.17.

Table 9.17

**Managers on employers' health responsibilities, N=50**

		number of respondents	% of respondents
1	Employers should undertake more effort to protect their employees' health, CHI is not enough	45	90
2	Employers should be more active in CHI system	5	10
3	Employers should rely on CHI.	0	0

The overwhelming majority of managers think they should do more for their employees, as CHI is not enough to secure good health status of workers. No one believe that employers can fully rely on CHI. Only five interviewees suggest that employers should develop more initiative in establishing good communications with CHI bodies to use the possibilities which might arise within CHI.

Table 9.18.

**Managers on the role of employers in CHI, N=50**

		number of respondents	% of respondents
1	Employers should have financial concessions in CHI system provided they finance their own health care plans.	25	50
2	Employers should deal with health insurance companies directly without any intermediaries.	20	40
3	Employers should have the right to choose between health insurance companies.	15	30
4	Employers should provide voluntary health insurance.	10	20
5	Present system is ok: employers should only pay CHI contributions.	10	20
6	Employers should directly participate in taking decisions on CHI.	5	10

The role employers can play in CHI system and opportunities the latter provides for enterprises are viewed differently (see table 9.18). First of all, only 10 respondents think that the present system is ok and there is a need for any initiative on the part of enterprises. It means that the majority of managers (40 people) are ready to consider changes in the way enterprises participate in CHI. Though only five managers are prepared to go as far as to participate in making decisions on organisation and financing of CHI. Managers typically favour certain changes. For example, 20 of them would prefer to deal with health insurance companies directly without any intermediates, practically bringing CHI funds to naught. This is, in fact, the way it was stipulated in the first CHI regulations (see figure 2 Appendix A). The right to choose between the health insurance companies appeals to 15 managers.

Two findings are rather unexpected. First, as much as 10 managers consider a possibility to pay for voluntary health insurance. Therefore, it is surprising that the idea of voluntary health insurance enjoys some popularity

among managers as all sample enterprises have in-kind health care arrangements. The plausible explanation may come from the fact that participation in CHI decision making is more tightly associated with voluntary health insurance (.667\*\*) than with working without intermediaries (.408\*\*) to say nothing about the right to get financial concessions (.333\*). It can be suggested that for those managers who are likely to favour voluntary health insurance it is, first of all, a possibility to influence actively the decision making process that counts. They feel that it is much more likely to happen in VHI than in CHI.

Second, all surveyed enterprises provide in one form or another health services for their employees but only half of the respondents is in favour of financial concessions in CHI system in case an enterprise owns health care facilities. It is even more surprising as the majority of managers complain about financial difficulties experienced by their enterprises. The analysis of managers' attitude towards CHI contributions can to a certain extent clarify this situation.

Table 9.19.

**Managers on CHI contributions, N=50**

		number of respondents	% of respondents
1	Earmarked tax	25	50
2	Ordinary tax	15	30
3	Rather social obligation	10	20

Table 9.19 demonstrates that managers in their majority treat CHI contributions as a tax, either ordinary or earmarked; therefore, they do not differ from other payments enterprises have to make. Only 10 respondents think of them as an expression of their social obligations.

Managers fail to comprehend that CHI contributions are, in fact, their input into the health care system, which supply services to their employees as well. The majority of respondents reject the idea of employees' right for preferential treatment in CHI (10 managers have no opinion on the matter) overlooking the

fact that enterprises' contributions amount to a significant share of CHI resources.

Table 9.20.

**Managers on the amount of CHI contributions, N=50**

		number of respondent s	% of respondent s
1	Increase	20	40
2	Remain the same	5	10
3	Decrease	10	20
4	Can't answer/ difficult to predict	15	30

Assessing what is likely to happen in the nearest future with CHI contributions few managers believe that they will remain the same while about one third find it difficult to predict (see table 9.20). Twenty respondents predict they increase while ten managers are of the opinion that they will decrease.

In their comments nearly all respondents have economic crises in mind. But they interpret it differently. The argument of those who think CHI contributions will increase is: "The state has no money -- it needs to raise more". It means that 20 respondents are quite sure that the state will first of all pursue its interest at the expense of enterprises. On the contrary, those who think CHI contributions will decrease suggest that "enterprises just can't pay more!»

The overwhelming majority of managers – 45 people -- do not think that employees should contribute to CHI. But five respondents who agree are concerned about how much employees should contribute. No one think that employees should pay more than employers. The answers are almost equally divided between "as much as employers" and "less than employers" with a slight prevalence of the latter (40 per cent and 50 per cent, accordingly).

Table 9.21.

**Managers on the role of enterprise in the health care system, N=50**

		number of respondents	% of respondents
1	An enterprise should pay for medical services for employees in case of emergency.	35	70
2	An enterprise could at its own discretion participate in voluntary health insurance in addition to CHI.	35	70
3	An enterprise could at its own discretion participate in health insurance programmes with the right to opt out of CHI.	25	50
4	An enterprise might provide medical services in-kind for employees with the right to opt out of CHI.	20	40
5	Budget medicine financed from general taxation should be preserved	15	30
6	An enterprise should participate in CHI as it is organised by the state at present.		
7	An enterprise is obliged by law to finance and administer its own health insurance plans with state-organised health care covering only some categories of population (disabled, unemployed).	10	10

At present enterprises participate in the state-organised CHI. However, there are several other options available (see Table 9.21). The most popular view shared by 35 respondents is that enterprises should help their employees financially in case of emergency. It is understandable as in Moscow many clinics, especially hospitals, officially charge for services they provide. Voluntary health insurance is also mentioned by 35 managers. Both choices, in fact, have one implication – managers do not consider any serious changes in enterprise position in the CHI system as both options imply that the system

of CHI stays unchanged while enterprises have to undertake additional measures to protect the health of their employees.

Quite a number of respondents think that enterprises should have the right to opt out of the system of CHI in case they either at own discretion participate in other health insurance programmes or provide medical services in kind for their employees. A relatively strong correlation between the two options should be noted (.408\*\*). It can be suggested that in both cases exit from CHI matters more for managers rather than concrete ways of doing so (either having own health centres or concluding insurance agreements).

Only five managers would prefer the most radical variant when an enterprise is obliged by law to finance and administer its own health insurance plans while the state-organised health care system covers only some disadvantaged groups of population (disabled, unemployed). In this case they are unlikely to pay employees for emergency medical treatment elsewhere (. - .509\*\*) or participate in voluntary health insurance in addition to CHI (-.509\*\*). Supplementary voluntary health insurance is also negatively correlated with paying for medical services for employees in case of emergency. Managers seem to believe that arranging for supplementary health insurance or financing and administering occupational health insurance plans will allow them to better care about the health needs of their workers who will not need to look for medical treatment elsewhere.

Managers' ranking of their views on the role of enterprise in the health care system is definitely quite instructive. Table 9.22 shows that 20 of them consider provision of health services in-kind with the right to opt out of CHI as the first option.

Table 9.22.

**Ranking of the responses presented in Table 9.21,  
number of respondents, N=50.**

<u>Rank 1 (first choice)</u>		<u>Rank 2 (second choice)</u>		<u>Rank 3 (third choice)</u>	
option		option	%	option	%
4. An enterprise might provide medical services in kind for employees with a right in such a case to opt out of CHI.	20	3. An enterprise could at its own discretion participate in health insurance programmes with a right in such a case to opt out of CHI.	20	1. An enterprise should pay for medical services for employees in case of emergency.	20
2. An enterprise could at its own discretion participate in voluntary health insurance in addition to CHI.	15	2. An enterprise could at its own discretion participate in voluntary health insurance in addition to CHI.	15	3. An enterprise could at its own discretion participate in health insurance programmes with a right in such a case to opt out of CHI.	10
5. The state system should be preserved, financed from the general budget revenues	10	6. An enterprise should participate in CHI as it is organised by the state at present.	10	2. An enterprise could at its own discretion participate in voluntary health insurance in addition to CHI	5
				4. An enterprise might provide medical services in kind for employees with a right in such a case to opt out of CHI.	5

Though voluntary health insurance is the most frequently mentioned option though only 15 managers choose it as the first or second preference and 5 managers -- as the third option. It is in an obvious contradiction with opinions of 45 respondents who do not plan to introduce voluntary health insurance.

But this situation might be better understood if one looks at a possibility for employers to participate in health insurance plans with the right to opt out of CHI. Twenty respondents rank it as the second and 10 as the third choice. It



may be suggested that an idea of having enterprise own programme appeal to managers as they already have experience of managing health services, the only difference being that now they provide health services in-kind rather than use insurance mechanisms.

Though the majority of respondents mention paying for medical treatment of employees in case of emergency, it is ranked only as a third option by 10 respondents. On the contrary, the idea that the old system, when health care was tax financed, should be preserved has rather strong advocates -- about 70 per cent of the managers who select this option place it as their first choice.

Ten managers do not see a need for any change; they think that enterprise should continue to participate in the CHI as it is organised at present. It, by the way, coincides with the number of respondents who believe that the place of enterprises occupy in the present CHI system is acceptable and they should continue just to pay CHI contributions (see Table 9.22).

Table 9.23

**Managers on their influence in CHI system,**  
number of respondents; N=50.

		To a great extent	To some extent	Very little	Not at all	Hard to say
1	Moscow CHI Fund	0	0	30	10	10
2	Moscow Department of Health	0	0	30	10	10
3	Local authorities in your area	0	0	30	10	10

Table 9.23 indicates that managers are very sceptical about their influence on the adoption of decisions by legislative and executive bodies, concerning participation of enterprises in health protection of their employees. Answers appear to be quite uniform. Thirty respondents mention that their influence on policy of such institutions as Moscow CHI Fund, Moscow Department of Health or local authorities in their area is very little while 10 think they have no influence at all. Share of those who find it difficult to answer this question is relatively big – 10 managers.

Table 9.24

**Managers on the need of employers' associations, N=50**

		number of respondents	% of respondents
1	This is the task of Federal and local Funds of CHI	25	50
2	It is necessary to better use organisations at the industry level	15	30
3	The creation of special associations in a new form is desirable	10	20

In managers' opinion, the special bodies should first of all settle health care problems; this is the aim of establishment of the system of CHI funds. The other half of respondents allows for more active role of enterprises and is divided into two groups. Some managers (15 people) are sure that better use of employers' organisations established at an industry level can help them to solve problems of employees' health protection. On the contrary, 10 respondents do not trust much already established organisations and speak in favour of creating new ones that will contribute to improvement of the situation.

Table 9.25

**Managers on functions of employers' associations, N=50**

		number of respondents	% of respondents
1	Representation of your interests on local level	30	60
2	Representation of your interest on national level on strategic issues	10	20
3	Nomination of employers' representatives to the Boards of CHI funds.	10	20
4	Administration and finance of local health plans	10	20
5	Use jointly local and ministerial health facilities	5	10
6	Organisation of commercial activities in health and health insurance	5	10
7	Promotion of international projects and links	0	0

Among the functions that employers' associations can perform, the majority of managers (see Table 9.25) mention, in the first instance, representation of their interests at a local level. They do not typically find attractive other activities such as representation of employers' interests on national level on strategic issues or nomination of employers' representatives to the Boards of CHI funds.

Administration and finance of local health insurance plans appeal to only 10 managers. Joint use of health facilities both local and enterprise-based, together with other employers appears to be least popular with them.

#### ***4. Enterprise-based Health Centres/Health Stations: Role in Occupational Health Care***

Managers' attitudes to enterprise-based health services are investigated with the aim to understand why they would stay despite the changes in enterprise and its environment, especially in enterprise-state relations.

Managers were asked to evaluate the influence of the health centres/health stations on the following processes in their enterprises (0 -- "no influence", 1-- "influence", 2 -- "influence very much").

Managers typically do not think that health services can help much to attract employees, but appreciate their role in retaining and stimulating workforce that is reflected in 100 per cent positive response rate (see table 9.27). These are the two most important functions of health centres mentioned by respondents. The third ranking factor is creation of a good employer image.

Table 9.26

**Managers on the role of health centres,**  
number of respondents, N=50

		No influence	Influence	Influence very much
1	Providing stimulus for employees	0	25	25
2	Trying to keep labour force	0	25	25
3	Attracting employees	30	10	10
4	Creating image of a good employer	15	30	5
5	Preserving enterprise traditions	40	10	0
6	Getting a tax relief.	45	5	0
7	Part of a recreation process	20	25	0
8	Constitutional right that goes with employment	20	15	10

Though 25 managers in general acknowledge that health centres contribute substantially to workers recreation, it is much lower than for the three first preferences. It looks that implementation of the rights of the employed for health protection is even more important because though it is also mentioned by 25 respondents, 10 of them believe that health centres contribute to this purpose very much.

Surprisingly, many respondents have almost ignored such function as preserving tradition. Managers do not feel enterprises are bound by the existing arrangements.

As Table 9.27 demonstrates, managers do not cast doubt on the very existence of enterprise-based health services and still want to provide health services in-kind. They would rather prefer to discuss practical things. The overwhelming majority (35 people) of respondents think that health services should be provided only for employees. Those having health posts even

consider a possibility to expand the range of services offered to workers who typically receive not only medical treatment but also medication free of charge.

Table 9.27.

**Managers on the future of enterprise-based health services, N=50.**

		number of respondents	% of respondents
1	Provide health services for employees only.	35	70
2	Expand the range of health services provided	25	50
3	Join CHI	5	10
4	Transfer them to local authorities.	0	0
5	Sell health care facilities.	0	0

The importance of health centres for stimulating employers strongly correlates with plans to expand the range of services provided (.600\*\*) while their significance in preserving tradition is positively associated with managers' intentions to offer services for employees only (.516\*\*) and negatively correlates with joining CHI (-.509\*\*).

Voluntary health insurance is not seriously considered, as 45 managers do not have any plans to participate in it in the nearest future. Only five speak in favour of joining CHI and nobody agrees that health facilities should be transferred to local authorities or sold out. It is interesting, cooperation with CHI system is closely associated with employers' belief that health centres influence process of workers' recreation very much (.395\*\*). It may be suggested that employers who are concerned with workers' health status are more inclined to use opportunities arising out of introduction of CHI.

### ***5. Managers' Attitudes: Factor Analysis***

To analyse the typical situations which stand behind the number of characteristics and attitudes of managers to CHI and their role in workers' health protection the factor analysis was performed. With the help of rotation

method varimax (9 iterations) five stable factors were distinguished which explained 80.5 per cent of information (1<sup>st</sup> - 17.662; 2<sup>nd</sup> - 35.023; 3<sup>rd</sup> -51.206; 4<sup>th</sup> -67.252; 5<sup>th</sup> -80.457). Both negative and positive correlations were analysed coefficients being considered as significant if more than 0.4 (see Table 9.28).

Table 9.28

**Rotated Component Matrix**

	1	2	3	4	5
Have competent opinion (Q.1.1)	.660			-.438	
Have an interest to know more (Q.1.2)				.910	
The development of CHI should not be accompanied by the decrease in the level of state financing (Q. 2.1)		.890			
CHI should be financed from local budgets as well as enterprise contributions (Q. 2.3)		.607	.531		
CHI should level the regional differences in health care (Q.2.5)		.715			-.443
Minimum health services should be guaranteed by the state (Q. 2.7)		-.740			
Decision of the shareholders meeting (Q. 6.2)		.545		.480	
Personal attitude of the director (Q.6.5)		-.632			.601
Financial status of your enterprise (Q. 6.3)				-.919	
Existence of health care facilities (Q.6.6)		-.514	.491		
Private health insurance companies are more interested in money (Q.8.2)					.742
Political instability (Q.9.2).	.977				
Lack of legislative regulations (Q.9.3)	.977				
Inflation (Q.9.5)			.614		
Incompetence of local authorities (Q.9.6)			.881		
Partially (Q.11.2)				.910	
To a certain extent (Q.11.3)				-.665	
(Q.13)	.515	.439			-.470
Attracting employees (Q.15.3)		.406	-.669		
Creating image of a good employer (Q.15.4)	-.626	.430			
Stick to tradition (Q.15.5)			-.853		
Part of a recreation process (Q.15.8)	-.416				.829
Constitutional right (Q.15.9)	-.780				.591
The present system is ok (Q.16.1)			-.446	.485	
Employers should deal with HIC directly (Q.16.3)	.501		.827		
Employers should choose between HIC (Q. 16.4)	.663				-.506
Employers should provide VHI (Q.16.5)		-.740			-.418
Have financial concessions in CHI (Q.16.6)			.663		
Ordinary tax (Q.17.1)	.804				
Earmarked tax (Q.17.2)	-.550	.584			
Social obligation rather than tax (Q. 17.3)		-.740			-.418
Budget system preserved (Q.22.1)				.465	
Participate in health insurance with the right to opt out of CHI (Q.22.4)	.444	.510	.423	-.428	

Provide medical services in kind with the right to out of CHI (Q.22.5)			.429	.618	.578
Pay for medical services in case of emergency (Q.22.7)			.476		
Discuss health related problems among managerial staff (Q. 25)				.743	
Reaching consensus (Q.26.1)		.831			
As decided by those in charge (Q.26.3)		-.831			
Serve only employees (Q.28.2)			-.428	.701	
Expand the range of services (Q.28.3)			-.626	-.650	
This is the task of CHI bodies (Q.30.1)			-.734		.521
It is necessary to make better use of industry health services (Q.30.2)	-.532		.679		-.439
Establishments of employers' associations is desirable (Q.30.3)	.977				
Representation at the national level (Q.31.1)				-.401	.632
Representation at a local level (Q.31.2)					.852
Nomination to CHI Fund Board (Q.31.3)		.607	.531		
Development of local health plans (Q.31.4)			-.434		-.666

Extraction method: principal component analysis  
Rotation method: Varimax with Kaiser Normalisation  
Rotation converged in 9 iterations.

#### First factor.

Managers have a competent opinion about CHI. They think that political instability and lack of regulations are two main obstacles that hamper the development of CHI. Provision of health services in kind does not by any mean influence the creation of image of a good employer, decrease of tax burden or recreation of labour force. It is important for an enterprise to deal with health insurance companies directly without intermediates and to have a right to choose between them. Managers consider CHI contributions as an ordinary tax. They think that enterprise could at its own discretion participate in health insurance programmes with a right in such a case to opt out of CHI.

