

Bulgaria: report on emerging themes from the interviews

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**Siyka Kovacheva - New Europe Centre for Regional
Studies**



Universiteit Utrecht



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Bulgaria: University hospital

This report presents results from the initial analysis of the qualitative data of the case-study organisation in Bulgaria, gathered within the framework of the research project Quality of life funded by the 6th FP of the EC. It will be followed by a presentation of the outcomes of the problem solving group in a separate report. For a fuller understanding of the quality of life of the employees in the organisation, it is necessary to take into account the findings of the survey carried out in the same company in comparison with the other 3 companies studied in Bulgaria, as well as with the organisations in the same sector in the other European countries taking part in the research.

Introduction

In Bulgaria the case study of a healthy organisation is a university hospital. The social context of the study is characterised by a wide-scale reform of the health sector which often rose to the top of the public debate. While other sectors of the economy in the country quickly started restructuring after the regime change in November 1989, the new political elite was slow and dubious whether and how to reform the health care in the country. As Pashev (2007) points out, there is no *acquis communautaire* at the European level, and hence the health reform was not among the priorities of Bulgaria's accession to the Union. However, the problems in the system for health protection in Bulgaria which had started to show up already in the 1980s accumulated in the first half of the 1990s together with a significant deterioration of the health status of the population manifested in a sharp rise in mortality and a decline in life expectancy (Kovacheva et al, 2006). The radical reform was launched in 1997, with the Law on Health Insurance, the Law on Health Institutions, the Law on the Professional Associations of Doctors and Dentists and the introduction of market mechanisms and democratic governance in the health system in Bulgaria. The state monopoly over health care was abolished, private services began to be offered in the market, the system of general practitioners was introduced to replace the former polyclinics and businesses and employees started paying for obligatory health insurance. For five years of a 'rationalisation of the health care', 1997-2001, the number of hospital beds was reduced by 38%, the number of patients – by 23%, the hospitalisation coefficient dropped by 10% (Dimova et al, 2007). The financing of the health care system shifted from mainly state support to health insurance. The private hospitals spread and the number of patients treated in them increased manifold. In the first decade of the 21st century the results from the reform began to be noticed in the halting of the negative trend of the health status of the population, however, without achieving a significant improvement. The Ministry of Health Protection (2007) admitted that the restructuring of health services in the hospitals still lagged far behind the reforms in pre-hospital care. The medical personnel in state hospitals began organising collective protests and the first patients' associations appeared in the country.

At the time of the fieldwork (June-July 2007) doctors and nurses from the emergency hospital in Sofia were on strike gathering in front of the hospital or the parliament or marching in the streets. For three days, 13-15 July, they declared an effective strike and refused to accept patients who were then directed to other hospitals. The media widely reported the protest, as well as the response of state officials who claimed that any increase in the financing of the hospital will destabilise the state budget and tried to focus public attention on informal payments made by patients to doctors and nurses. On 16 July 2007 the strike committee and the Ministry of Health Care signed an agreement over a pay rise and a change of the Board

of Directors managing the hospital. The strike of the medical personnel was followed a successful collective action by Sofia public transport drivers in May and coincided with protest actions of miners in South Bulgaria. The inadequate payment of medical services by the Health Insurance Institute and the low level of doctors' and nurses' salaries, as well as cases of corruption, illegal payments of services, party interference in privatisation deals and in election of the executive boards of healthcare institutions, cases of patients' dissatisfaction all featured in the public debate accompanying the strike. Many of our interviewees commented on these events and the way the government dealt with them. At the time this report was being written (September-October 2007), other public sector employees, namely teachers from kindergartens, primary and secondary schools were on strike with universities threatening to follow. University hospitals did not feature as active agents in this latest mobilisation wave.

Organisational background

The university hospital we studied is the largest hospital in the South Central area of the country. It deals with regular patient care, education and training of medical students and research, as well as acts as an emergency centre for patients from Southern Bulgaria and a National centre for organ and tissue donation. The hospital has 2550 employees. It has a long tradition of delivering health services (founded in 1879, the first year of the formation of an independent Bulgarian state) and still is one of the stable health care institutions in the country compared to many struggling hospitals under the conditions of a painful wide scale health reform in the country.