In their opinion, there is no need to jointly use industry health programmes but creation of special employers' associations of in new forms is desirable.

#### Second factor.

Managers believe that introduction of CHI should not lead to decrease in the state funding of health care and health care system should be financed from regional budgets and enterprise contributions. They see the aim of CHI in

eliminating regional differences in health care. But this does not mean, however, that the state should guarantee provision of minimum health services and health care system should be built depending on financial status of regions, organisations and individuals.

Enterprise policy towards health centres is mainly influenced by the attitude of shareholders rather than personal position of directors or by the very fact of availability of health services. Provision of health services in-kind helps managers to attract labour force and create image of a good employer.

They consider CHI contributions as earmarked tax rather than social obligation.

Enterprise can at its own discretion participate in health insurance programmes with a right to opt out of CHI. At the same time employers should not buy voluntary health insurance for employees as supplementary to paying CHI contributions and supplying health services in-kind to employees.

Decisions on health care are taken by reaching consensus among managers but not by managers, directly in charge of the problem. In joining employers efforts to protect workers health nomination of employers' representatives to the Boards of CHI funds is the most important.

### Third factor.

Managers conceive that CHI should be financed from regional budgets and enterprise contributions. Development of health plans is influenced by the very fact of existence of health centres.

Decrease in enterprise profits and incompetence of local authorities affect negatively the process of implementation of CHI.

Health centres and health station does not help to attract employees or carry out enterprise traditions.

Employers should deal with HIC directly without any intermediaries. The existing system is not satisfactory: employers should not only pay CHI contributions but get financial concessions if they have their own health centres.

At that it is desirable that enterprise:



- participate at its own discretion in health insurance programmes with a right to opt out of CHI;
- provide medical services in-kind for employees with the right to opt out of CHI;
- pay for medical treatment elsewhere in case of emergency.

There are no plans to continue to serve only employees or expand the range of services provided. Managers consider it necessary to make a better use out of industry organisations. Nomination of employers' representatives to the Boards of CHI funds is mentioned as a function of associations of employers. However, managers do not support the idea of their participation in administration and financing of local health insurance programmes.

#### Fourth factor.

Managers know little about CHI and are interested to get more information. The development of the health centres is mainly influenced by the attitude of shareholders while enterprise financial status does not have any importance.

Participating in CHI as it is organised today employers fulfil health protection obligations towards employees to a large extent. Existing organisation of CHI is ok: employers should only pay CHI contributions. At the same time managers would rather advocate maintaining national health service financed from budget revenues. Such possibilities as participation in health insurance programmes or provision of medical services in-kind for employees with a right to opt out of CHI are rejected.

Health care problems are often discussed among managers. For the nearest future managers plan to provide medical treatment to employees only without expanding the range of services. They think that there is no need for employers to represent their interests at the national level in deciding health care issues.

*Fifth factor.*

The fate of health centre depends first of all on the director of an enterprise. It is seen as a real possibility of implementation of constitutional rights of the employed as well as a part of recreation process.

Managers do not trust private health insurance companies as they are more interested to get money and, therefore, their activities should be controlled.

It is not necessary for employers to choose between health insurance companies or participate in voluntary health insurance. Managers would prefer to provide medical services in-kind for employees opting out of CHI.

Health care problems are to be solved by federal and regional CHI funds. Representation of employers interests at the national and local levels are mentioned as the most up to day possibilities.

Table 9.29.

***Correlation matrix between factors and selected variables***

	FACTOR				
	1	2	3	4	5
Generator of ideas				-.401**	.632**
Concept developer	-.381**		.642**	.434**	
Expert-consultant	.977**				
Critic-opponent	-.298*	.352*		-.526**	-.592**
Head of development team			-.387**		
Diplomat				-.729**	-.420**
Centrist	-.365*				.564**
Conservative	-.315*			.465**	
Gender		.437**			-.560**
Age		.657**			-.461**
Education	-.804**			.309**	-.311**

The size of coefficients in Table 9.29 suggests a number of rather strong influences.

The first factor reflects opinion of expert-consultant with humanitarian backgrounds, who do not consider him/herself as a concept developer or a critic-opponents and is not likely to behave like a centrist or a conservative. It

can be considered as “a competency factor” when managers are sure they know the situation and can offer specialist advice on related problems.

The second factor positively correlates with critic-opponent style of young men. In his case managers seem to try to have quite a practical attitude towards health centres. They are ready to adopt new realities and think that they can really influence enterprise policies.

The third factor is positively associated with concept developer and negatively with head of development team. It can be described as “a factor of external influences” when a manager is taking into account events taking place in an enterprise environment.

The fourth factor corresponds with concept developer who has technical backgrounds. It can be referred to as “a factor of satisfaction / comfort” when a manager is content with the existing state of affairs. This factor is strongly associated with conservative style of behaviour. At the same time there is a negative correlation with critic-opponent and generator of ideas. Therefore, managers are not likely to be involved in promoting new ideas and change in their enterprises.

The fifth factor correlates positively with generator of ideas and conservative style of behaviour. Attitudes seem to be rather strong influenced by gender (women), education (humanities) and age (elders). It also has a strong negative correlation with diplomatic style of behaviour and critic-opponent method of participation in decision- making. It is a factor of “subordination” when managers are likely to share opinions and follow the patterns established by directors of enterprises

### ***Conclusions***

The survey was carried out to define the status of occupational welfare and particularly occupational health care in contemporary Russia. It was centred on principal issues that, in my opinion, in the long run determine conditions of occupational welfare provision.

Political, social and economic environment in Russia has undergone radical transformation during the transition period. It cannot but affect all

spheres of the nation's life. Health care reforms and, first of all, introduction of compulsory health insurance (CHI) have changed the scenery in which occupational health services operate.

The general opinion is that the state has to play, as before, the leading role in health care. It should guarantee at least minimum medical treatment through a new system built on the basis of financial resources of federal government, regions, enterprises and population. It is regarded inconceivable that the state may go so far as to privatise health services.

Though participants in the survey are convinced that the state financial allocations for health care should not be decreased, present alterations in the structure of health care funding are intended to use CHI contributions from enterprises as compensation for factual downfall in the state financing.

These developments determine the role of enterprises in the national health service and occupational health care. Respondents in the survey think that there are two institutions in society that should bear responsibility for the health status of the employed -- the state comes first, enterprises second. Enterprise contributions to CHI are, in fact, a very substantial input into financing the national health care. The majority of respondents treat these contributions as a tax, which does not differ from other obligatory payments.

The survey has revealed that the majority of respondents are in principle in favour of providing health services in-kind for employees but the degree of doing so is a matter of controversy. Occupational health care is considered a supplement to CHI that is not enough to secure good health status of employees.

Respondents seem to be very cautious in evaluating overall participation of enterprises in health protection of the employed; their position has not yet taken a final shape. There are, for instance, unsolved problems in relationships with CHI (amount of contributions, the right to opt out of CHI in certain circumstances, financial concessions in CHI payments in case they organise own health care programmes, participation in voluntary health insurance).

The interviewed are very sceptical about enterprise influence on adoption of legislation and executive decisions concerning their participation in the field of health care.

Enterprise-based health centres/health stations are the core of occupational health care in Russia. In spite of criticism for allegedly being a manifestation of paternalism and economic efficiency, pressure on the part of government to divest social facilities and financial difficulties there are enterprises that still maintain health centres and even intend to expand the range of services provided to employees. Impression is that chances of health centres to survive surpass those of some other occupational welfare components.

## **Chapter 10**

### **Case Studies of Two Moscow Industrial Enterprises**

Chapter 10 describes general characteristics of the two enterprises and their management as well as functioning and funding of health centres. It sets out to explain, by comparing and contrasting the two cases and resorting to some additional relevant evidence, perspectives of health centres which chances to survive in a new environment seem in absolute and relative terms to surpass those of other social services as indicated by empirical evidence provided by various surveys. Special attention in this chapter is paid to such unexplored issue as managers' explicit and implicit self-interests in maintaining employer-provided health care.

In the course of the survey it became obvious that a questionnaire was not a sufficient instrument of collecting full information on managers' attitudes to occupational health care. Observations and informal comments of respondents showed that there were some hidden agendas, which could not be revealed by means of structured interviews. It transpired that motives usually emerging in surveys were likely to be manifestations of only a limited number of phenomena deeply rooted in the life of enterprises. It is a result of shortcomings of survey as a method of social research rather than ill will of managers. Therefore, I have decided to turn to case studies. Though covering only two enterprises, they enable to analyse managers' attitudes "in depth". Other researchers used such an approach. For example, after completing a wide scale survey of Russian industrial enterprises Dolgopyatova (Долгопятова, 1995) came to the conclusion that survey should be combined with case study as another method of social research affording an opportunity to comprehensively explore enterprise functioning in concrete circumstances.

One of the main objectives of the studies was to better understand managers' motivation in favour of provision of health services by enterprises.

This chapter is a logical continuation of empirical research which outcomes have been previously analysed in the thesis. Two Moscow industrial enterprises were selected for case studies because, first, they both had health

centres and were well known for commitment to workers' health protection, and, second, their senior managers displayed interest in the research. The information was obtained through interviews with managerial staff, study of enterprises' accessible records and publications in the press.

### **1. Case One: Kroct**

#### General characteristics of factory and management

Kroct is a well-known Moscow confectionery factory. It was founded in 1887 at the bank of the Moskva river in the centre of Moscow just opposite the Kremlin. In the early 1997 Kroct employed 3,100 people.

Kroct is a true Moscow factory: it is situated in Moscow and sells 75 per cent of its products in the city making 30 per cent of its market share. The factory covers 6 per cent of the national market, about the same part of the output is exported to countries outside the CIS.

During privatisation campaign in 1991-1992 Kroct was turned into an open joint stock company. Employees chose the variant of privatisation according to which they bought the controlling package of shares (51 per cent of the authorised assets) at lower prices. In its determination to stay independent the factory still adheres to this policy: it turned down a good outside investor, as the management did not want him to get a control over the factory.

Table 10.1

#### **Composition of Kroct shareholders, % of votes**

<u>Shareholders</u>	<u>% of votes in 1997</u>
Employees and management	30.7
Moscow government	19.7
Foreign shareholders	25.3
Russian legal entities	24.3

Source: Kroct records

10,000 individuals and 150 legal entities hold Kroct shares, the Moscow government being one of the major shareholders. The enterprise is controlled

by the management, which is backed by employees and the Moscow authorities. Several issues of shares were carried out without any scandal. As the Moscow government trusted its shares to the Kroct director (he is on a friendly footing with the Moscow mayor and actively participated in his last election campaign) it can be assumed that the management controls at least forty per cent of votes.

Kroct is a successful enterprise. In 1996 it produced 55,000 tons of various brands of chocolate and its profit reached 22 millions USD. The market value of Kroct is about 220 millions USD. Its market strategy is quite aggressive, basing upon expansion of market share and production under its trademark. Therefore, Kroct invests in production, extension of distribution networks and purchase of other companies' shares. Much attention is paid to advertising as competition in the industry is becoming very tough.

Kroct has started to make investments in other factories in confectionary industry aiming at creating a concern. The factory already owns more than 50 per cent of shares in 12 subsidiaries and has minor interests in 25 other enterprises.

The intention of the management is to produce traditional Russian chocolate. Allegedly it differs from Western products and is preferred by the Russians: it indeed is very popular all over the country as one of the best in the product line.

The chairman of the board of directors is a man in his early sixties who started his employment career in the factory and worked his way up to the top management. He is a clever, ambitious and energetic person with a scientific degree in engineering. His progressive vision of the future helps to work out strategic plans of the factory development. Managers often refer to him as the driving force of many successful undertakings. He is businesslike and in early 1990s he knocked together a team of managers -- former factory's employees - many of whom had underwent special training and then returned to continue to work in the factory.

Kroct has a good reputation for the way it treats employees. There have never been any delays in payment of wages that under the present Russian



conditions is a considerable achievement. Wages are higher than industry average. Workers usually receive bonuses every month plus special bonuses by the end of the year depending on profits.

The management view social benefits as a means of securing normal employment climate in the factory and stimulating employees to work better. It understands the importance of human assets and, as one of managers said:

“Of course, output is important but people who are the foundation of the factory, working for its success, are important, too.”

The management takes measures to retain workers who bring profit and prosperity to the factory. Social services for workers are seen as an effective instrument of reaching this aim. There is a special manager appointed to supervise enterprise social activities -- deputy director on personnel and social services.

He is a professional Soviet manager and a new person in the factory. He is in late fifties and represents the "old directors guild» consisting of managers who made their careers in the Soviet times. For many years he held different managerial posts in a big meat-processing factory in Moscow. But when his factory was bought out by a bank he resigned as he disagreed with the bank's policy "destroying the factory". For him it goes without saying that employers should offer social support for employees.

Kroct provides a number of social benefits to its employees. For example, consumer goods are purchased in market and then sold to workers at wholesale prices. The factory has a developed social infrastructure, including a canteen, a crèche, and a health centre. Kroct owned these social assets for a long time except a health centre that was opened only in the early 1990s.

#### Functioning and funding of the health centre

The health centre, including a polyclinic and a rehabilitation centre, was set going after the process of transition to a market economy had already started. The Chairman moved the proposition.

Until 1993 the health services for factory's workers were provided by the health centre (*medsanchast*) No 29 financed by the Moscow health authorities to ensure health care for employees of nine enterprises. It was at a distance from the factory. When the Moscow government ceased financing most of health centres for industrial workers Kroct decided to build up its own one. There were several reasons for it.

Poor working conditions in the factory were one of the main arguments in favour of such a decision. Managers acknowledged that it was not easy to work in shops. Premises were old, many production processes, despite investment in modern equipment, still required physical labour. Labour process was very monotonous, often harmful to the health of workers. But because some technologies would necessitate manual labour for some time, management felt responsible for keeping up workers' health.

Another reason was that in accordance with the state regulations the health of food industry workers should be periodically checked and newcomers should undergo medical examination at the expense of the factory. With a health centre on premises it was easier to handle the problem.

It is worth noting that Kroct managers rather negatively regard the role of the state in provision of medical treatment to people. They stress that the state definitely wants to minimise its responsibilities. For example, the Deputy Director on personnel and social services put it in the following way:

"..there is clear evidence that the state will be spending less on health services, providing only legislative framework for their development. We need to be prepared for this".

The head of the health centre is an energetic man in his forties who advocates market-oriented reforms. He shares the ideas of the chairman and supports him in his endeavour. He is medical doctor: before coming to Kroct he worked in *medsanchast* No 29 mentioned above. Now he has no medical practice and is engaged only in administrative work. He does not express any doubt in the factory running a health centre that many apologists of free market would think undesirable.

Such an attitude is typical of Kroc managers. For them market economy means first of all new opportunities in organisation of the factory life and its relations with environment.

Now the policlinic provides health services to about 9,000 people -- workers, their dependents and patients on fee for service basis. The health centre includes a policlinic and a rehabilitation centre. In the policlinic a wide range of services is provided, including consultations on seventeen specialities. dental care, laboratory tests, physic-therapy.

The health centre has two lines of accountability: it reports to the Kroc chairman and simultaneously follows instructions issued by health authorities including the Ministry of Health and Moscow health department. Medical staff is on factory payroll and is covered by the same system of bonuses as other employees (thirteenth and fourteenth monthly payments; monthly bonuses; special bonuses). Doctors have equal rights with other employees and are doing relatively better than their colleagues in local polyclinics.

Equipment of the Kroc polyclinic is really modern -- latest technologies, some of them unique even for Moscow. It is bought at the expense of the factory from net profit. Today to maintain the health centre is not profitable but the management is sure that strategic policy of making investments aimed to build it up will pay off. The policlinic is situated on factory premises that are very convenient for employees who can drop at it during the break. Managers use its services quite often, too.

The rehabilitation centre is situated ten km south east of Moscow in a prestigious holiday area called *Novo-Peredelkino*. 12,000 sq. meters premises on 39 hectares of land consist of two bedroom apartments with all modern conveniences. It provides a wide range of different services such as massage, water therapy, inhalation, etc. Sporting equipment can be hired.

The strategies for which the factory is well known in business are also applied to development of the health centre as an integral part of the enterprise. Kroc does not want any partners in carrying out its activities, so that it can stay independent and managers take decisions themselves as real businessmen.

It is naturally reflected in Kroct health policy of unwillingness to cooperate with near-by enterprises on health issues. Factory contributions to CHI amount to two billion roubles a year. Managers do not see a need to influence the state health policy but they are convinced that the factory should care about health of its employees. Now the factory covers all health centre expenses. It is intended to make use of the existing situation in factory interests. Kroct management is sure that in the new environment health services will have to compete for resources and patients. Managers seek any opportunity to get money for the health centre. Therefore, it has been decided that Kroct should act quickly to occupy a niche in health services "market". The underpinning idea is to finance the health centre from the Moscow CHI fund and fees for service.

Health services working in the CHI system are compensated from the CHI fund for medical treatment provided in accordance with the Moscow CHI programme. The system functions quite simple: more patients you have -- more money you get.

The factory wants to sign an agreement with the Moscow CHI fund, which seems to be reluctant to do so undertaking different manoeuvres to postpone it. The main reason is evident enough: every time a new health service enters the CHI system the fund will have to apportion its money between a bigger number of health services that means lower compensation rates. But deputy chairman and head of the health centre are optimistic about the prospects and think that "reaching this agreement is only question of time" because factory's intention fully complies with legislation in force. The only problem is the size of its health centre. To join CHI it needs to have a licence, which is issued to a health service supplying compulsory standard set of medical treatment. It might be too much of a burden for a not-very- big enterprise.

Solution is seen in providing health service to population. In Kroct area there is no good polyclinic. When Kroct joins CHI local people would only need to have CHI policy. Besides, there are a few factories around without health services. When in 1996 the Ministry of Health adopted special regulations stipulating that employers in industries, where working conditions were harmful

for health, should arrange for an annual screening of personnel Kroc managers immediately spotted an opportunity to receive money from near-by factories in case their workers get services and undergo compulsory annual screening in Kroc polyclinic.