According to the check list of workplace characteristics filled in during the fieldwork, the mean age of the personnel is 45 years; the proportion of male/female employees is 650/1900 while the proportion of male/female managers is 30/24. The most common form of contract is the permanent full-time contract. Thus 2502 employees work full-time and only 48 work part-time, of the latter 27 are women and 21 are men. The part-time contracts have not been requested by the employees – either the position is for half a post linked to the volume of work in the clinic/department or they are given to university faculty as a second contract of 25% to 50% while their main and full-time contract is with the medical university. The temporary contracts are 143 and are held by people acting as replacements for permanent personnel who are on a long leave (maternity, parental or temporary disability/sick leave).

The management did not have official statistics about the sickness rate of the personnel (the other companies in the survey also did not have data on such an indicator). There is very little turnover of the personnel in the past few years – the new recruits were about 1% of the staff and 0.75% left the hospital in 2006. The management did not report any problems of recruiting or keeping the staff. Most of the positions (doctors and senior nurses, middle and high management) are filled in by a process of competition. There are three professional associations in the hospital and the degree of unionisation is very high – about 90%. The interviewed trade union leader said that the hospital is the biggest union in the city while previously these were the big industrial enterprises.

The flexibility of working time policies is rather low – less than 2% work on a part-time basis. The typical working week is 40 hours which makes 2080 yearly working hours. There is no flexitime, compressed work week, job share, or tele-work even for the administrative personnel who also have fixed starting and ending hours of the working day. However, there is a widespread practice of shift work, the so called 'dezurstva', so that while the normal working time is from 7.30 till 16.00 with half an hour lunch break,

there is always medical personnel caring for the patients in the clinics 24 hours seven days a week. Many doctors and nurses have 7 or 6 hour working day in recognition of their particular working conditions (e.g. working with x-ray machines).

The yearly leave (called also summer holidays) is between 30 and 48 days a year depending on the position in the organizational hierarchy and the collective agreement. Maternity leave, paid at 90% of the salary, is 315 days (at the time of the survey there were 38 mothers on such a leave). It can be taken only by the mother and on a full-time basis. Parental leave is up to the second year of the child, paid at a flat rate (the minimum salary in the country) and at the time of the fieldwork 24 mothers and 2 fathers were on such a leave. Family or other emergency leave is unpaid and can be taken for a period from 15 days to one year. There were five nurses and two doctors who were using such a leave while trying to establish themselves in jobs abroad. Their places at the hospital were kept for one year after which they could return or leave the organization. Working parents are also eligible for a sick child care leave of 60 days per child per year fully paid and 10 days per year for care of a severely ill family member.

All the family leave policies are statutory and valid for both public and private companies in Bulgaria. There were no particular organisational policies in the hospital to help the integration of work and family life. The medical personnel were using the shift work arrangements to negotiate convenient time for different commitments (child care, care of sick relatives, second jobs, additional training). There was no workplace crèche or kindergarten, no financial or organisational support for finding a place in kindergartens in the city (most of which are public and charging very low monthly fees – about half a per cent of the monthly salary of a doctor). The hospital has inherited two holiday homes (one at the Black sea and one in the Rhodopi Mountains) from the communist past when summer holidays were typically organised by the state enterprises for their employees. However, the practice of private holidays was becoming more and more spread. The hospital offered free medical services for the personnel, prophylactics in particular, and insurance for professional risks.

Organisational change

In 2000 the university hospital was transformed into a trade corporation and was licensed as a teaching hospital in January 2001 under the auspices of the Ministry of Health while the Medical University was registered as a separate company under the auspices of the Ministry of Education. The two organisations continue to cooperate in education and research. This act was a major change in the financing of the hospital – the basic share in the hospital budget now comes from the Health Insurance Institute linked to preset sums for the treatment of various diseases (the so called ‘clinical paths’) while the financing from the Ministry was curtailed and is now provided only for some specific activities. The first years of the restructuring resulted in accumulation of debts by the ‘trade corporation’ (similarly to most hospitals in the country) and a sharp fall in the salaries of the personnel. However, after a change in the hospital management in 2005 and new regulations of the Health Insurance Institute the hospital started to pay its debts and is now registering a small profit (unlike most other hospitals in the country). There were two increases in the salaries of the personnel in 2007 – the first in January 2007 linked to the rise of the minimum salary in the country and the next in July 2007. The staff were fully aware how their salaries were formed at present and our respondents – not only the financial officer but also doctors in training and nurses – freely commented on the mechanisms and how these should be changed in their opinion.