It is a modern one, the staff is well qualified and attentive and, therefore, managers hope it can attract clients. Besides, though polyclinic is on the factory territory, it has a separate entrance and is easily accessible to general public: a patient does not need to enter the factory in order to get to polyclinic. It is planned that Kroc health service owned by the factory will operate as a local polyclinic. Thus, it will be able to provide high quality health services for workers and, at the same time, to get extra resources from treating other clients to cover the expenses on medical treatment of factory employees.

Kroc health centre also works on fee-for-service basis charging for certain services not included into the Moscow CHI programme. For example, the polyclinic has right to carry out medical checks necessary to get a driving license. For some categories of population -- pensioners, low-income people-- special rates are fixed.

## **2. Case Two: LIZ**

### General characteristics of plant and management

LIZ was founded in 1926 and was one of the biggest industrial undertakings in Russia and in Moscow by the 1990s employing about 40,000 people.<sup>4</sup> It is a modern diversified trucks producing enterprise with the full production cycle: from materials and parts to assembly of trucks.

LIZ was among the first Russian enterprises turned into joint stock companies in accordance with the voucher privatisation plan. Employees voted for the variant of privatisation under which they got less than half of shares free others being sold at open auctions. As a result, outsiders bought quite a bulk that led to a lengthy controversy between them and management. This struggle is one of many examples of attempts of industrial enterprises

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<sup>4</sup>LIZ incorporates a number of companies in different Russian towns. Under "LIZ" in this study the Moscow plant is understood.

managers to prevent outsiders from acquiring significant influence over the respective enterprises.

By the late 1996 the Moscow government became LIZ major shareholder. It got quite poor inheritance: the plant was going through hard times. Extremely difficult financial status brought it to the verge of bankruptcy several times. An extraordinary event happened in 1994 -- for the first time in its history LIZ had to stop production lines. Such practices as four days week and compulsory vacations were introduced and production having been steadily shrinking lay-offs were started. As a result the number of employees decreased substantially.

Management style at LIZ practiced by its first director who held that post for about 25 years was always very personal. Senior managers were supposed to visit shops, to shake hands with workers and to know the old cadre by name. Such a partnership was based on the idea that all people working in the plant -- from director to worker -- were equally important contributing to prosperity of the country. The Soviet state set a priority goal to create an efficient automobile industry in the country competitive in the world market. It was one of the fast developing industries and LIZ played the key part in the process its success being not only of economic but, first of all, of political importance. That was one of the reasons why newcomers failed in their attempts to introduce an "impersonal", businesslike style of management.

In LIZ working conditions in many shops were harmful to health (dust, vibration, high temperature). Therefore, the plant extensively employed people from different parts of the country who were attracted by a possibility to move to the capital where living standards were better than in other places. After several years work they were, as a rule, given permission to stay in Moscow on a permanent basis.<sup>5</sup> It was for these people that enterprise social services, especially housing, were vitally important.

LIZ workforce was quite specific for Moscow enterprises. Up till 1994 about 20 per cent of workers were short time (employed for 2-6 months). In

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<sup>5</sup> In the USSR there was a system of *propiska* when a person was registered with local authorities and had a stamp in his passport. The easiest way to get *propiska* in Moscow was to take the job in Moscow industrial enterprises.

general, the labour force used to be quite stable: the majority of workers and engineers worked in the plant for quite a long time (71 per cent for over ten years, including 52 per cent -- for more than 15 years). But in the mid 1990s labour turnover began to increase (14.5 per cent in 1996).

The level of occupational and general sickness among LIZ workers is rather high and no apparent downgrade tendency is observed. The share in illness of temporary workers is almost twice as high as that of permanently employed.

It is significant to keep in mind that: some performance indicators of LIZ health centre are better than in the local health system; despite high level of referrals the number of people who became disabled is small, anyway much lower than Moscow average.

#### Functioning and funding of the health centre

LIZ used to have a vast social infrastructure. It owned the whole spectrum of social assets -- housing, dormitories, kindergartens, etc. Since 1991 financial problems grew like a snowball and many social services were transferred to local authorities, first of all housing stock and kindergartens. But the health centre stays with the plant and though its relations with LIZ have changed it is still referred to as "LIZ health centre".

The health centre is a big health service employing 1,300 people, well equipped and fully staffed in accordance with the state standards that allows it to provide high quality specialist care.

Table 10.2

**Number of personnel in LIZ health centre, 1997; numbers**

	Number of staff positions			
	according to the state regulations		actually occupied	
	total	including polyclinic	total	including polyclinic
Doctors	424	190.25*	423.5*	187.0
Nurses	878.25*	350.0	868.0	343.0
Other staff	471.5*	75.0	435.0	75.0
Total	1959.0	622.75*	1903.25*	612.5*

\* It is common practice in Russian health services to divide one post between several people on a part-time basis to increase salaries of medical staff.

The health centre includes:

1. polyclinic - 4,500 visits per day (in two shifts), including dentist service;
2. *ambulatoria* in one of the main plant's branches - 320 visits per day (160 visits per shift);
3. hospital for 1,400 beds, including emergency unit;
4. three doctors' health stations;
5. 12 health stations.

It is one of the specific features of LIZ health centre that it keeps the Soviet standards by running 12 health stations in the plant shops. A health station team typically include a paramedic and several nurses.

The management of the LIZ health centre consists of an executive director and two deputies: one is in charge of the polyclinic and health stations, another – of the hospital and the emergency unit (see figure 4 in Appendix A)

LIZ health centre started in 1926 as a small health service with two doctors and several nurses and paramedics. Since that time the health centre developed together with the plant: new buildings were constructed, number of personnel increased, modern equipment bought. In the 1970s it was decided to build a hospital. LIZ and another Moscow automobile plant, which later



withdrew from the partnership, financed the project. A new hospital for 1080 beds opened in 1981 was well equipped and could provide a full range of medical treatment. By 1994 the organisation of the health centre had improved: one more building to extend its premises was constructed; each section in the polyclinic (*uchastok*) was made to cover less workers (one for 1,600 workers); reception and registration systems were improved with IT, every plant employee got a personal number; two new wards -- psychiatric and oncology -- were opened.

Today LIZ hospital has several wards each for 60 beds, including two cardiological, general surgery, neuro surgery, cardio-vascular surgery, gastrointestinal, gynaecological, urological, eye surgery, trauma and orthopaedic. It works in close cooperation with several Moscow medical universities, which use LIZ hospital for training and research.

The hospital differs favourably from other health services in the capital as it:

- has good equipment bought by the plant;
- supplies services all day long so that patients can be referred to the hospital at any time;
- provides services for local population of the south district of Moscow: every day a local polyclinic can refer 30 patients to LIZ hospital;
- is on duty in the city one day a week when emergency patients can be referred to it.

The polyclinic with capacity of 4,500 visits a day is situated in the plant territory and employs consultants of nineteen specialities. About 75 per cent of patients can get a full course of treatment there including:

advice of well-known consultants;  
recommendations on work regime;  
referral to recreation services.

The health centre used to be financed by the Moscow authorities via the department of health. But LIZ also contributed quite a lot paying for:

- new equipment;
- maintenance and repair expenses (buildings, equipment);

- electricity and gas;
- transport and gasoline;
- catering services;
- extra 25 per cent of the health centre payroll.

LIZ health centre was of a "closed" type offering treatment to employees and, therefore, inaccessible to local people. Now it has more freedom of action. In general, the share of outsiders has been increasing but LIZ workers definitely enjoy preferential treatment.

In the early 1990s LIZ health centre set about to conclude agreements with voluntary health insurance companies. Later it entered the CHI system to become one of the first enterprise-based health services operating in it. LIZ management established working connections with the Moscow CHI fund.

Relations between LIZ and the health centre changed. In 1995 LIZ health centre was transformed into a non-commercial medical fund "*Medsantchast N1 AMO/ LIZ*" with LIZ as one of the founders. It is now an independent legal entity controlled by a special Council. The latter consists of five members representing the Moscow government (now it is one of the former LIZ directors); LIZ; Moscow Medical Academy, LIZ health centre and a CHI company.

The health centre has got more freedom of action especially in matters of earning extra money. It has led to a certain downfall in the number of LIZ patients in the hospital: unlike the polyclinic that still treats mostly LIZ employees being situated in plant territory entrance to which is only on a special permit, it also provide treatment to outsiders. As a result the share of LIZ workers among the hospital patients decreased to about 55 per cent. At the same time it should be stressed that LIZ employees continue to enjoy preferential treatment -- they are the first to be served and get all the services free of charge.

The health centre values its relations with LIZ very much. The plant fulfils previous financial obligations except granting extra percent of wage supplement. It puts the health centre in an advantageous position in comparison with other health services in Moscow. Its management does not

need to care much about many financial problems whereas funding capital expenditures, food, electricity and gas, etc., is a headache for local health services because local authorities being short of funds are usually reluctant to fully cover these expenditures.

Health stations are a good example of special relations between LIZ and the health centre. According to CHI regulations, only health services supplied by organisations with a licence can be compensated. Therefore, the Moscow CHI fund does pay for services provided by health stations. But LIZ management knows that LIZ workers need them. So, the health centre in spite of financial difficulties still maintains 12 health stations based in the plant shops, redistributing wages of its personnel to pay the stations staff which typically consists of a paramedic and several nurses.

LIZ management actively participates in the running of the health centre and is always aware of its problems. LIZ obligations to the health centre are discussed and approved every year at annual joint meetings of the plant managers headed by its Chairman.

### ***3. Evidence from the Case Studies on the Future of Health Centres***

#### **Are these cases unique?**

Information on Russian industrial enterprises engaged in occupational welfare is scarce. Only a few case studies instrumental in explaining why employer-provided health services are likely to survive are available. Among recent ones are those by Gough and McMyllor (1995) and Clarke (1996). There are some other examples definitely suggesting that the two cases are not unique. The following is taken from Kabalina (1996) case studies on ore enterprises in Central Russia. Their aim was to analyse how internal and external control affected enterprise restructuring. The conclusion was that a widely accepted assumption that insider control might negatively influence restructuring was not necessarily true. One of the studied enterprises was internally controlled; nevertheless, it proved to be entrepreneurial and successful. Its achievements were not impeded by the fact that the enterprise kept all its social assets, including a health centre.

The enterprise described by Kabalina is very similar to Kroct as it is profitable, has good performance indicators, and discloses a high potential for innovation. Social assets do not prevent it from being competitive in market, investing in production and employees' health as well. Both enterprises have good financial status, despite developing social assets even during the transformation period. They have money to spend on social programmes and are ready to do so. Their directors and management have a strong positive attitude to employer- provided health services.

The only noteworthy difference between the two enterprises is their relations with local communities, which are determined by peculiarities in geographical location. Kroct is a not-very-big enterprise in the metropolis with developed social infrastructure. The other one is the main employer of about 16,000 workers in a small town. It feels responsible to local community and is closely tied to local authorities on social matters while Kroct tries to make commercial use of neighbourhood.

As to LIZ it has a distinctive feature: it definitely can count on the state support. It is one of the biggest industrial establishments in Moscow and a general belief is that the state will never let it go bankrupt. A few government decrees have recently been passed to help LIZ; a possibility of granting it tax concessions has been actively discussed. But its attitude to the health centre is similar to that of the two enterprises mentioned above. The Moscow authorities have been urging LIZ to sell social assets to raise additional funds for restructuring. Nevertheless, LIZ management does its best to resist it in order to preserve the integrity of the plant as well as its image of good employer well known all over the country. This, in fact, runs against speculations that Russian industrial enterprises can use social assets to get subsidies from the state.

#### Differences between Kroct and LIZ

On the surface the two cases are of discrepant nature. Kroct and LIZ belong to different industries and their workforce varies. The first enterprise employs 3,000 people and is quite prosperous. It wants to fully control its

health centre, which has been built up quite recently, and to make commercial use of it. The second is a large enterprise with about 40,000 employees, in a financial quandary but with prospects to improve its performance. It tries to keep a traditionally functioning health centre now getting more independence from the plant and working in close co-operation with local health authorities.

Kroct is definitely internal-oriented. It considers the Moscow government to be rather a source of funds than a partner. The role of the chairman is important since he has not only got a very influential personal standing in the enterprise but also managed to gather around a team of subordinates who share his vision and fully support him in all undertakings.

LIZ, on the contrary, is open to cooperation and sees a partner in the city authorities. It is not surprising because the plant needs investments badly in order to overcome deep recession. The director and senior management do not play too great a role, moreover, during the 1990s LIZ directors changed several times.

#### Similarities between Kroct and LIZ

But in spite of differences, there are many similarities between Kroct and LIZ. Both are old enterprises founded long before economic reforms started. They have well equipped health centres providing high quality medical treatment and are proud of them. Health centres are more important for enterprises than other social assets: Kroct having other social arrangements definitely favours its health centre, LIZ having divested of most social assets tries to find ways to keep its health services.

The matter is that, first, it is recognised that working conditions in both enterprises are damaging to workers health and it is unlikely that they will improve in the nearest future. Providing health care for workers to some extent compensates bad influence of these conditions on their health status.

Second, the Moscow health system is in such a state that, as a rule, it fails to ensure reasonable health services for the Muscovites. Therefore, workers of Kroct and LIZ are likely to face considerable difficulties in getting quality medical treatment through that system.

Third, both enterprises have already invested a lot of resources in health centres turning them into modern establishments and they are not at all interested in transferring them free of charge to local health authorities. Kroct and LIZ are more inclined to earn money to finance their health centres or, to put it the other way, to gain profit from their operation. Attempts have already been made to find the ways that would help to go on providing free medical treatment to employees.

While acknowledging responsibilities of Kroct and LIZ for their workers health, managers understand that health centres cannot survive in the old form, which has to be changed. In looking for new means to make efficient use of health centres two major possibilities to raise additional funds have emerged:

- to join CHI;
- to charge fees for services.

The case studies show that both enterprises are ready to cooperate with the state health system as one of the main opportunities for health centres to survive. Such collaboration seems advantageous for both parties. Participating in CHI guarantees enterprises a substantial financial support as the CHI fund covers the provision of medical treatment. In 1997 a new scheme of CHI finance flows was introduced in Moscow -- the Moscow CHI fund accumulates only employers' contributions while the Moscow authorities contributions go directly to the city health budget. Enterprises, on their part, continue financing capital investment thus taking off some of financial pressures on the Moscow health system.

In these circumstances managers have a space for manoeuvre: now it largely depends on them to choose a right decision in searching for effective ways of solving problems related to health centres. The two cases discussed give evidence that it is possible to do in a new environment using opportunities that it offers in the field of health care for employees

Modern market ideology has come to Russia with its liberal claims that social welfare should not be included into enterprise responsibilities. Russian industrial enterprises are often criticised for being over-paternalistic and senior

managers compared with kings. Proponents of market-oriented reforms view paternalism quite negatively as a remnant of the Soviet past. Their choice is liquidation of social assets that would allegedly improve financial status of enterprises.

But Kroc and LIZ experience shows that it is possible to be both paternalistic and entrepreneurial. Their management policy towards health centres is, in fact, a kind of a merger of old traditions originated back in Imperial and Soviet Russia and a newly born market ideology.

#### Employer-provided health care and managers' self-interests

Importance of occupational health benefits for workers and enterprises is well examined while distinct interests of one more stakeholder -- managers-- are left aside. It is quite understandable that having their own ambitions, power, etc., they acquire personal interests — otherwise self-interests — which may differ from those of other major enterprise stakeholders. Very little is said about them getting personal benefits out of provision of health care. Transformation of social and economic situation threatens the very existence of industrial enterprise as social organisation that cannot but affect managers. Therefore, it seems appropriate that including managers self interests alongside pragmatic-profit and social-paternalistic motives as presented in Table 2.2 should expand summary of motives for provision of occupational welfare from organisation perspective. (see Table 10.3).

Table 10.3

**Organisation interests in occupational welfare – revised**

<b>Pragmatic-- Profit</b>		<b>Social-- Paternalistic</b>	
production	employers' economic gains	employers' social gains	employees' welfare
Managers' self-interests			

Source: compiled by the author.

The case studies have confirmed that managers' self-interests are of a distinct nature and can be divided into explicit and implicit ones.

Explicit self-interests are the ones managers have as all other enterprise employees including the possibility of getting medical treatment. In the two cases managers actively used health centres.

In fact, in Russian industrial enterprises managers as well as workers benefit personally from occupational welfare. It may often be as important for managers as for workers since their wages, especially of middle managers, usually differ insignificantly. They face the same problems in communities where shortage of some social facilities might arise. For example, even in Moscow to have a possibility to receive medical treatment in their enterprises is equally attractive to managers and to workers because the city health care system suffers from a lot of deficiencies.

In connection with this Gough and McMyllor (1995) mentioned managers' abuse of power when they get extra benefits. But it should be noted that this is not only the case of Russian enterprises. The difference between Western and Russian organisations is that in the West such practices are institutionalised and managers can officially have preferential treatment in occupational plans while in Russia they have a touch of "illegality" in a sense that typically all employees formally have equal rights but managers using higher status actually get more.



Implicit self-interests are the ones connected with exercise of power: health centres contribute to building up managerial power.

Power is a notoriously elusive term to identify within organisations. It is not captured in formal organisational charts and is insufficiently studied in organisational literature. Research that does exist on power concentrates on the very existence of the phenomenon, taking formal organisation and deeper power relations for granted. It makes Thompson and McHugh (1995) to note that power is a hidden agenda when managerial prerogatives are stressed.

Power is usually defined as ability to exert actions that either directly or indirectly cause a change in behaviour or attitudes of other individuals or groups. Power is derived from an individual's standing in division of labour and communication system of organisation, namely:

- official position in an enterprise;
- personal characteristics such as self-confidence, sensitivity, etc.;
- control over resources.

The notion of power presupposes:

- ability to get something one wants;
- dependence of others upon the resource one controls and lack of its alternative sources.

Therefore, health centres ought to be discussed as a source of managerial power. I suggest that this notion in connection with employer-provided health care has two dimensions — political/economic and structural/spatial.

As far as political/economic aspect is concerned it is displayed in managers' control over workers.

In an attempt to explain provision of social services Clarke (1996) explored the social structure of an enterprise arguing that both workers and management wanted to keep the same mode of relations of production. He mentioned that during privatisation in the course of which labour collectives were to have preferential treatment management used social services to keep their influence over an enterprise. It was a part of social contract between employers and employees when availability of social benefits was exchanged

for workers' loyalty and support of administration of an enterprise. After all, managers ought to manage and should be allowed to do so.

Gough and McMyllor referring to Polanyi (1944) came to the conclusion that

"enterprise welfare was an integral part of the ministerial organisation of economy and of the provision of welfare in state socialism. It was securely embedded in an economic system which in turn was embedded in a cohesive set of social relations." (Gough and McMyllor, 1995:38).

The case studies revealed that the major difference between health centres and other social assets is that health services are most employees targeted. Occupational health care is basically supplied to workers of a particular enterprise whereas studies on enterprises housing stock, for example, found out that many tenants did not work in enterprises, which owned it. The same is often the case with kindergartens. Therefore, health centres influence social relations in an enterprise in a much more fundamental way.

The structural/spatial dimension stems from the fact that managers exercise their right to manage within certain domain.

Health services are situated within the boundaries of enterprises shaping their territories. Managers make everything possible to have intact these boundaries within which they can exercise their power. Russian industrial managers are likely to measure their power in terms of quantity / size rather than quality / profit. This tendency may be even reinforced when enterprise discretion in running health services increases.

This is one of the explanations why managers tend to consider health centres as an inseparable enterprise component. It actually questions a widely held assumption that social assets can be quite easily separated from an enterprise without damaging it. Enterprise general strategy is applied to health centres as well. Managers of the two enterprises do not regard them as additional trouble or headache. Thus, trying to preserve enterprise as a unit where their power is embedded managers are in favour of health centres. In attempts to adjust to a new environment problems related to health centres

are incorporated in enterprise general strategic development plan with the motto: if enterprise survives then together with a health centre.

### ***Conclusions***

The main conclusion to be drawn from the case studies is that they have confirmed the principal findings of the previous chapters on employer-provided health care providing an opportunity to discuss several issues in more detail.

Case studies present examples of enterprise that keep their health centres and want to further develop them. They demonstrate that occupational health care has a great potential to adapt to new realities and, thus, survive in a transformation. Both enterprises are among those that consider cooperation with the state health system as one of the important elements of their strategy of maintaining health centres. They realise that entering CHI can be of a substance support of their health plans. At the same time case studies confirm the survey's conclusion that managers fail to display political vision and their activities are definitely limited by enterprise boundaries.

The case studies enable to introduce into the research on occupational health care such an important subject as managers' self-interests.

Traditional interpretations of managers' attitudes to occupational welfare leave no place for their self-interests be they of economic or social nature; they form a hidden agenda that is very unlikely to be reflected in surveys. One can hardly expect personnel and social welfare managers to openly admit, for example, that they use health services to obtain any personal gains or are ready to advocate enterprise health services in order to keep their positions. Indeed, the more social services are provided by an enterprise — the more influential managers who administer them. It is much easier for managers to choose among socially acceptable and legitimate variants.

It should be stressed that managers are not fully aware of personal social and economic gains they can get out of employer-provided health care and have difficulties in clearly articulating their interests as members of enterprises. No wonder that though traditional motives like production and employees' welfare are very likely to be important for managers they can be

interpreted differently and are by no means straightforward. For example, paternalism can be also viewed as a means of managers' self-realisation.

In case of occupational health care such managers' self-interests as maintaining political and structural power within enterprises can not but principally coincide with interests of all enterprise stakeholders, thus reinforcing other economic and social considerations in favour of health centres. The latter, in fact, become points of crossing of interests of all enterprise members. The finding of common grounds between various stakeholders, including society at large, contributes to building up the integrity of an enterprise as social organisation leading, in its turn, to continuity in provision of health services for the employed. The case studies show that managers play a significant part in defining health policy of an enterprise and their self-interests, both explicit and implicit, facilitate taking decisions to keep occupational health services.

## Chapter 11

### Some Topics Ensuing from Empirical Evidence

As a follow up of the empirical evidence examined in Chapters 9 and 10 it is instrumental to return to some topics explored elsewhere in the thesis. Those are the state-related problems of occupational welfare, compulsory health insurance and occupational health care, reasons for employers to provide social and health services to employees, health responsibility and enterprise/house ideology of managerial staff and perspectives of health centres survival and development. In addition to the analysis of empirical evidence gathered during my field work other relevant data of Russian and foreign researches are disclosed, too.

#### ***1. Social Policy Related Problems of Occupational Welfare as Reflected in Health Care***

##### Compulsory and voluntary occupational welfare: generalisations from empirical evidence

Relations between the state and industrial establishments in occupational welfare domain are of a paramount importance. They are best reflected in interplay between its compulsory and voluntary trends.

The state liberal like rhetoric on the subject of voluntary occupational welfare is absolutely biased. It is considered unprofitable and inappropriate for an enterprise in market environment whereas enterprises' involvement in social policy via taxation and social funds remains extremely high to the extent that, in fact, enterprises are the main taxpayers. The share of income tax in budget revenues is less than 10 per cent and individuals do not contribute to social funds from personal income (except a symbolic one per cent to the Pension fund). It indicates that Russian government still largely relies on the Soviet model of taxation based on payments of organisations/ enterprises.

In order to change the situation the purchasing power of population should be increased because the level of wages has been intact since the Soviet times when the existence of public consumption funds from which people were

provided with free social services facilitated keeping it relatively low. In the early 1990s those funds were substituted by non-budget social insurance funds. If the state wants to get more in taxes and/or to make people cover social expenditures the need for reforms arises to secure due growth in income. But there are no signs of any measures being planned in this field.

Without accusing the state of an "ill will" it can be stressed that two trends come into contradiction at the present stage of transformation: on one hand, necessity to ensure state expenditures, including social, and, on the other hand, promotion of market-oriented reforms with industrial enterprises finding themselves in the midst of this contradiction.

The only thing that the state has chosen to do to make the burden of occupational welfare lighter for enterprises is to encourage them to get rid of voluntary arrangements while preserving high level of compulsory elements. Divestiture of social assets in this case looks more like a demonstration project to show to the developed world or, to be precise, to the international financial institutions how market reforms have been developing in Russia.

It might be argued that the state interference in occupational welfare has even increased in the course of transformation. In the Soviet Union enterprises were obliged to set up special social funds but they had a certain degree of control over them because, first, such funds were spent by an enterprise and, second, it had a choice of the concrete ways of doing it. Now enterprises pay much the same money to social funds fully controlled by the state without having a say in running them, or enjoying any preferential treatment.<sup>6</sup>

The state now tries to squeeze money out of anyone who could have it to balance public expenditures. In the case of CHI enterprises must pay contributions – evasion is practically impossible, penalties are imposed for delays – while federal and regional authorities might easily violate their obligations to the health system. Introduction of CHI in Russia is a convincing example of how under the conditions of budgetary restraints the state is

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<sup>6</sup> There are a few problems around the issue of how taxation and social funds money should be spent with a lot of speculations about fraud and corruption.

aiming to involve enterprises tightly in bearing a considerable part of a burden of health responsibilities not only for the employed but, possibly, for those not working.

It has transpired that enterprises may accept certain responsibilities, first, in much more limited scope than envisaged by the state and, second, for their employees only. Two polar situations which might arise when enterprises

- either participate in social insurance, including CHI, as the state programme and feel free from supplying occupational services in addition;
- or opt out of the state scheme and provide occupational services for their employees.

If the present variant is preserved when compulsory contributions of enterprises to the state-run social security system are dominant in their social expenditures the financial load on enterprises is likely to increase further as only 40 per cent of population is in employment (the dependency ratio is 1,7). The possible way of easing it for enterprises with social assets might be tax exemptions calculated in accordance with the norms fixed by local authorities.

The existence of enterprises that apart from participation in social insurance provide occupational services in-kind to their employees raises the problem of a proper balance between compulsory and voluntary occupational welfare. In the new system of social funds a high level of redistribution, which in democratic society implies a high degree of social solidarity, is preserved. However, the state does not provide any incentives to stimulate voluntary occupational welfare. The assertion that this is damaging to entrepreneurial initiative is at odds with heavy load of social taxation on enterprises.

The state is now preoccupied with compulsory occupational welfare that often results in neglecting or underestimating other issues. Enterprises, on the contrary, are interested in voluntary occupational provisions covering, in the first instance, their own employees. For them voluntary occupational welfare is a real thing as it gives an enterprise control over money, quality and range of services that can be adjusted to its specific needs. But accustomed to the Soviet model when in many cases employer-provided services duplicated the

state system (at least formally employees covered by occupational plans remained eligible for the state social benefits) managers are cautious to choose between enterprise-based services and the state-organised compulsory social insurance.

The lack of coordination between the state and employers in occupational welfare matters could lead to serious problems. Concentration on voluntary provisions is likely to negatively influence the state social revenues and patterns of social solidarity. Cancellation of occupational services combined with a decline in the public system of social welfare is likely to make substantial gaps in societal welfare in general.

A flexible system might be viable incorporating both compulsory and voluntary occupational welfare into social policy strategy. It would allow enterprises a space to manoeuvre and might include various arrangements ranging from their involvement in administration of social funds and getting preferential treatment for the employed to opting out of the state plans in favour for occupational schemes.

In this light vital is the idea of social partnership, which has been promoted in Russia since the early 1990. Unfortunately, it does not work well the weakness of trade unions being one of the reasons. The tripartite agreements imply that each of the partners (the state, employers and trade unions) should bear certain social responsibilities. In case of Moscow, according to labour statistics, only in 93 of 297 industrial enterprises surveyed in 1997, or 31.1 per cent, collective agreements were concluded. Besides, the framework collective agreement of the city government, local association of trade unions and entrepreneurs stipulates mainly enterprise responsibilities in relations with local authorities and in employment matters, including the level of wages. There are only two brief references to occupational welfare — employers should not reduce the scope of social services provided to employees preserving the existing standards; number of personnel and proper maintained of services should be ensured. Enterprise-based health centres are not alluded at all.



A special mention is to be made about employers, one of the main players in social policy in the field of occupational welfare. Their role and the state -- employers' relationships are a neglected subject in research of social and health policy in Russia. But one thing is evident -- employers' potential in formulating modern Russian social policy is not used. The following reasons can be suggested.

Russian enterprises' strategy is often defined as "survival." This concept is widely used by Russian and foreign scholars and, in practice, means that at present short-term objectives might be given a priority and hinder development of a long term strategy as everyday fight for survival evidently prevents employers from seeing perspective. As a result, they do not clearly understand what part they might play in implementing social policy. For example, employers fail to realise the present role of enterprises in social policy financing and tend to consider social security contributions as tax-like payments to be paid and forgotten about rather than to try to have their burden eased or restructured, as distinct from the patterns of behaviour in the West.

Enterprises do not have much trust in the state, which on many occasions failed to be a reliable partner trying to get unilateral advantages. They are prudent about any new arrangements initiated by the state and do not want to "play games" with it and be involved in a broader social policy realising that there are discrepancies between the state and enterprises and it is better to stay aside in matters that lay beyond their direct competence. As there is little rapport between the state and employers in working out and implementing social policy measures occupational welfare issues are typically settled through a local bargaining process when success or failure depends on the status of an individual enterprise.

Therefore, employers are unlikely to be seriously engaged in a nationwide social policy as a distinct political force. On the contrary, the state, whether it is welcomed or not, will presently continue to be a leader in social policy and changes in social welfare will be introduced from the top.

### Compulsory health insurance (CHI) and occupational health care

Enterprise-based health centres are actually an important element of provision of health services to employees in kind and every opportunity should be used to have their present-day status, functioning, management and perspectives examined in more detail, especially in the light of introduction of new enterprise health obligations in the form of CHI. Their interrelation is one of the vivid examples of compulsory-voluntary occupational welfare mix.

Survey demonstrates that despite the fact that respondents' approach towards the state is rather wary because of a common assumption that the state always endeavours in one way or another to make use of organisations, including enterprises, in its own interests, health care issues have proved to be closely linked with the state: Moreover, occupational health services used to be explicitly state-regulated. This is generally considered that the state should continue actively to participate in securing adequate health care for people. Such an attitude may be regarded as an aftermath of a long period of functioning of the comprehensive National Health Service in Russia. Managers who cannot even imagine the state health services to be privatised do not trust private arrangements in this sphere. The dominant view is that the state is a better provider than a private organisation. The role of commercial agencies in health care is approached negatively with, presumably, a very important implication: profit is not good for health services.

It should be noted that establishment and maintenance of health centres that are usually well equipped and staffed require considerable funds. It explains why they, as a rule, go in a package: if an enterprise can afford to maintain a health centre than it almost for sure provides other types of occupational welfare. On the contrary, possession of social assets does not necessarily imply that an enterprise operates a health centre or a health station.

Enterprises' reaction to CHI as the mainstream of the health care reform that has been recently underway in Russia is a mixture of resigning themselves to the inevitable and handling matters pertaining to CHI with caution. It is an indifference that can be accounted by the fact that managers

seem to be little aware of possibilities their enterprises could have in the CHI system.

The majority of managers do not find attractive the right to choose a health insurance company or to deal with it directly without any intermediaries. They do not even think about an opportunity of preferential treatment of workers in CHI: nobody suggests that employees should ask for such a treatment on the grounds that enterprises regularly pay CHI contributions. The prevailing opinion is that it would be unfair in regard to other groups of population, especially pensioners.

Only a few managers admit that they would like their health centre/health stations to join CHI. It seems to be rather odd as doing so might help to solve financial problems: CHI funds compensate health services for medical treatment provided to the insured. It would give enterprises, in case their health centres work in CHI, a chance to get back at least some of the money they spent on health care for employees.

Managers evidently lack the knowledge about intricacies of CHI operation at the national and local level. They do not appear, for instance, to be fully aware of what has been happening in the Moscow CHI branch.

Enterprises are reluctant to lobby their interests in the CHI system and do not typically maintain contacts with the state bodies on issues of health protection of the employed. They do not also appear to have any links with other industrial establishments in order to influence health policy of the federal or local authorities. In these circumstances managers are definitely more inclined to concentrate on matters within their competence.

It seems rather doubtful that Russian enterprises or their associations will display any initiative in health care except, may be, in seeking CHI contributions decreased for those organisations, which have health centres. The national tripartite committee has already negotiated this arrangement for almost five years.

The impression is that enterprises, as a rule, want to preserve status quo in relations with the CHI system. The fact that the majority of them consider CHI contributions as a tax means – in the modern Russian realities – that

enterprises just pay money to the state without expecting any reciprocity/mutual benefit.

In general reaction of managers to health care reform and CHI may be called a "patient syndrome". They all complain about the shortcomings of the existing system and express dissatisfaction with the way it works. Managers respond as patients who failed to receive appropriate treatment. It is indicative of the fact that they perceive themselves in the CHI system as users rather than people who have any other stake in it. There are many grounds to justify such behaviour. Even in Moscow that has a developed health care infrastructure in terms of the network of health services and medical personnel available the situation leaves much to be desired. For instance, according to the Moscow department of health, 60 per cent of medical equipment is out of date.

Managers' responses in my survey were definitely influenced by the state of the health system in Moscow. Though in Moscow with its developed health infrastructure the closure of health centre is not a disaster, managers think that the city health services are in a poor state and there is a real danger for workers to be left without any medical treatment at all.

Many health centres in Moscow enterprises used to work in close contact with local health authorities that compensated enterprises some expenses. Staff was paid from local budget while enterprises supplied and renovated premises, purchased and maintained equipment and paid for gas/electricity, etc. But in 1991 the Moscow government ceased to financially support the majority of enterprise-based health centres and resolved that enterprises were free to take over full responsibility for them.

The state policy towards employer-provided health services is concerned with drawing additional resources into health care and on coordinating occupational health care with local health networks. The matter is that provision of medical treatment by an enterprise duplicates local health services. Under the National Health Service every citizen is eligible for treatment in his/her locality and a worker can go either to a local polyclinic or to an enterprise-based service. In 1997 the Moscow government adopted a

concept of development of the health care system aimed, first of all, at strengthening locally- based health care with almost no place left for enterprise- based health centres. They are only mentioned in the context of the necessity to better co-ordinate the activities between health services belonging to the Moscow government and other organisations, though nothing is said about how it should be achieved. Besides, city authorities are mostly concerned with services that supply medical treatment to the Federal government/ President administration/Duma staff (for example Presidential medical centre).

As a result, health centres in industrial enterprises were practically cut off Moscow health care system and at present report only to directors of enterprises. Their relations with the Moscow health authorities are restricted to supplying information on medical statistics (morbidity patterns, including occupational diseases and injuries, etc.). Medical staff is now on enterprises payroll like other employees. The local health authorities are not informed on financial aspects of health centres performance. Managers, in turn, do not consider health centres to be a part of the city health system.

Only several enterprises at the time of the survey co-operated with the Moscow CHI fund. There are certain limitations on both sides for enterprise health centres to join CHI.

In this case a health centre should have a licence. To qualify it should supply a certain range of health services that can be difficult for small health centres or health stations to ensure. It is inefficient for a relatively small enterprise, which is forced to give up an idea of obtaining a licence in exchange for expanding services provided.

Another obstacle is that health centres are typically situated on enterprises territories the access to which of people other than workers is impeded or even impossible. For example, to enter the territory of many enterprises it is necessary to get a special permission.

Besides, Moscow CHI fund is often unwilling to collaborate with them. It is at present disinclined to cover more health services for purely financial reasons: the fund would have to spread the same amount of money over

larger number of health services that would lead to decreasing compensation to each of them. That is why some enterprises encounter difficulties in negotiating an entry into the CHI system.

It is not supposed that employees should contribute to CHI, the main reason being meagre wages of industrial workers as well as low living standards in Russia in general. Ordinary people just cannot spare it. If Moscow is taken as an example, in 1997, when empirical studies were completed, 47 per cent of Muscovites lived below poverty line in comparison with the country average of 27 per cent. There was also high polarisation of population: the difference between the first and the fifth income quintiles was 31.6 times. The share of those working in industry among declined to 19 per cent of the employed. The average wages of industrial workers were lower than the city average.