Other changes concern the way patient care is reported, new regulations for the payment of maternity and sick leaves of the staff, introduction of internal computer links between the departments of the hospital. Rising numbers of patients and a wider range of services were also aspects affecting the quality of work of employees. New medical equipment was being introduced in some of the clinics. The premises of the hospital were built in 1980 and at the time of the interviews there was a reconstruction work going on in some of the departments. All the organisational changes were officially motivated by the need for greater competitiveness of the hospital in terms of economic efficiency and better health care for the patients. Clearly both arguments are more closely targeting organisational effectiveness than employees' quality of life which nonetheless is also affected by them.

In general, the hospital is considered a good employer offering secure jobs, with fixed working time (rarely requiring extra time), not badly paid and providing all family leaves allowed by the state. Working in it has the additional prestige of working in a university hospital with the most advanced technology, good career prospects and intellectual climate. With the private sector developing in the country most of the doctors and many nurses work additionally in private clinics or have their own practices. In the university hospital there are no organisational policies for gender equality besides the official proclamation of adhering to the general non-discrimination policies. A strict professional hierarchy is part of the organisational culture while cooperation and trust seem limited to the smaller units – clinics and departments.

The fieldwork

The interviews were conducted by a team of four university students and the national coordinator in Bulgaria. The Human Resources manager of the hospital ensured a signed agreement by the Director for the interviews and the problem solving group (previously his signature and agreement were provided for the survey). The team received a list of respondents spread among the three main categories of staff: doctors, nurses and administration. In the previous stage of the research the survey targeted other groups of employees as well - carers and drivers/security guards in the hospital. The management had plans to start subcontracting the latter services. In the course of the fieldwork four employees were added to the initial list. All in all we interviewed 14 employees, eight women and six men. Of these three were administrative workers, seven doctors and four nurses. Three of the doctors also had managerial functions and one was a trade union leader. Two of the doctors were in training working to gain residency (clinical training in a chosen specialty). Two of the doctors and one of the nurses were in their thirties, four interviewees were in their fifties, and the rest, seven people were in their forties. The medical personnel interviewed worked in five different divisions of the hospital (out of 25 divisions).

The interviews were conducted on the site of the hospital – in the offices of the interviewees and in department meeting rooms. This was the wish of the interviewees although we offered them sites outside the hospital and in the city centre. The interviews lasted between an hour and an hour and a half, with almost a third of them having short (less than 5 minutes) interruptions for phone calls to the interviewees. In general the respondents were interested in the theme of the study and freely expressed their opinions. One of the doctors commented that such a study would not have been possible 15 years ago when nobody would have been interested in the quality of work and life of the medical personnel and at best the interviewers would have been allowed to listen to declarative speeches by the most obedient (and old) Professors.

Emerging themes as challenges and supports for organisational health

The interviews focused on respondents' perceptions of the challenges and resources for achieving the dual agenda of the hospital as a healthy organisation (Rappoport et al, 2002). In the following we first present interviewees' views on the dual agenda, quality of work and quality of life (Beham et al, 2006). We then discuss the two aspects of workplace practices and underlying assumptions about gender equity and work/life balance. The paragraph continues with a list of other emerging themes discussed by the employees closely linked to the integration of the goals of economic efficiency and quality of life. We end with a discussion of the perceived challenges in front of the organisation in the near future.

1. The 'dual agenda' of the hospital

First of all, we should state that all employees – managers, doctors and nurses – accepted that a healthy organisation is both desirable and possible. They varied in their opinions whether the hospital they worked in was close or far away from being such an organisation.