## ***2. Management and Occupational Welfare: The Role of Health Centres***

### **Reasons for provision of enterprise-based health/social services: corroborating evidence**

The proper knowledge and understanding of the nature of enterprise-based services as an intrinsic element of occupational welfare are indispensable for its analysis. The evidence that comes from a number of recently conducted surveys supports the findings of my study on reasons for provision of such services. Though not necessarily devoted to social issues these studies contain questions aimed to define the attitudes of industrial managers to problems of enterprises performance. Hence, it might be useful to scan the corroborating evidence. Tratch and colleagues research (1996), for example, gives the relevant instructive information (see Table 11.1).

In the surveys by Russian and foreign scholars employees welfare as a rule comes first. There is an evident trend for managers to mention social reasons in the first instance and express intention to support employees' living standards. In the World Bank survey (1996) 50 per cent of respondents consider social cum ethical motives decisive for continuing to provide

occupational benefits. Even more, employers are concerned about local people -- 22.7 per cent of respondents believe that services supplied via enterprises' social assets are important for local communities as well.

Internal labour market considerations -- attracting and stimulating employees -- usually come second. In the World Bank survey (1996) they were mentioned by 25 per cent of respondents. The survey cited by Vinogradova (Виноградова, 1996) shows that 43.7 per cent and 17 per cent of directors of industrial enterprises think that social assets help them, respectively, to retain and attract labour force, 30 per cent - to stimulate employees.

Table 11.1

**Reasons for provision of enterprise-based social services,  
% of respondents**

		% of respondents
1	To support the living standards of employees	79
2	Benefits and services have always been provided by the enterprise and this policy is not going to change	46
3	The reason is a social one	45
4	We must provide social services to satisfy the work collectives requirements	35
5	We must provide social services to satisfy the trade union requirements	25
6	It is a customary practice for all enterprises	10
7	We must provide social services to satisfy the government requirements'	5
8	Social assets are profitable	3
9	We must provide social services to satisfy the firms' management requirements	1
10	Other reasons	0

Source: adapted from: OECD, 1996:110.

There are different viewpoints on the part employer-provided health benefits play in labour markets. Robinson (1968) analysing the experience of

three Western countries -- Sweden, the Netherlands and the UK -- argues that housing and travelling arrangements are the most effective ways to attract labour force to a particular firm. In his opinion, other benefits (including health services) have very little effect on it. The reason is that in these countries

"...level of state provision of welfare services is such that there is relatively little that firms can do in the way of additional provision or coverage of such things as pensions, health services and so on" (Robinson, 1968:102).

Mikhalev (OECD, 1996) supports this point of view claiming that the impact of health and recreation services on labour market is not very significant. He refers to the 1993 *VC/OM* (Russian Centre for public opinion survey) study when only one per cent of respondents considered fringe benefits more important than salary/wages. Health services provided by an enterprise have much less influence than housing and child care facilities on decision to retain the job. It is particularly true for urban population having better access to health services elsewhere.

Managerial textbooks assert that social expenses are productive in term of winning employees' loyalty and commitment. But it should be taken into account that occupational benefits are not the only means that can be used to achieve this goal and facilitate increase in productivity: general level of wages, opportunities for promotion and possibilities for training and development are among other things that might be important. There is no yet response to the question why employers would not increase wages to stimulate employees to work better and enable them to buy health services outside an enterprise. In this case the problem of the so called managerial specialisation, namely the share of managers dealing with non production issues, including running social assets, will be solved as well.

As to labour motivation, useful data come from a small-scale survey of directors of industrial enterprises carried out by the Russian economic journal *EKO* in the late 1996. They were asked to evaluate the effectiveness of its various forms, ranging them from "5"– the most effective" to "1"– "the least effective". The survey is especially instructive as it compares indicators for two



years (1992 and 1996) that makes it possible to trace changes in directors' attitudes over time. The results are presented in Table 11.2

Table 11.2.

**Directors on the effectiveness of various forms of labour motivation  
for workers and managers and other staff,  
% of respondents**

	<u>for workers</u>		<u>for managers and other staff</u>	
	1992	1996	1992	1996
Putting more pressure, using threat of unemployment	4.0	1.9	3.8	2.5
Increasing wages	3.8	4.3	3.6	4.1
Increasing financial independence and responsibility	3.5	2.6	3.4	3.1
Participation in profits	3.2	1.5	3.6	1.6
Improving working conditions	3.2	2.6	2.4	2.3
Improving enterprise image	2.7	2.8	2.8	3.1
Showing concern for people's needs	2.5	2.8	2.5	2.8
Social benefits and services	2.4	3.1	2.2	3.0
Moral stimulus	2.0	1.6	2.1	1.8
Involving in management	1.8	1.6	2.5	2.7
Possibility to get education and training	--	2.5	--	2.6

Source: EKO, 1996:110.

The Table 11.2 shows that an attitude to such stimulus as "showing concern for people's needs" did not change during the four years despite the fact that workers could get more in wages. The two stimuli which importance increased were wages and social benefits and services. It confirms that an idea of social benefits contributing to better work is still quite popular among senior managers.

If responses are ranked, in 1992 social benefits came only the eighth for workers and the ninth for managers and other staff. In four years they were among the first three (wages, social benefits and concern plus image) for workers and (wages, responsibility and image, social benefits) for managers and other staff. So, there was an increase in interest in social benefits as stimulus for both workers and managers.

According the Table 11.2 such stimuli as concern for people and social benefits were a bit more important for workers than managers. During the observed period the first stimulus moved up by three positions for workers and by one position for managers; the second stimulus was six and five positions up for workers and managers, respectively.

The third place in other surveys is shared by profit considerations and necessity to create the image of a good employer. 17.4 per cent of respondents in the World Bank survey (1996) mention that they can get profit from social facilities. Enterprises typically do not want to transfer social assets to local authorities free because some of them cost much money and, besides, can be used for commercial purposes.

#### Manager's attitudes to employer-provided health services

An evident continuity in enterprise-based health services in Russia suggests that either factors which do influence managers' decisions in their favour have not changed in the course of transformation or new problems which have been brought about can be solved with the help of employer-provided health care.

The Table 11.3 sums up arguments "for" and "against" employer-provided health care from both the social policy and the organisation perspectives.

Table 11.3

**Arguments "for" and "against" enterprise-based health services.**

<b>Against</b>	<b>For</b>
Economically inefficient / financial burden	Improvement of economic performance via increasing labour stabilisation and commitment
Wage-earner / consumer choice	Care for employees / improvement of their health status
Wrong targeting	<i>Stability of enterprise as a social organisation</i>
Limited social solidarity	Support of a local community

Source: adapted from Domanski, 1997: 66; Le Cacheux, 1996: 25-26.

There is nothing in "against" factors that has changed significantly in the course of reforms. It is traditionally argued that such kind of health care is inefficient in many ways. It is

- a financial burden for an enterprise;
- limiting employees choice as consumers because, though using enterprise health services free of charge, they might prefer to obtain them elsewhere;
- targeted on the employed while there are other groups of population which being in less advantageous position in society need better health care;
- undermining social solidarity as employer-provided health services are usually separated from the mainstream health care systems.

As market has been only emerging in Russia the profit argument which, as a rule, runs strongly against enterprise-based health services is not that important since efficiency is likely to be evaluated not only according to purely

economic criteria. It makes the World Bank experts (1996) to conclude that Russian industrial enterprises should be treated as profit-maximising entities with some reservations. Of course, financial considerations are significant in explaining changes as many enterprises divest their health care assets: in extreme cases when an enterprise is threatened with bankruptcy it simply makes no sense to discuss health benefits at all. Such "against" factors as consumer choice or wrong targeting lie beyond enterprise domain and concern, in the first instance, the state social and health policies.

Positive attitude to occupational health services is determined by, first of all, workforce considerations. Need for an employer to protect workers' health arises from the fact that the working conditions in industrial enterprises are often harmful to health and the level of injuries is rather high. Manual labour is quite common in Russian industrial establishments.

In many cases it is convenient for an enterprise to have a health centre on the premises. In accordance with the 1995 Ministry of Health regulations enterprises in some industries (for example, food processing, confectionary) are required to check health of potential employees and then arrange for regular medical examination of the employed.

The case of a meat-processing enterprise is quite revealing. As injuries occur quite often it is necessary workers could timely receive the first aid. Besides, the chance for a worker to get the specific and very rare occupational disease affecting bones is very high. It is almost impossible for sick workers to receive specialised treatment through local health services. One of the tasks of the health centre, which has special equipment to check the health of such patients, is to diagnose and cure the disease. Pensioners who suffer from it are also treated there.

Financial status of an enterprise and attitude of management are the two main factors "for" or "against" occupational health services. The research leads me to conclude that maintenance of health centres evidently lack any economic rationale and in-kind health plans are not backed by sound economic calculations. Some managers actually responsible for occupational welfare find it difficult to estimate on the spot how much money is spent on

health care to say nothing about long-term planning. Such a situation is in principle characteristic of many enterprises though it is much more apparent in badly doing ones. In one of enterprise with a poor financial status a head of health service just gives a personal and social welfare manager a list of what it needs, including wage bill, and then these requirements are adjusted to real financial capabilities of the enterprise at the moment.

When financial status of an enterprise is in jeopardy some provisions may be cancelled and quality of health services deteriorates. However, these facts should not be overemphasised because medical treatment offered by health centres can still be – and usually is– better than that provided by local health services.

Thus, the following paradox is evident. On one hand, financial issues dominated every conversation (crisis, economic decline, shortage of money, etc.), but, on the other hand, correlation between enterprise financial status and its determination to keep health centres / health stations is not simply detected. Lack of finances obviously hinders provision of occupational health care though it does not necessarily result in closure of health facilities.

Taking into account the important role of management in enterprises, on one hand, and lack of close correlation between availability of occupational health services and financial status of an enterprise, on the other hand, management attitude becomes crucial in explaining why health centres in industrial enterprises are likely to survive. To understand managers' motives in favour of provision of health services for workers, the frame of reference offered in Table 2.1 (see Chapter 2) suggests the two reasons – pragmatic/production and social/paternalistic – that come first on the list of reasons for management to advocate health protection of employees. The stress is made, therefore, on how do managers treat and legitimise health centres. They either care about enterprise performance or about employees' welfare claiming recognition of their needs and aspirations.<sup>7</sup>

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<sup>7</sup> Rose (1994) questioned the idea that employer-provided social benefits contributed to the improvement of living standards claiming that there was evidence that benefits in-kind were not so important for the Russians as protection in economic crisis.

Personal characteristics such as gender and educational level do not affect substantially the answers of respondents. Only age appears to have some bearing on them. Correlation coefficients demonstrate that opinions of respondents 41-50 and 51-60 years old are closer in comparison with that of respondents 31-40 years old, while positions of people 31-40 and 51-60 years old diverge more. The data might be biased as age is described by the three-interval scale while gender and education variables have only the two meanings. It helps to trace influence of age on responses more accurately. The captured differences can be explained by common sense considerations reflecting respondents perceived roles and behaviour in society. For example, younger people are inclined to more resolute and boisterous behaviour than the elders and are likely to have more liberal attitudes. Respondents of the elder ages with life and work experience have more balanced approaches. Women are likely to be more concerned about subjective feelings than objective reasons as well as about servicing and caring for others.

Although it can be admitted that personal characteristics are not that important it does not necessarily mean that managers' motivation is not personal. It is simply difficult to say to what extent their decisions are personally inspired.

#### Concept of managers' health responsibility

Managers' conceptual, ideological so to say, attitude towards occupational health care that otherwise may be called health responsibility deserves special scrutiny.

Their understanding of the notion is quite specific. It might be unrealistic to expect managers to use it as a working concept: they do not normally consider their involvement in health protection of employees in terms of health responsibility. They simply deal with day-to-day problems requiring solution. The situation is well illustrated by participants' indifferent reaction to description of my project aims and methods.

There is no exactly defined concept of health responsibility used by managers, a few alternatives existing. For managers with a long working

experience comparison with the past practices is high ranking. One of the interviewed who worked in a food processing factory in the Soviet times when asked what health services her factory provided to employees replied: "Almost nothing". But actually their list was quite impressive including a health station, free medication for employees and compensation for recreation treatment elsewhere.

Managers' vision of their health responsibilities is confined to enterprise boundaries. It is clearly illustrated by their treatment of CHI contributions. Their introduction does not seem to change the attitude of employers who provide health services in kind towards their responsibilities in health protection of employees. They are still ready to fulfil some health obligations towards employees viewing them in terms of enterprise-based arrangements. Managers do not think that CHI payments free them from carrying out additional occupational health schemes.

Therefore, it looks like managers' perception of health responsibility is restricted to their enterprise only and they are inclined to consider running of health centres as an expression of such responsibilities while CHI contributions are viewed to be an ordinary tax rather than fulfilment of health responsibility to employees and just the minority is ready to treat these contributions as health care obligation.

There are several variants of understanding health responsibility depending on the degree of enterprise involvement in health protection. While acknowledging the supremacy of the state in providing health care to population a half of managers explicitly state that employers should also make contribution to it thus expressing their health responsibility. What is also significant, in spite of financial resources mentioned as a limitation it is nevertheless admitted that employers should take part in securing employees' health. Of the three institutions which are considered as its protectors – the state, enterprise and individual – enterprise comes the second, close to the state but far ahead of individual.

Managers are cautious in evaluating their present role in employees' health protection. The absolute majority mentions that there are some things

that still can be done and do not seem to be satisfied with their own efforts, the more so that they do not think that CHI may offer a sufficient level of health care to the employed.

One more thing should be mentioned in connection with managers' health responsibility. Managers of various personal standings are exposed to processes which have encultured them a shared understanding resulting in common attitudes on a number of topics. Regardless of their status, they are usually under the influence of what is characteristic of the culture of organisation and vice versa -- contribute to maintenance of organisational culture.

This unifying approach may also be referred to as enterprise, or house ideology. It is not simply imposed on them – rather managers play an active part in putting it into practice through enterprise-based health care. But since they are in many cases not versed in operating occupational health services and do not have any inter-enterprise organisations they have difficulties in independently accessing interests of their organisations and defining the responsibility to be assumed.

Managers point out at the crucial role of management in decision-making on occupational health care and health centres. They form a vital group in working out enterprise health policy for they choose the kind of response their enterprises give to social pressures and then implement adopted policies. Managers feel themselves in a position to settle health problem. When some of them say it is not their responsibility it does not mean the lack of concern but is rather an expression of belief in that an enterprise simply cannot afford it.

Occupational health care proved to be rather difficult to conceptualise. Enterprise health policies are likely to have more to do with ideology than pure social or commercial rationality. Domanski (1997) is right to stress that employers act out of belief. Believing as they seem to do that provision of health benefits will lead to certain positive results management might not be fully aware of the scientific basis of its strategies relying more on common sense and past experiences.



By providing occupational health services managers become involved in socially valuable activities, in fact responding to widely held public perceptions. It could even be argued that socialism made better use of managerialist recommendations.

At present managers stand at the crossroads of two seemingly conflicting ideologies – free market and managerialist. But, in fact, both ideologies are basically concerned with the same thing – improving enterprise performance and increasing profit though by different means. But as theoretical substantiation of occupational welfare in both cases is not very persuasive the attitude to occupational benefits is to a large extent determined by an individual employer's own assessments and social outlook.

#### On enterprise-based health services perspectives

The discussed above empirical evidence provides some information on the future of enterprise-based health services. None of the managers I interviewed is in favour of closing health centres/health stations. On the contrary, they want their operation to be continued. Managers of enterprises, which have health stations, even express intention to extend the range of services provided.

My findings, by the way, correspond with the results of the TACIS survey (Виноградова (Vinogradova), 1998; Котова (Kotova), 1999), which has failed to discover strongly articulated intention of directors to get rid of social assets. Their attitude towards divestiture was rather negative than positive; many of them ready to keep social assets subject to certain conditions.

The body of knowledge available on the subject makes it possible to identify two contrary viewpoints expressed by the people who have definite strategy and work actively to implement it by either building up occupational welfare schemes or getting rid of them.

One motto could be read as follows: "Free us from any health obligations! We are here to gain profit and have no time to think about health issues". The assumption in this case is that health responsibilities should be vested in the

state and individuals. So, even if an enterprise has money it will not spend it on occupational health services.

The other motto is: "We are ready to do as much as possible for our employees". It is somewhat egoistic for an enterprise to neglect social solidarity in society at large but at the same time it clearly indicates management awareness of health care responsibilities to employees and readiness to carry them on.

Between these two extremes the whole spectrum of other opinions lies that are not clearly articulated. Some employers just do not have any idea about what they should or could do about protecting employees' health and how it could affect their enterprises.

It is possible to define the following types of managers' behaviour based on combination of their attitudes and enterprise financial status:

- have money -- should maintain health plans;
- have money -- should not have health plans;
- lack of money -- should maintain health plans;
- lack of money -- should not have health plans.

Moscow industrial enterprises, which have health arrangements, are very likely to favour their continuation even if they experience financial difficulties and are forced to allocate less money on health centres and health stations, thus falling into the first and the third groups. This, in fact, challenges the now predominant view that enterprises should be willing to cut social benefits, including health care provision.

### ***Conclusions***

This chapter should be viewed as a proof of occupational welfare versatility. As far as occupational health care is concerned, it has many nuances that require further elucidation and debate. It is from this standpoint that recurring exploration of the above-mentioned issues has been made. What is more, in its course a few problems cropped up that may be worthy of researchers' attention. Among them the following may be mentioned:

- practice of coordinating of the state, local authorities and enterprises' activities in the field of occupational welfare;
- rapport of the state and employers in formulation and carrying out of social policy, occupational welfare including;
- correlation of compulsory and voluntary health insurance and proper balance between them;
- comparison of advantages of pecuniary and in-kind occupational welfare benefits;
- funding and managing of enterprise-based health centres in a new political, social and economic environment;
- managers' conceptual attitude towards health responsibility and enterprise/house ideology;
- education and training of managers to be engaged in occupational health care provision;
- methodology of occupational welfare research.

It does not mean that other issues concerning occupational welfare may not be taken for consideration.

## **Chapter 12.**

### **Occupational Health Care in Russia: A Synthesis of Reflections**

My reading of available material leads me to assert that this thesis is the first attempt systematically to analyse the key issues of occupational welfare with special reference to health care in Russia. The study has attempted a systematic examination of the three elements central to an understanding of employment-conditioned health services in contemporary Russian society.