The sustainable organisation was perceived as one that was both efficient in economic terms providing high quality services and in social terms, ensuring high quality of work and life for the employees. It seemed that a third factor interfered in the Interviewees' perceptions of the organisation with a dual agenda – the moral responsibility to the patient. So the healthy organisation was one which was, first, economically efficient, second, caring for the patients, and third, caring for the employees.

The positive opinions about the university hospital as a healthy organisation stressed the financial stability of the organization, the satisfaction of patients with the services as well as the satisfaction of the medical personnel with the working conditions. As in our previous study Transitions (Kovacheva and Matev, 2005), it was considered that organizations in the state sector offered better working conditions and adhered to state social legislation more strictly than those in the private sector. (The negative opinions about the hospital as being far from a healthy organization model are presented in 5.5. Perceptions of current challenges).

I. Do you think that a 'healthy' organization is possible in Bulgaria?

R. Yes, this is an organization with a healthy proportion of money, work, satisfied patients and satisfied doctors. We are coming close to this model.

Man, doctor

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R. The main goal of our hospital, being now a for-profit organization, is for the two things to be advancing simultaneously – the quality of work, the satisfaction of both patients and hospital employees... we want to be able to achieve both together.

Woman, main nurse

I. What does it mean to work in a state hospital these days?

R. I haven't worked in a private hospital but I have worked in a private organization. A state organization means a better social policy: you can take medical leave, annual leave, you have a

stable labour contract, you have the right to be a member of a labour union, the extra work is paid as well as the night work... For example a person can have difficulties if one is a woman with a child and the child is frequently sick. Here, in this workplace this is not a problem. I myself have not had to use up my leave for such reasons but I have seen my colleagues do it. This is a thing that cannot be tolerated at a private organization. There you simply must work non stop. If you take leave all the time, then the whole organization would suffer.

I. Here, in this hospital, doesn't this affect the economic effectiveness?

R. Well, here I work in the emergency room, so this practice of taking leaves is not that much tolerated either. When an employee is unavailable for this or that reason, the rest need to cover for her, because our work is constant – we work 24-hour shifts. In the end, the state organization takes care of you when you have difficulties, so that you are not sacked from your job. In a private organization they won't even think about it and sack you immediately.

Woman, doctor

2. Quality of work and quality of life

The interviewees also commented about their understanding of the quality of work and quality of life. Commonly the quality of work was linked to workplace efficiency – the fast and successful care of the patient. Quality of life was mostly associated with a high living standard rather than with goals beyond. Most opinions linked the two concepts – the quality of work led to higher financial rewards which in turn led to a higher quality of life of the medics and their families.

I. What do you understand when you say quality of life?

R. For me quality of life means to be financially independent, to be able to afford... for example, to own a home, a car, to be able to support your family, to buy food, medicines, to go on vacation, and for all this not to be luxury as it has been in these last years in Bulgaria. The quality of life is still too low, because all the time you have to think before you buy the most simple things. Unfortunately, there is so much left to be desired.

Woman, doctor

I. How would you define, in general terms, quality of work?

R. Well, I think it implies that the patient has to leave happy the doctor's office and the doctor needs to be satisfied with the work conditions, with the amount of money that is sent to his bank account as salary and to achieve a truly higher standard of life so that the doctors don't have financial worries, in order to be able to concentrate on their work. This is important because here they not only do check-ups on patients but also they do scientific research. That is why we need a high level of work quality.

I. What about quality of life – how do you imagine a good quality of life in Bulgaria?

R. Well, a person has to be able to afford more things, both for consumption, as well as better housing, furnishing, and a good car. Overall, a better living standard. This is a thing that already has been achieved by some countries. Because we don't work less than they do [in other countries].

Woman, manager

I. In your view what does quality of work mean?

R. Quality of work means to work well and for this work to receive a good salary. This is what quality of work means for me.

I. In your view what does quality of life mean?

R. It is determined by the quality of work. If you don't have a good quality of work, you cannot have a good quality of life.

Man, doctor

3. Gender equity

All the nurses in the hospital are women, doctors are equally divided between men and women and the administrative staff is comprised of more women than men. Men are the majority in the managerial positions of the clinics and the hospital as a whole. Respondents did not perceive an equity problem in the organisation and all stated that women had equal chances for a career. Professionalism, abilities, and devotion to work were cited as conditions for recruitment and advance. Only one woman doctor admitted having problems when applying for jobs before coming to the hospital. In this hospital she reported noticing a different attitude to women and men shown by experts when invited for consultations in the emergency clinic. The underlying assumptions in those cases were that women were less capable of establishing order and discipline and that women doctors were more prone to panic than men doctors in cases of emergency.

However, it was clear from the interviews that the dominant conviction among administrative and medical personnel and particularly among male managers was that women doctors when becoming mothers would start caring for their children and would be less devoted to their job. The practices of combining work and family responsibilities in the hospital confirmed this. There were only two male doctors among the 2500 staff of the hospital who used part of the parental leave and it was women doctors and nurses who used child sick leaves after returning to work. Women were not demoted after coming back from a lengthy parental leave (up to 3 years) but the need to catch up with new developments and the additional burden on colleagues from frequent absences of mothers caring for sick children were pointed at as problems associated with having young women employees. In the hospital, as well as in the wider society, it is considered and practiced that the mother should take the main responsibility in terms of time and career slow down to care for small children while the father's responsibility is mainly to provide the financial security of the family (while the mother traditionally adds an important but smaller amount to it).

I. Is there a difference in the working conditions of men and women?

R. They are the same. There is no division based on gender. After all we do observe here the law against discrimination. We do not allow any such gender division to exist.

Woman, manager

I. If a woman applies for a job and the other candidates are men, who do you think would be chosen?

R. I personally have not had a problem here so far. However, when I finished medical school there was a position as a school physician in a secondary vocational school and it was stipulated that they were looking for a man. Also, there was another position as a GP (general practitioner) and that job also got a colleague of mine, not because he was better than me but

because he was a man. Only when I started looking for a job, I realized that being a woman is a disadvantage. No one asks you for your diploma to see how you've done in school or gives you a test to determine if you are better than them... simply, it is a condition, you cannot change, you are either a man or a woman.

I. How do you explain this, why is it that they prefer to hire men?

R. The problem is that when a woman is young, she hasn't finished her parental obligations. This is a question that they ask whether you are married, whether you intend on having kids. I haven't experienced this myself but I have heard it from women colleagues of mine. And when you have kids they can be sick and you have to take a leave to care for them and in the industry this can be a serious disadvantage. Besides, if you are unmarried you might decide to get married and to leave work and this is perceived as irresponsible, as if you are not a responsible person, whereas a man cares about his career to a greater extent. That is how society perceives it although I myself am not convinced this is true.

Woman, doctor, emergency

I. Is it more difficult for a woman to succeed in surgery than a man?

R. Well, I think that if you are good enough you would succeed. If you haven't, this is simply because you are not good enough.

I. Does it matter if a woman is not only a physician but also a mother?

R. Well, this again is a personal choice. If one wants something badly enough she will succeed regardless of her gender or marital status. Nothing can stop her. Moreover, we woman are tougher than men.

Nurse in a cardiovascular unit

I. Is it different, in your opinion, for men and women? Are the requirements in the hospital the same?

R. Everyone is required to do what is stipulated in their job description. Man, woman, it doesn't matter at all. For example, we had a man nurse, and he worked the same tasks as the other nurses.

I. Does this apply to women doctors?

R. Of course, they have the same shifts as we do. We even have a woman surgeon. Of course, she is a young colleague, and is still learning. She is yet to complete her training and so on, but there is no gender discrimination.

I. So there is not perception that women cannot make good surgeons?

R. There is such a perception only in people's minds and in their attitude towards questions such as pregnancy, maternity leave, afterwards sick leaves to care for a child, all these things... when a child is sick and the woman cannot come to work, someone else has to come as a substitute, the schedule needs to be changed, it is changed, then the woman comes back and so on. We make sure that we don't leave the patients without an attending.

Male doctor, chief of a hospital unit

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R. There is no discrimination here but you know that at the moment a woman marries and has children, she can no longer be that invested in her work duties.