In the first place, the fundamental theoretical problems of occupational welfare were approached in the light of research in the West, the Soviet Union and post-Soviet Russia. The principal issues addressed in the thesis concerned the relationship of occupational welfare to social policy, social citizenship and human rights, employment, state and non-statutory provisions and economic efficiency, as well as the social assets of enterprises. In order to relate the Russian theoretical treatment of occupational welfare to that of other developed countries an international comparison of understandings about occupational welfare was made, with emphasis laid on divergences and common grounds. This permitted a venture towards a general definition of the notion of occupational welfare.

The second general objective was to examine occupational welfare and its health care component in historical context, tracing its evolution from Imperial Russia, through the Soviet era to post-Soviet times, with the specific aim of exploring continuities in the policy pathways. Overarching issues as well as those which are sector specific are aired: for example, the role of factory medicine and compulsory health insurance in the Tsarist Russia and services for workers in the Soviet system of health care. More topical are the factors associated with the initial outcomes of health reforms in the 1990s, which are indispensable for arriving at a projection of future perspectives of occupational welfare.

Thirdly, the empirical element of the study related to the reporting results of fieldwork carried out in Moscow between 1995 and 1997. Its brief was to

explore the contemporary status of Russian occupational welfare in the context of changing social policy aims and methods, in order to determine the factors contributing to the current survival of occupational health plans. Evidence from the field concerned the role of enterprises in occupational welfare, the functioning of enterprise-based health centres, and the place of industrial employers and managers in organising health protection of the employed. The findings drew out several important theoretical and practical implications that are discussed below.

The theoretical research was underpinned by an extensive reading of the substantial 'grey literature'. This, together with the empirical observations, led to the following key conclusions concerning the social role of Russian occupational welfare; a universal conceptual approach to the sector; the clarification of the position of the occupational sector in the 'welfare mix'; the motives of employers in providing occupational health care; and, finally, the compatibility of occupational health care and democratic welfare capitalism.

### **The Social Role of Russian Occupational Welfare**

This study has substantiated an assumption that occupational welfare has always played an important social role in the Russian society. Its underestimation is an evident error in works of Shleifer and Boycko (1994) and Rein (1997). The analysis presented here shows that both Western and Soviet scholars have theoretically approached occupational welfare in terms of similar issues, such as equality and justice, the role of the state, and the access to social services. This is not to say that occupational health services in the Soviet Union did not have their own specific characteristics, but in principle they performed much the same functions as counterpart services in capitalist countries. What is more, in terms of 'lesson learning', their experience was considered valuable for other countries by such influential international organisations as WHO (1978).

Since occupational welfare was by no means an invention of the Soviet hegemony - despite specific features it was, in fact, a particular reflection of

mainstream world tendencies – the consequence has been that it was not doomed to wither away with the communist state.

In essence, then, occupational welfare has deep roots in the Russian history and society, spanning more than a century and a half. During all that time it has been a channel for the protection of working people against social risks. The Soviet state exploited the century-long tradition and the practices of the previous political regime by modifying occupational welfare to conform to the Soviet welfare system and ideology.

### **Two Perspectives and General Definition of Occupational Welfare**

Any attempts to separate Soviet experience from that of the West are artificial and ultimately unproductive. On the contrary, overcoming ideological barriers renders a possibility of their interaction. As a result, two approaches to occupational welfare, namely social policy and organisation perspectives, are suggested.

Working people are not only employees of companies but also members of wider society. Thus, the social responsibility that enterprises bear concerns not only their employees' welfare but also helps to solve social problems of population at large. That is why I propose an approach to occupational welfare through two dimensions: the social policy perspective and the organisational perspective. Apropos, one of the differences of the Soviet and Western approaches to occupational welfare was that the former stressed the social policy dimension whereas, in my judgement, in the latter it was more latent.

Understanding this study convinced me of the necessity to make an attempt to formulate a wide definition of the concept of occupational welfare. I suggest the following wording, albeit one that requires further elaboration:

*Occupational welfare, as an integral part of comprehensive social policy, is the provision of social services and benefits other than salaries/wages, incident to or arising out of employment, in various forms, voluntary or statutory, offered through employer in compliance with the interests of an individual, organisation, the state and society.*

### **Occupational Services in the 'Welfare Mix'**

The transition of Russia to a market economy raises the question of how welfare responsibilities may be distributed among various sources of welfare, such as the state, industry and individuals in a new emerging society: in short, who is to pay the social costs of a transition that has already been very high.

As I have argued throughout, the state in Russia always played an active part in the working of occupational welfare, trying to incorporate it into the general structure of social policy. Thus, the division of welfare was never just a private or informal affair, but rather an integral part of the system of national social protection - "welfare mix" - with a specific role.

Today, the stereotypes of free market are very strong in Russia and it is generally assumed that everything should be changed and reformed. The ideology and practice of occupational welfare have been strongly influenced by the Western liberal ideas. In this re-appraisal it is easy to forget the opinion of those Western researchers who, whilst stressing many malfunctions of the Soviet state, judge its achievements in the social sphere to be not inconsiderable and deserving to be taken seriously by Western countries. In this environment, the social policy dimension tends to be downplayed and the enterprise perspective is given a priority that, in fact, means that the role of occupational welfare is underestimated. These trends have serious implications for occupational welfare in post-Soviet Russia: the state has all but withdrawn its support for occupational programmes, which have become voluntary. The lack of co-ordination between social and occupational welfare could lead to serious problems. The closure of enterprise social facilities, alongside the poor state of public social welfare is very likely to result in gaps in welfare provision for the public as a whole.

### **Provision of Occupational Health Care and Motives of Employers**

Occupational health care in contemporary Russia is an integral and indispensable part of occupational welfare. Influenced by the historical, social and political factors already outlined, it has some specific features.

Industrial enterprises are major health provision actors, as currently occupational health services in Russia in many cases are outside the national health service. In these circumstances, the analysis of their role is an important component in understanding why Russian enterprises that have traditionally maintained occupational health centres continue to do so, despite changing economic incentives and political ideology.

A major empirical finding of this thesis is that external factors such as the state policy and financial constraints are not decisive in forming industrial managers' attitudes towards occupational health services. The introduction of new compulsory health insurance and the changing position of enterprise within the health care system, which are the outcome of the state policy initiatives, do not appear significantly to influence the attitudes of managers towards occupational health care provision. On the contrary, the lack of financial resources is regarded as an obstacle for implementing health plans, rather than provision of health care is considered as undermining the financial status of an enterprise. Managers, as a rule, not only accept that they should protect their employee's health, but also in some cases think that they should do more. In particular, enterprises would rather keep health centres running and expand the range of services provided than divest them.

Managers typically mention reasons that fall within economic-pragmatic and social- paternalistic motives in the classification suggested in this study, for example, retaining and motivating workers, and creating the image of a good employer. But the lack of clear evidence of the contribution of health centres to achieving the stated objectives and strong economic rationale behind the decision to keep them suggests that managerial attitudes are informed by personal beliefs rather than generalised knowledge.

Some enterprises attempt to fuse paternalistic and economic motives, namely, not only to provide services for their own employees free of charge, but also to profit from the operation of their health centres. Compulsory health insurance provides a good opportunity to implement this idea because health centres that joined the system are compensated by it for services provided for the insured. Enterprises try to attract local people for whom health insurance



system will pay, as their health centres are better staffed and equipped than local health services and, thus, have a reputation of providing higher quality medical treatment. For this reason these enterprises are ready to invest more in their health centres and even bear losses, at least of a short-term nature.

At the moment, it is clear that the new political, economic and social environment in which Russian enterprises operate can hardly be referred to as a 'market' in the sense accepted in the West. In such a situation it is difficult to realise expectations that they should behave as "free enterprises": considerations other than profits are important for them as well. Though there are a number of factors that would influence management attitudes towards social assets, the maintenance of workforce within a company can be considered as a tactic for survival in the turbulent environment of transformation, and, in this, forms a part of the strategy to retain the integrity of an enterprise.

This highlights the third group of motives: that of managerial self-interests. Maintenance of health centres, which are usually situated on the site of enterprises, may be important for managers in their own personal interests. First, they receive medical treatment in enterprise health centres, where managers definitely enjoy a better response from clinicians and often have access to facilities superior to those in a local health network. There is no need for out-of-pocket payments in the form of 'fee-for-service' and gratuity payments to doctors. Second, for reasons related to motivation and compliance of the workforce, health centres serve as a basis of managerial influence and power.

While a "political" dimension of managerial power provides mechanisms for control over employees, a "structural" dimension is linked to managers' perception of their power within the spatial boundaries of their enterprises. This is supported by the fact that managers' vision of health responsibilities incorporates only enterprise based-health services and excludes considerations of broader health and social policy, for example, compulsory health insurance contributions.

The importance of managerial self-interests should by no means be interpreted in negative terms, implying that managers either simply ignore other functions of occupational health services or merely use them to legitimise enterprise health centres. Rather it is evidence of the fact that managers are among major organisational stakeholders -- employees, employers, shareholders, and wider society -- that have a vested interest in enterprise health centres. For managers specifically the significance of health centres, that are typically expensive to operate and not necessarily profit-promoting, lies in that they help to fulfil multiple objectives: they contribute to employees welfare, the standing of the organisation and, not least, to managers' welfare and status.

### **Occupational Health Care and Democratic Welfare Capitalism**

The existence of occupational welfare in contemporary Russia is, in principle, compatible with the market economy and democratic transition, by serving as a means of continuity in the midst of change. Hence, occupational welfare could be one of the survival techniques for a social protection system under the current conditions of its near collapse. This is naturally subject to certain prerequisites, such as the attitude of companies and the support they may receive from the state.

Although the role of the state has been changing because of the evolving status of many enterprises with regard to making decisions to maintain or close welfare facilities, it would, therefore, be in the interests of the state to find ways to incorporate existing complementary institutions that have proven their usefulness into a new political and economic environment. Accordingly, it would be wise for the state to take into account the potential of enterprises for solving welfare problems and support occupational welfare, if only to shift a part of its own social responsibilities to employers in a systematic manner. Indeed, it is my contention that there is sufficient evidence to suggest that occupational welfare has its own role to play in the life of contemporary Russia and has a potential not only for survival but also for further development in the new environment emerging from market-oriented reforms. However, policy trajectories are unlikely to be smooth. While the case studies demonstrate that

enterprises are ready to co-operate with the state in providing health services for employees, at the same time they are unlikely of their own accord to put forward any plausible ideas on their social and health care roles, given the vagaries of current industrial trends in Russia. Moreover, critically, at present there is very little communication between the state and industrial employers on health issues.

### **A Final Defence of This New Approach to Understanding Occupational Welfare.**

The empirical study has focused exclusively on health services for workers; whereas other studies either explore a number of occupational welfare provisions altogether or include only their marginal treatment. In the existing surveys examined, enterprises have been selected on criteria that do not usually take the existence of social assets into account. My sample, on the contrary, includes industrial enterprises that continue to maintain occupational health services as I have explored the reasons that motivate employers to do so, despite opposing rational factors, such as poor financial status and lack of the state support.

The investigation combines survey methods and case studies to approach the problematic of occupational health services in Russia from different perspectives. Such a focused approach permits a deeper understanding of the attitudes of industrial managers towards these provisions. Yet, it is inevitable that a study of this kind will be limited in several respects. Above all, the empirical material available is very fragmented and often contradictory. Thus, reliable data on the present state of occupational welfare in Russia are hard to obtain. Since the situation has been altering rapidly and the changes are poorly documented, even the available data soon become obsolete. Moreover, for a large and diverse country like Russia, it would be unwise to make too many extrapolations from a locally based, single person research which necessarily relied on a relatively small sample of cases.

Neither official documents nor direct contacts with enterprises can produce a fully comprehensive and unbiased evaluation. In describing the current state

of occupational welfare in Russia and the associated changes, one can scarcely avoid some reliance on personal impressions gained from various sources. There is no doubt that many of the conclusions arrived at here could be questioned by those adopting a different conceptual position or drawing on different personal experiences. My outlook rests on the fact that the study is the first of its kind in Russia and its value, perhaps, lies in its exploratory nature. Many of the answers are inevitably provisional and the inferences need further investigation.

### **Speculations on Future Research and Practical Agendas.**

It is assumed that this study represents but a first step towards a deeper analysis of occupational welfare. Above all, theoretical issues need much more attention, not least in reaching consensus on the definition of the phenomenon. An important contribution would be further study of its history in Russia.

As for other outstanding tasks the following list, although not exhaustive, may be offered: the correlation between provisions in cash and in-kind; the organisation and financing of occupational welfare arrangements; the specific design of occupational programmes; the interaction between enterprises, on one hand, and local authorities and governmental and non-governmental bodies, on the other hand. This latter area will, perhaps, be the most productive of effort, given the increasing role of NGOs. For example, NGOs in Russia carry out family planning programmes in enterprise health centres, especially where women form the majority of the workforce.

Finally, of particular relevance for the further development of Russian occupational welfare is the resolution of the following trinity of problems:

- the elaboration of a new social policy incorporating occupational welfare into new institutional arrangements in a society in the course of transformation;
- the definition of a compulsory-voluntary occupational welfare mix to allow for more effective use of human resources and physical capital; and

- the targeted training of managers of enterprise social programmes to ensure their proper functioning and cost - effectiveness.

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## **APPENDIX A**

### **TABLES AND FIGURES**

Table A.1

**HOURLY LABOUR COSTS IN MANUFACTURING IN OECD COUNTRIES,  
1995**

	<i>Nor- wage labour costs*</i>			<i>Rank by total labour costs</i>	<i>Rank by non-wage labour costs</i>
	USD	of total labour costs	of wage costs		
Germany West	20.44	44.9	81.5	1	5
Switzerland	14.66	34.3	52.3	2	12
Belgium	18.22	47.5	90.6	3	3
The Netherlands	15.74	44.3	79.5	4	6
Japan	14.56	41.0	69.6	5	10
Sweden	12.82	41.2	70.0	6	9
Germany East	12.88	43.1	75.9	7	8
France	13.99	48.2	92.9	8	2
USA	7.42	29.5	41.8	9	13
Italy	12.40	50.3	101	10	1
Canada	6.51	27.8	38.5	11	16
Spain	10.16	45.5	80.0	12	4
Australia	6.07	27.5	88.0	13	17
UK	6.00	28.6	40.1	14	14-15
Ireland	5.89	28.6	40.0	15	14-15
Greece	5.13	39.8	66.0	16	11
Portugal	4.08	44.0	78.5	17	7

\* non-wage labour costs include social security, pensions and fringe benefits

Source: Financial Times, 02.1997.

Table A.2

**LABOUR COSTS STRUCTURE IN RUSSIAN INDUSTRY, %**

	LABOUR COSTS total	WAGES	NON-WAGE LABOUR COSTS						
			% of Total Labour Costs	including					
				housing	social protection		retraining	cultural and welfare services	other
					total	compulsory payments			
NATIONAL ECONOMY									
1995	100	60.5	39.5	4.6	28.3	23.4	0.3	3.3	3.0
1996	100	59.7	40.3	3.5	29.9	27.1	0.4	3.5	3.0
1998	100	63.2	36.8	2.0	30.2	27.2	0.3	1.5	2.8
INDUSTRY									
1995	100	58.0	42.0	6.2	28.5	26.3	0.3	4.2	2.8
1996	100	57.2	42.8	4.5	30.4	27.6	0.5	4.6	2.8
1998	100	60.5	39.5	3.1	30.7	27.9	0.3	2.4	3.0

Source: adapted from Госкомстат (*Goscomstat*), 1999: 288



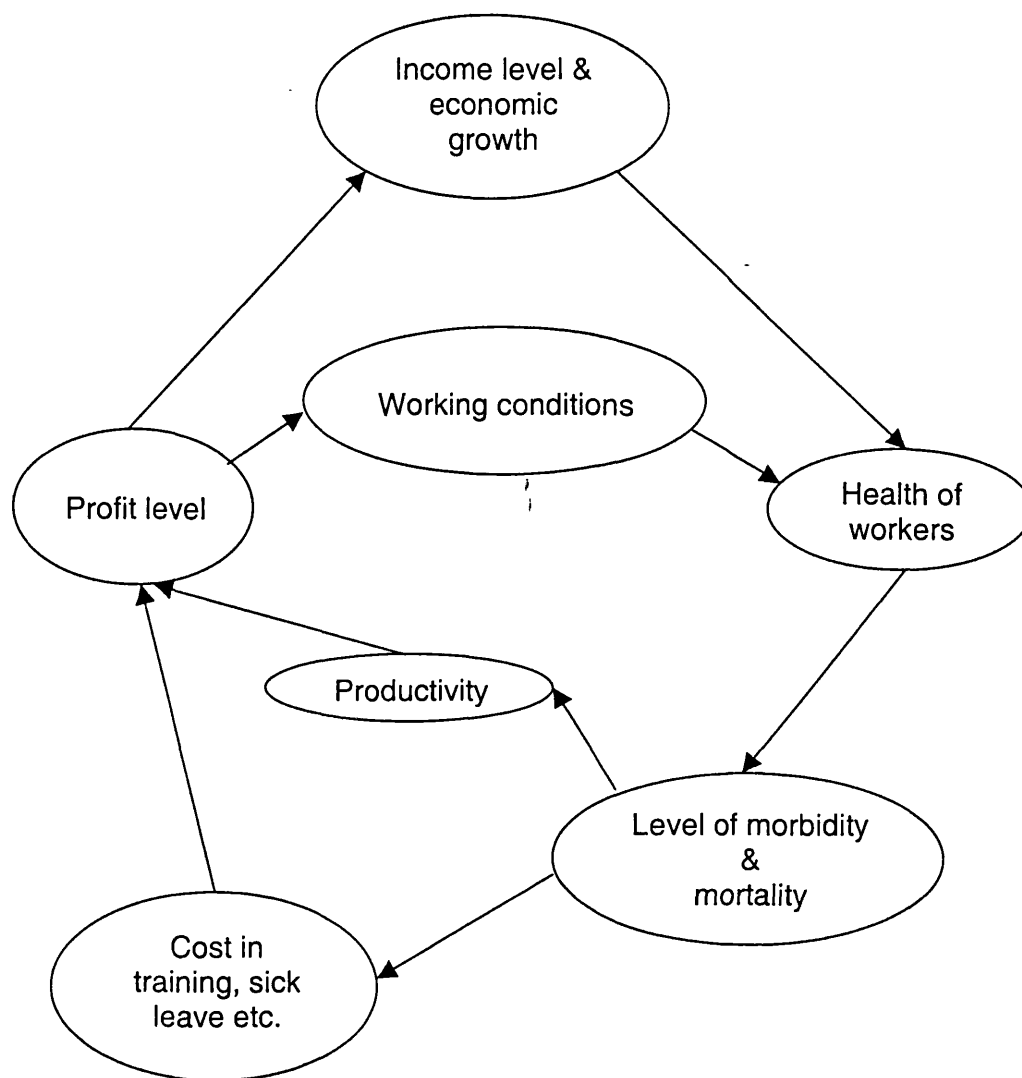
Table A.3

## STRUCTURE OF SOCIAL EXPENDITURES OF INDUSTRIAL ENTERPRISES, %

	Total	Compulsory contributions to Social insurance funds	Additional private pension insurance	Voluntary health insurance	Employees' life and estate insurance premiums	Compensation for job-related injuries	Sanatoriums, vacations	Resignation allowance	Family support	Other
1994	100	81.1	0.2	0.5	5.5	—	1.4	0.7	1.9	8.5
1998	100	90.8	0.3	0.5	1.7	1.3		1.1	1.1	2.8

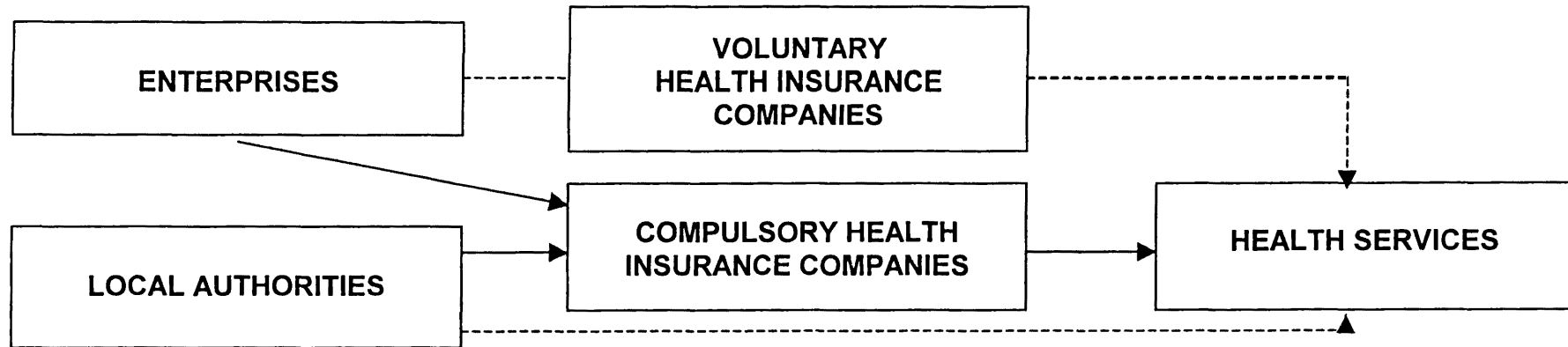
\* The data in Table A.3 present results of the two large-scale surveys carried out by the State Statistics Committee (*Goskomstat/Государственный комитет по статистике РФ*) in 1994 and 1998.

Source: Госкомстат (*Goscomstat*), 1996: 44-45; 1999:291



**Figure 1. Health and profit circle**

I. Flow of CHI Funds according to 1991 Law



II. Flow of CHI Funds changed by 1993 Amendments

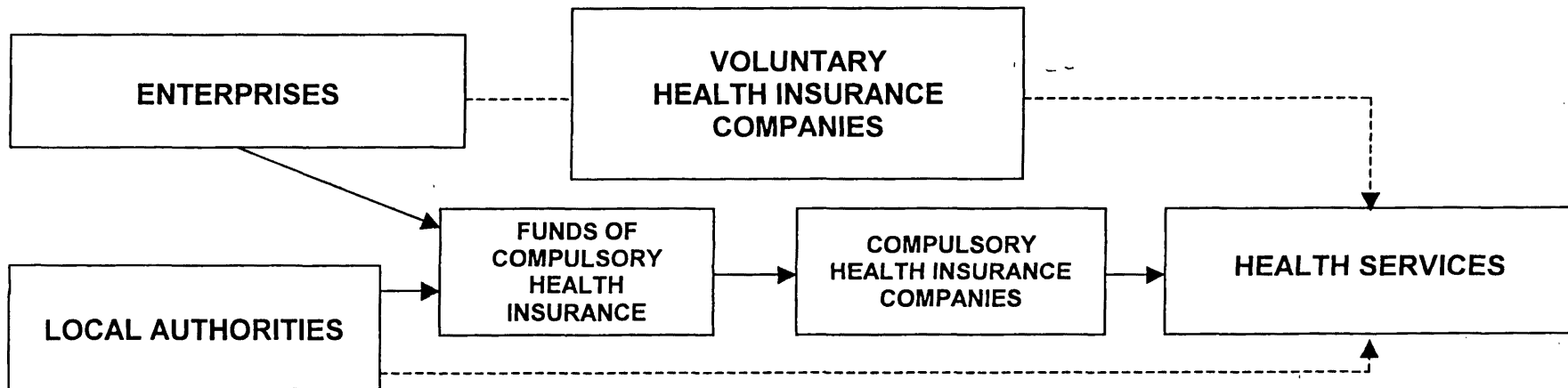


Figure 2. Flow of CHI Funds

Broken lines show relations outside CHI  
Source: compiled by the author

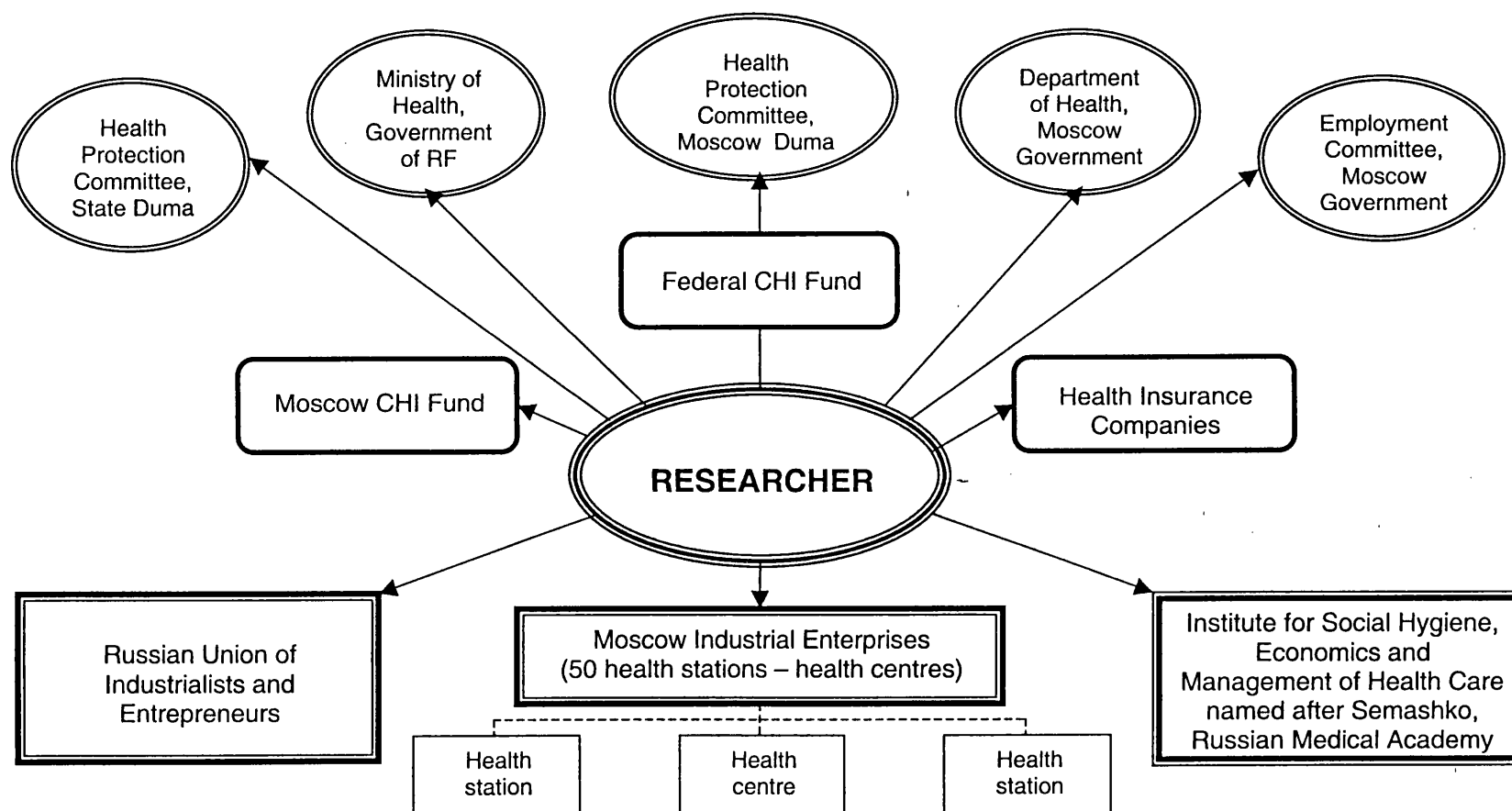


Figure 3. Field Work Map

Source: compiled by the author

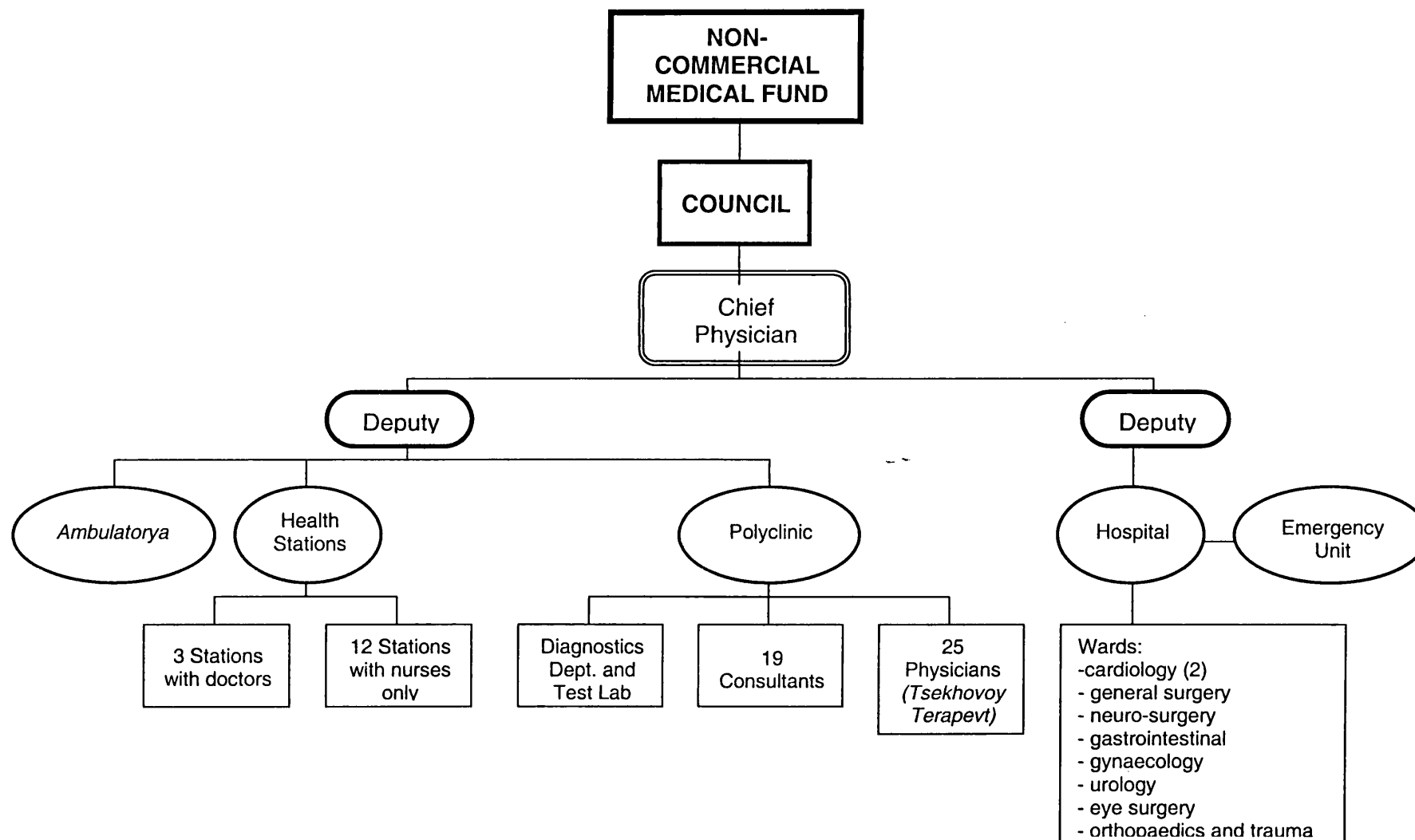


Figure 4. LIZ Health Centre

Source: compiled by the author

**APPENDIX B**

**QUESTIONNAIRE**

### **QUESTIONNAIRE FOR MANAGERS**

**We would like you to express your opinion as an employer on the problems and ways of reforming health care system in Russia, introduction of CHI and, in connection with this, on the role of employers in health protection of their employees.**

**Q. 1. To which extent are you informed about the development of CHI system in Russia? circle the appropriate statement**

1. Have been aware of the system development for a long time; have competent opinion.
2. Have got to know about the system recently, have an interest to know more.
3. Have heard a little about it, have got some information by chance.
4. Have not come across any information.
5. Have not got any interest in this information.

**Q. 2. Please, circle the statements that reflect your opinion.**

1. Introduction of CHI should not be accompanied by decrease in the level of the state financing.
2. CHI should be organised on a regional basis and financed mainly through local budgets.
3. CHI should be financed from local budgets and enterprise contributions.
4. People should contribute to CHI.
5. CHI system should level regional differences in health care.
6. The aim of CHI is to make access to health services easier for people
7. Minimum health services should be guaranteed by the state, the health care system should be built depending on financial resources of regions, enterprises, population.

**Q. 3. What aims do you think the government seeks to achieve, starting the current health care reform? Circle the number of the appropriate statements.**

1. To introduce enterprise contributions as a supplementary source of health care financing.
2. To change the structure of health care financing, using enterprises contributions to compensate for decrease in the state financing.
3. To improve quality of health care.
4. To give patients more choice.
5. To increase efficiency of health care system.
6. To make the first step towards privatisation of health services.

**Q. 4. What are you impressions about the activities of CHI bodies (funds, HIC)?**

1. This is a reliable system, working for people.
2. This is one of the many bureaucratic structures.
3. Health insurance companies use them for their own purposes, they hardly serve the interests of society.
4. Have not yet got any particular opinion.

**Q. 5. How would you evaluate the activities of the federal and local authorities in reforming the health care system in Russia? Please, mark in each row.**

	positive	rather positive	rather negative	negative	can't say	have no information
President						
Federal Assembly						
Ministry of Health						
Federal CHI Fund						
Moscow CHI fund						
Moscow authorities						
Employers						

**Q. 6. What are the factors that mainly influence the development of health centres/health stations in your enterprise?**

1. Pressure from employees (through collective agreement)
2. Decision of the shareholders' meeting
3. Financial status of your enterprise
4. Decision of the Board
5. Personal attitude of the director

**Q. 7. What, in your opinion, is the stage of development of CHI in Moscow? Circle the appropriate in each row**

1. The formation of CHI has been completed	2. The formation of the system has not yet been completed
3. The regional financing mechanism has been established	4. The regional financing mechanism is not working
5. CHI covers only the employed	6. CHI covers the majority of population
7. CHI compensates for only some types of medical treatment	8. CHI compensate for almost all types of medical treatment
9. Only some health services joined CHI	10. The majority of health services joined CHI
11. Have no idea about the organisation of CHI	



**Q. 8. Please, from the statements below choose the one that reflects your opinion best.**

1. The right to carry out health insurance should be given only to state or municipal -owned firms.
2. Private health insurance companies are more interested in money turnover, their activities should be under strict scrutiny.
3. Establishment of private companies will only allow at the first stage to overcome residual principle of health care financing and to create favourable conditions for CHI development.

**Q. 9. What are the reasons that hamper the development of CHI in Moscow? Please, circle only the most important or write in your own**

1. Nothing hampers.
2. Political instability
3. Lack of legislative regulations.
4. Lack of interest on the part of Moscow authorities.
5. Drop in enterprise profits.
6. Incompetence of Moscow authorities.
7. Hard to say.

**Q.10. Please, circle the statements with which you agree**

1. The state should assume the whole responsibility for the health care of its citizens
2. Every person should take care about his/her own health.
3. Employers should contribute to health care of employees, it is their social responsibility.
4. Employers could take part in health protection of their employees, but only in case they have financial resources.
5. Expenses on health protection of employees are additional non-productive expenditures.
6. Issues connected with employees' health protection are beyond employer's responsibilities.