Male doctor, manager of a hospital department

4. Individual strategies for integrating work and wider life and organisational support

Most of the employees said that they tried to keep work and family life separated. More often it was work that spilled over life at home – with fatigue, lack of time when needed, thoughts and fears about patients. There were no cases of a reduced working time demanded by employees with care responsibilities. It was considered that the working schedules gave enough flexibility and when the week schedule was decided there was enough understanding and collaboration between colleagues to arrange the hours to match everybody's needs. Many of the doctors and some of the nurses reported working additionally in private clinics and this was felt as a serious limitation of the time spent in the family but also as a great financial support to the family in time of economic difficulties. No demands were raised to the university hospital as an employer to provide additional support for work-life balance. The colleagues at the department were seen as the source of greatest support. Low income was defined as the main barrier for a better work-life balance. The traditional division of housework and child care was not questioned at all.

I. Would you say that the hospital as an organization provides opportunities to combine work with family life? For example, if an employee has a small child or a sick parent?

R. Well, I think that these spheres can be combined. The majority of the personnel here, over 2000 people, work in shifts. It is possible for the schedule to be organized in such a way so that it is convenient for the individual employees. Overall there is an understanding about this in the different clinics here. Whenever one is free they take the shift of a colleague and then the colleague returns the favor. At the beginning of the month the schedule is created by taking into account the employees' engagements outside work. However, they are aware that this is their job and they are required to complete all their shifts.

Woman, administrative manager

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R...Here, I am a doctor, and my wife is a doctor, too. She comes home from work and starts cooking. She is not only a doctor but also a housewife. It should be possible for her to come home to rest after her busy workday. For example I repaint the windows at home and I do the repairs of the car myself. I don't think this is right. The doctor needs to be able when he or she comes home to relax and to think of how to further one's professional training. Instead we come home to fry food or change the oil of the car. Such things need to be fixed...

Male doctor

I. You mentioned that there were times when you had to work 24 hours. How do people with small children cope?

R. Well, they manage. Why shouldn't they be able to manage, they are young girls and I have done this myself. I've managed to make sure that my family does not suffer from my absence, neither my children nor my husband. When I am here I concentrate myself entirely on the patients. When I leave work I no longer think about here. I have a personal life; I take care of my family and my husband. So, I think that the young ones would manage as well.

I. Did you sacrifice work for the family or vice versa?

R. No... I am trying to combine the two. When it is very stressed as was yesterday and in addition the heat wave added additional burden with the walk to the bus stop, then a person comes home stressed and this has some effect. However, my children are grown up, my elder daughter is 18 and the younger one is 17, but I still consider them children. At some point one feels that one is too strict, that I was unjustifiably angry with them for messing up the house, so then I stopped myself and apologized.

Woman nurse

I. How do you succeed in combining personal life with the professional career?

R. This busy schedule affects the personal life. I think the biggest impact is the absence from home during the night. The whole family needs to adjust their rhythm to my schedule when I have a night shift. I do think this affects the family but they are used to it by now. Yet it is me the one who makes them in some way change their rhythm of life. They are used to it and they support me. Another problem is going on vacations – out of four weekends in the month, very often I have only one weekend in which I don't have a shift either during the day or at night.

Woman, nurse

5. Perceptions of current challenges in front of the hospital and its dual agenda

The three most commonly commented themes by the employees were the financial stability of the hospital in the new market environment, the need for constant improvement of the equipment and training of the personnel. The latter two were considered to be limited by the former. Many employees expressed their dissatisfaction with the state withdrawal from financing the hospital, and more generally the health sector in the country, including technological innovation and training of human resources. All agreed that there was an inadequate payment of the medical profession. Dissatisfaction, however, was not very strong and many interviewees admitted that their hospital as a company and they personally were not doing as bad as other medical institutions in the country. The administrative personnel considered that the hospital provided better financial remuneration than others and many doctors approved of the new market opportunities to hold a second job.

The discussion of salaries was very often prompted by the public debate over the strike of personnel in the 'Pirogov' hospital in Sofia who insisted on a better pay by the state. Another more significant reason was linked to the economic reforms of the health care. During communism the salaries were fixed with the positions and, as one of the interviewed doctors put it, 'it didn't matter how much you worked, all got the same at the end of the month'. The current change aiming toward making the payment dependent on the personal contribution arose debates about justice, doctor's moral responsibility, about the moral balance between consideration of profit and patient care. Health insurance, clinical paths, profits and debts were very new themes in the experiences of the personnel and all seemed interested and held opinions about them. Other emerging themes were the growing work intensity, problems with the further training of the personnel, and rising demands and expectations by patients.

- ***financial problems of the hospital***

Most interviewees cited inadequate payment of services by the National Health Insurance Institute, lack of state support for public health, inadequate level of salaries in comparison with the work done by doctors and particularly nurses. However this was perceived more of a problem of the health care sector in the country than of the hospital and many respondents stated that their payment was higher than in other medical organisations. The fact that there were additions to the salaries depending on the number of patients treated was seen as a positive change in the past 3 years.

R. The problems are mainly caused by the financing of the National Health Insurance Institute (NHII). The hospital is a for-profit organization but doesn't have the right to determine the prices of the medical services. The NHII is a monopoly and you cannot negotiate with another insurance institute if this one doesn't pay for the services according to their real costs. The main reason for our financial instability is the incompatibility between our real expenses for a given clinical path and that which is paid by the NHII.

Man, administrative director

R. We are a very long way from such [healthy] organization. Here, the financing is only coming from the NHII, but we also have a lot of patients who do not have health insurance who make their way here after injuries from a fight, or car accidents and we need to help them immediately. When we work night shifts we don't have time to check whether they are insured or not, we need to provide emergency care and this is our practice, it happens every day... in this way money for such patients does not come from the state... the state has abdicated. For example, our clinic works exactly like this, we look after the patient, use medicaments, labor and all this is not paid by the NHII.

Woman, nurse

I. Which would you consider the main challenges that your organization is facing at the moment?

R. One of the main problems is that we, the nurses here, are responsible for almost everything but we are paid next to nothing. Only the crumbs are left for us, sometimes we don't even get the necessary respect. The pay is terrible and does not allow a reasonable standard of life. On principle the pay is low in the whole country, for everyone, not only for us. At least that's what I think.

Woman, nurse

I. Which would you consider the main challenges that your organization is facing at the moment?

R. Economic ones. The low pay of the specialists in the state hospital compared to private clinics. It is necessary to change the pay that is given to doctors at the moment. What is missing, in my opinion, are investments and they need to be encouraged.

I. How does this challenge affect the quality of work in the hospital?

R. I would say, not in a positive way. The doctors especially at this university hospital, which hospital is being supported by the NHII, are trying to be professionals to the maximum. As

doctors they give everything. Despite this they see that they do not get an adequate pay for their efforts.

Man, doctor

- *ageing medical equipment*

Most of the doctors complained that the equipment was replaced much more slowly than needed for achieving the highest efficiency. They admitted that this was due to economic restrictions but stressed that this should be a greater priority than it was now. At the same time they thought that the situation at present was much better than 10 years ago when they lacked not only the latest technologies but even ordinary consumables such as bandages and medicines.

R. Our organization is far from such a 'healthy organisation' and even it is getting further.

I. How is this happening and in what sense?

R. In terms of equipment. Our equipment is morally outdated. We have machines that are from 30 years ago. So these do not satisfy the requirements that must exist in a hospital. We are forced to use equipment that does not satisfy the modern standards to give modern diagnoses. This is the biggest problem that exists for absolutely all doctors. Besides we are a university hospital and must teach the students the latest techniques. We simply cannot match the theory with practice.

I. Are there other important challenges?

R. Another challenge that the hospital faces is to get modern equipment in order to guarantee the good patient care...

I. In your view, how do these challenges affect the quality of work?

R. Well, a doctor who at the moment is suffering from a 40 degree heat wave outside, is asked to stay inside in a room that is 45 degrees and to treat patients. I don't think he will be satisfied. But these are all expenses. It is very simple – just an air conditioning, right? We are talking here about work conditions and that the person who works needs to be satisfied. And these are small problems that can cause everything to go wrong. These are investments that need to be made into the health provision. And spheres such as health provision and education are vitally important for each country, not only for Bulgaria. Indeed, a lot of financial resources are needed in order to raise the quality of work.