**Q.11. Do you think that participating in CHI as it is organised now you fulfil your responsibilities as employer in health protection of your employees?**

fully	partly	considerably	to some extent	not at all	hard to say
6	5	4	3	2	1

**Q.12. Has an introduction of CHI contributions changed your attitude towards the role of enterprise in health protection of its employees?**

1. Yes
2. No ( if no go to Q 15).
3. Can't say

**Q.13. To what extent introduction of CHI contributions has changed your position to health care protection of your employees?**

to a great extent	to considerable extent	to some extent	very little	not at all	hard to say
6	5	4	3	2	1

**Q.14. If it has changed then how (circle the appropriate)**

1. Employers should undertake more effort to protect their own employees' health, CHI is not enough
2. Employers should fully rely on CHI
3. Employers should be more active in CHI system

**Q.15. How the development of health care plans at your firm could influence the following processes . Please, mark in each row: 0- do not influence, 1-influence, 2-Influence very much**

1. Providing stimulus for employees	
2. Trying to keep labour force	
3. Attracting employees	
4. Creating image of a good employer	
5. Preserving tradition	
6. Getting tax relief.	
7. As a part of recreation process	
8. Implementation of the constitutional right that goes with employment	

**Q.16. There are a lot of discussions now about the role which enterprises might play in health care. In connection with this what would be important for you as an employer? Please, circle the appropriate.**

1. Present system is ok: employers should only pay CHI contributions.
2. Employers should directly participate in taking decisions on CHI.
3. Employers should deal with HIC directly without any intermediaries.
4. Employers should have the right to choose between HIC.
5. Employers should pay for voluntary health insurance.
6. Employers should have financial concessions in CHI system provided they finance their own health care plans.

**Q.17. Do you think that CHI contributions are:**

1. ordinary tax
2. earmarked tax
3. rather a social obligation

**Q.18. Do you think in the nearest future would the contributions to CHI system are likely to:**

1. Increase
2. Remain the same
3. Decrease.
4. Can't answer/ difficult to predict

**Q.19. Do you think that in CHI system those employed should have (please, circle the appropriate)**

1. special regime
2. be treated equally with other groups of population
3. no opinion

Please, give a reason for your response

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**Q.20 Should employees contribute to CHI?**

1. Yes
2. No (if no, go to Q.21)
3. Hard to say

**Q.21. In what proportion?**

1. More than employers.
2. As much as employers.
3. Less than employers.
4. Hard to say

**Q 22. . At present firms participate in CHI, organised at the state level. What do you think might be other arrangements for a firm to participate in the health care system?**

1. Budget medicine should be preserved, financed from taxation
2. An enterprise should participate in CHI as it is organised by the state at present.
3. An enterprise could at its own discretion participate in voluntary health insurance in addition to CHI.
4. An enterprise could at its own discretion participate in health insurance programmes with the right in such a case to opt out of CHI.
5. An enterprise might provide medical services in kind for its employees with the right in such a case to opt out of CHI.
6. An enterprise is obliged by law to finance as well as administer its own health insurance plans with the state-organised health care system in this case covering only some categories of population (disabled, unemployed).
7. An enterprise should pay for medical services for their employees in case of emergency.

**Q. 23. Please, rank your choice for Q.22**

- 1.
- 2.
- 3.

**Q.24. To what extent you can in practice influence the adoption of decisions by legislative and executive bodies, concerning participation of firms in health protection of their employees:**

	to a great extent	to some extent	very little	not at all	hard to say
Moscow CHI fund					
Moscow Department of Health					
Local authorities in your area					

**Q.25. Do you discuss health care problems among the managerial staff of your enterprise?**

1. Often ( more than once a month)
2. Sometimes ( less than once a month)
3. Almost never.

**Q. 26. How decisions on health issues are usually taken at your enterprise?**

1. Reaching consensus between managers.
2. Voting at managerial meetings.
3. By those in charge.
4. Voting at labour collective meetings.

**Q 27. What is your role in the process of development of health plans at your enterprise? Please, circle one statement in each column.**

<u>methods of participation</u>	<u>style of behaviour</u>
1. generator of ideas	1. observer
2. concept developer	2. diplomat
3. analyst	3. centrist
4. expert-consultant	4. reformer
5. critic-opponent	5. conservative
6. head of the development team	
7 project manager	

**Q.28. What do your enterprise plan to do with health centres/health stations in the nearest future,**

1. Sell health care facilities.
2. Transfer them to local authorities.
3. Join CHI.
4. Provide treatment for employees only.
5. Expand the range of services provided.

**Q.29.Do you plan to arrange for voluntary health insurance in the nearest future:**

1. Yes
2. No
3. Hard to say

**Q 30. There are different opinions about whether employers need associations on federal and local level to help them to solve health care problems. What do you think about it?**

1. This is the task of Federal and Moscow CHI Funds
2. The creation of special associations in a new form is desirable
3. It is necessary to make better use of industry organisations
4. Have no opinion
5. Other, please, specify

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**Q 31. What among their tasks would be the most important for you (tick the appropriate)**

1. Representation of your interest on the national level on strategic issues
2. Representation of your interests on the local level
3. Nomination of employers' representatives to the Boards of CHI funds
4. Administration and finance of local health plans
5. Use jointly health facilities
6. Organisation of commercial activities in health and health insurance

**Personal details.**

**Sex:** 1. M 2. F

**Age:**

1. under 30 years old
2. 31-40 years old
3. 41-50 years old
4. 51-60 years old
5. above 60 years old

**Education:**

Graduate degrees

1. technical
2. humanitarian
3. natural sciences

other degrees\_\_\_\_\_

**THANK YOU FOR CO-OPERATION!**

## **АНКЕТА ДЛЯ МЕНЕДЖЕРОВ**

Просим Вас высказать свое отношение как работодателя к проблемам и путям реформирования здравоохранения в РФ, созданию системы обязательного медицинского страхования (ОМС) и в связи с этим к той роли, которую предприятие (организация) играет в охране здоровья своих сотрудников .

Для заполнения анкеты обведите номера ответов, соответствующих Вашему мнению, или напишите свое.

### **1. В какой степени Вы информированы о развитии в России системы обязательного медицинского страхования (ОМС)?**

1. Знаю о развитии системы давно, имею компетентное мнение.
2. Знаю недавно, заинтересован узнать побольше.
3. Кое-что слышал, имею случайную информацию.
4. Не встречал ни какой информации.
5. Меня эта информация не интересует.

### **2. Отметьте те суждения, с которыми Вы согласны.**

1. Развитие ОМС не должно сопровождаться снижением уровня госбюджетного финансирования.
2. ОМС должна строиться по территориальному принципу, финансирование в основном должно вестись из бюджетов регионов.
3. Финансирование ОМС должно вестись из бюджетов регионов и взносов предприятий (организаций).
4. Население должно принимать непосредственное участие в финансировании системы ОМС.
5. Система ОМС призвана нивелировать необоснованные различия в предоставлении медицинских услуг, возникшие в регионах.
6. Система ОМС направлена на то, чтобы медицинские услуги были более доступны для населения.
7. Минимум медицинских услуг должно гарантировать государство, система здравоохранения должна строиться в соответствии с финансовыми возможностями регионов, предприятий, населения.

**3 Какие цели, на Ваш взгляд, преследовало правительство, начиная современную реформу здравоохранения? Обведите необходимое.**

1. Ввести непосредственные взносы предприятий на ОМС как дополнительный источник финансовых средств для системы здравоохранения.
2. Изменить структуру финансирования отрасли, снизив государственное финансирование за счет привлечения средств предприятий (организаций).
3. Улучшить качество медицинских услуг.
4. Дать пациенту возможность выбора.
5. Повысить эффективность системы здравоохранения.
6. Сделать первый шаг к приватизации медицинских учреждений.

**4 Какое впечатление у Вас складывается в целом о работе организаций системы ОМС (фондов и страховых компаний)?**

1. Это надежная, нужная для населения система.
2. Это одна из многочисленных бюрократических структур.
3. Коммерческие структуры используют их для своих целей, они мало служат обществу.
4. Об этом у меня пока не сложилось впечатления.

**5. Как Вы оцениваете деятельность центральных и местных органов власти по реформированию системы здравоохранения в РФ? Отметьте по каждой строке**

-	Положительно	Скорее положительно	Скорее отрицательно	Отрицательно	Затрудняюсь ответить.	Не имею информации
Президента РФ						
Федерального Собрания РФ						
Минздрава РФ						
Федерального фонда ОМС						
местных исполнительных органов						
местного фонда ОМС						
руководителей предприятий						



**6. Какие факторы преимущественно влияют на развитие программ в области здравоохранения на Вашем предприятии? Отметьте необходимое.**

1. Давление со стороны работников (условия коллективного договора).
2. Позиция (решение собрания) акционеров.
3. Позиция (решение) правления.
4. Личная позиция руководителя предприятия (организации).
5. Финансовая ситуация на предприятии.
6. Наличие на балансе предприятия объектов здравоохранения.

**7. Что характерно для организации ОМС в Москве? Отметьте подходящее**

1. Формирование системы ОМС завершено	2. Система формируется
3. Создан региональный механизм финансовых поступлений	4. Финансирование системы затруднено
5. ОМС охватывает лишь работающих	6. ОМС охватывает большую часть населения
7. ОМС распространяется лишь на отдельные виды медицинской помощи	8. ОМС распространяется на большинство видов медицинской помощи
9. ОМС введено лишь в отдельных медицинских учреждениях	10. ОМС введено в большинстве медицинских учреждениях
11. С организацией ОМС в городе не знаком	

**8. Из приведенных ниже высказываний выберите одно, в наибольшей степени отвечающее Вашему мнению.**

1. Право заниматься страховой деятельностью в области медицины должно быть предоставлено лишь предприятиям государственной и муниципальной форм собственности.
2. Частные страховые компании больше заинтересованы в прокручивании денег, их деятельность нужно строго контролировать.
3. Только развитие частных страховых компаний позволит на первом этапе преодолеть остаточный принцип финансирования медицины, создать условия для полноценного развития ОМС.

**9. Какие причины, по Вашему мнению, осложняют создание системы ОМС в Вашем городе? Отметьте только самое важное или напишите свое.**

1. Ничего не осложняет.
2. Политическая нестабильность.
3. Отсутствие законодательной базы.
4. Незаинтересованность местных органов власти.
5. Снижение доходов предприятий.
6. Некомпетентность руководителей исполнительной власти.
7. Затрудняюсь ответить.

**10. Отметьте те суждения, с которыми Вы согласны.**

1. Государство должно полностью взять на себя заботу об охране здоровья населения.
2. Каждый человек должен прежде всего сам думать об охране своего здоровья.
3. Работодатели должны внести свой вклад в охрану здоровья своих сотрудников, это выражение их социальной ответственности.
4. Работодатели могут участвовать в охране здоровья своих сотрудников, но только в том случае, если для этого имеются соответствующие финансовые возможности.
5. Расходы по охране здоровья работников - это дополнительные непроизводительные расходы.
6. Вопросы, связанные с охраной здоровья работников, лежат вне пределов обязанностей работодателя.

**11. Считаете ли Вы, что участвуя в ОМС в том виде как оно организовано в настоящий момент Вы выполняете свои обязательства как работодатель по охране здоровья своих сотрудников? Выберите и обведите необходимое**

1. Полностью выполняю.
2. В значительной мере.
3. Выполняю частично.
4. В определенной степени.
5. Совсем не выполняю.
6. Затрудняюсь ответить.

**12. Повлияло ли введение отчислений на ОМС на Вашу позицию по вопросу о роли предприятия в охране здоровья работников?**

1. Да
2. Нет (пропустите вопросы 13 и 14, переходите к 15 вопросу)
3. Затрудняюсь ответить.

**13. Если да то насколько? Обведите необходимое**

Очень сильно	Значительно	В некоторой степени	Незначительно	Совсем не изменилась	Трудно сказать
6	5	4	3	2	1

**14.Если она изменилась, то каким образом?**

1. Работодателю следует предпринимать дополнительные усилия по охране здоровья своих работников, система ОМС не обеспечивает потребностей сотрудников.
2. Работодателю следует ограничиться участием в ОМС как оно организовано в настоящий момент.
3. Работодателю следует проявлять большую активность в системе ОМС.

**15. Насколько развитие медицинских программ на Вашем предприятии (организации) может повлиять на следующие процессы. Оцените, пожалуйста, по каждой позиции по баллам: 0-не влияет, 1-влияет, 2-сильно влияет.**

Стимулирование трудовой активности.	
Сохранение кадров.	
Привлечение кадров нужной квалификации.	
Создание имиджа предприятия, предпринимателя.	
Поддержание традиций предприятия.	
Снижение налогового бремени.	
Часть процесса восстановления рабочей силы	
Реализация конституционных прав занятых.	

**16 Сейчас много говорят о той роли, которую предприятие могло бы сыграть в системе ОМС, складывающейся сейчас в России. В связи с этим что было бы важно для Вас как работодателя?**

1. Существующая система удовлетворительна: работодателям достаточно просто платить взносы на финансирование ОМС.
2. Работодатели должны принимать непосредственное участие в принятии решений по поводу организации и финансирования системы ОМС.
3. Работодатели должны иметь дело непосредственно со страховыми компаниями без участия посредников.
4. Работодатели должны иметь право выбирать между страховыми компаниями.
5. Работодатели должно заключать договоры о добровольном медицинском страховании своих сотрудников.
6. Работодатели должны иметь право на финансовые льготы в системе ОМС при условии организации ими собственных программ по здравоохранению.

**17. Как Вы рассматриваете взносы на ОМС?**

1. Обычный налог.
2. Специальный налог.
3. Скорее как социальное обязательство.

**18. Как Вы считаете, что в ближайшем будущем произойдет с взносами на ОМС?**

1. Увеличатся.
2. Останутся такими же.
3. Уменьшатся.
4. Трудно предсказать.

**19. Как Вы считаете, каково должно быть отношение к работающим в системе ОМС,**

1. Должны пользоваться специальным режимом.
2. На общих основаниях.
3. Затрудняюсь ответить.

Укажите, пожалуйста, почему \_\_\_\_\_

\_\_\_\_\_

**20. Должны ли работники нести расходы по ОМС?**

1. Да.
2. Нет. ( пропустите 21 вопрос, переходите сразу к 22 вопросу).
3. Затрудняюсь ответить.

**21. Если да, то в какой пропорции?**

1. Больше, чем работодатель.
2. В равной доле с работодателем.
3. Меньше, чем работодатель.

**22. В настоящее время предприятие (организация) участвует в системе ОМС, организованного на государственном уровне. Как Вы считаете, в каких других формах может предприятие (организация) участвовать в работе системе здравоохранения? Отметьте необходимое.**

1. Сохраняется система государственного здравоохранения, финансируемого из общих бюджетных средств.
2. Предприятие участвует в ОМС, организованном на государственном уровне в его современном виде.
3. Предприятие по желанию помимо участия в ОМС заключает договор о добровольном медицинском страховании.
4. Предприятие по желанию участвует в страховых медицинских программах, получая при этом возможность не участвовать в общей системе ОМС.
5. Предприятие непосредственно обеспечивает своих сотрудников медицинскими услугами в собственных медико-санитарных частях, получая при этом право на выхода из системы ОМС.
6. Предприятие обязано по закону финансировать собственные медицинские программы для работников, государственное здравоохранение при этом ограничено отдельными категориями населения (нетрудоспособные, безработные).
7. Предприятие оплачивает медицинскую помощь сотрудникам в экстренных случаях.

**23 Проранжируйте, пожалуйста, Ваш выбор.**

- 1.
- 2.
- 3.

**24. Оцените степень Вашего влияния как работодателя на практике на принятие государственными органами решений, касающихся участия предприятия (организации) в системе здравоохранения?**

	высокая	средняя	низкая	нет влияния	затрудняюсь ответить
Московский Фонд ОМС					
Департамент здравоохранения Москвы					
Местные органы исполнительной власти					

**25. Обсуждаете ли Вы проблемы, связанные с охраной здоровья работников, среди руководителей Вашего предприятия?**

1. Часто ( чаще, чем раз в месяц)
2. Иногда (реже, чем раз в месяц)
3. Почти никогда.

**26. Как принимаются решения по вопросам охраны здоровья сотрудников на Вашем предприятии?**

1. Достижение консенсуса среди руководства предприятия.
2. Проведение голосования среди руководителей предприятия/акционеров.
3. По решению руководителей, непосредственно отвечающих за данные вопросы
4. Проведение голосования на общем собрании трудового коллектива.

**27. Какова Ваша роль в процессе разработки системы социальной защиты ( в том числе в области здравоохранения) на Вашем предприятии? Отметьте необходимое по каждому столбцу**

<u>По методам участия</u>	<u>По стилю поведения</u>
1. генератор идей	1. наблюдатель
2. разработчик концепции	2. дипломат
3. аналитик-прогнозист	3. центрист
4. эксперт-консультант	4. радикал-революционер
5. критик-оппонент	5. сторонник традиций
6. организатор группы разработчиков	
7. руководитель проекта в целом	

**28. Что Вы планируете предпринять в ближайшем будущем по поводу объектов здравоохранения? Отметьте необходимое.**

1. Открыть их для системы ОМС.
2. Продолжать обслуживать только своих работников.
3. Расширить объем предоставляемых медицинских услуг.
4. Продать.
5. Передать на баланс местных органов власти.

**29. Планируете ли Вы в ближайшем будущем принять участие в добровольном медицинском страховании?**

1. Да
2. Нет
3. Трудно сказать

Укажите, пожалуйста, почему \_\_\_\_\_

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**30. Есть разные мнения о необходимости объединения усилий работодателей в решении проблем здравоохранения на общероссийском и региональном уровне. Что Вы об этом думаете? Отметьте необходимое или напишите свое.**

1. Это задача федерального и территориальных фондов ОМС.
2. Необходимо лучше использовать отраслевые/ведомственные организации
3. Желательно создание специальных ассоциаций работодателей в новых формах
4. Не имею определенного мнения
5. Другое, напишите \_\_\_\_\_

**31. Какие из возможных функций таких организаций (ассоциаций) наиболее актуальны для Вас? Подчеркните необходимое.**

1. Представительство интересов работодателей в центральных органах власти.
2. Представительство интересов работодателей в местных органах власти.
3. Номинация представителей работодателей в правления фондов ОМС.
4. Организация и финансирование местных страховых медицинских программ.
5. Совместная эксплуатация местных и ведомственных объектов здравоохранения.
6. Организация коммерческой деятельности в области здравоохранения и медицинского страхования.
7. Развитие международных связей и проектов.

Ваш пол: 1. мужской      2. женский

Ваш возраст:

- 1.- до 30 лет
- 2- от 31 до 40 лет
- 3 от 41-50 лет
- 4 51-60 лет
- 5 старше 60 лет

Образование:

- 1 высшее техническое
- 2 высшее гуманитарное
- 3 высшее естественно-научное
- 4 среднее специальное

**СПАСИБО ЗА СОТРУДНИЧЕСТВО!**



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