Woman, manager

- *rising intensity of work*

This was another theme commented commonly by all three categories of staff. The interviewees explained this first of all by the growing number of patients of the hospital. Economic effectiveness required that the hospital accepted more and more patients and that they were treated quickly and released home as soon as possible while the quality of work suffered as both doctors and nurses experienced greater stress. Nurses in particular felt that they had much less time to offer emotional support to patients and had to limit their efforts to medical procedures mostly. The administrative personnel also reported having an increasing workload.

R. More patients are coming to the hospital, employees were laid off in many units, there is no break anymore, before there existed some sort of arrangement of sending patients to particular hospitals based on the region they are from. Now it is much, much easily accessed than before. People come from the villages, they just hop on a car, because they know that here there is someone to treat them. They come in the middle of the night, whenever they decide, even if they have experienced pain for couple of months now. It doesn't matter, you cannot send them back. You need to examine them. For example we have statistics here in the unit how many people have been examined in one year. For example 5000 used to be the number years ago, and now we have 5000 only in the first quarter. This means that the workload has quadrupled from 3-4 years ago.

Woman, doctor

I. In your opinion which are the main challenges that your hospital is facing at the moment?

R. This is an issue that concerns the whole hospital and it is the rising workload. In the clinic I work in, it is the same. What is more our cardio-surgery clinic is the only one in all of Southern Bulgaria. Here they redirect the patients from the smaller towns... That is why our workload grew by a lot. You can stay around the surgical table for 20 hours but then our patients survive.

I. How does the rising workload affect the quality of life?

R. The stress increases. The way of life... I mean, more or less you devote yourself to this kind of work. Your personal time decreases, I would even say that there are moments when you don't have any personal time. In our clinic we work at the brink of capacity, i.e. with many patients, with a huge workload. The personnel is small, and the work increases all the time. But in our clinic the personnel is small because of the policy of the clinic for cardio-surgery.

I. What is this policy?

R. No money is given unless there is work completed. This should become the maxim of all units. The fewer the people who do the job, the more the money for each of them. It's a very elementary arithmetic.

Woman, nurse

- *rising demands for wider qualifications*

This was another reason for the increasing workload, intensity and stress of the medical personnel. As the hospital also acts as an emergency centre, the need to treat patients with multiple health problems was often underlined by the medical staff. Nurses in particular stated that while previously there had been a division between an operating assistant, an anaesthetic assistant, a reanimation nurse, etc. now they had to be capable to do everything with the same high-level professional skills.

R. So, I, being a chief nurse in this clinic, my day is taken by organizing medicaments, coupons, bandages. It is very intensive. Moreover, I don't work all day as a chief nurse, but I also perform visitations in the intensive unit and sometimes I also work as an anesthesiology nurse. My colleague who is an operation nurse according to her job description also does bandages in the intensive care unit and the nurse who is assigned to do that also does

visitations. So, we are striving to make sure that the unit and the hospital do not suffer from the absence of three girls [nurses who are on maternity leave.]

Woman, nurse

I. What can we identify as a second challenge?

R. Being prepared enough. Here [emergency unit] we get cases which are very different, so you cannot be a specialist in a very narrow area. You need to be dynamic, not a phlegmatic sort of person, to be able to act quickly and correctly which is also a challenge. In other units there is always more repetitiveness, there are emergency cases but most of them are planned cases which are known to you and you work in a set direction, with a set model, whereas here you never know what will happen in the next moment. You need to be able to do everything, including foreign languages in order to succeed. I am young and at the moment I feel very good. I like this, I am temperamental, but I suppose that in 10-15 years I will no longer be that good at this and also all of this takes its toll on one's nerves. It is a very high stress level.

Woman doctor

- *rising demands for reporting*

A third reason for the increasing workload is the great and constantly increasing demand for reporting. The new economic conditions required an ever rising amount of paper work, complicated procedures of accepting patients, of reporting the treatment services, of checking the insurance status of the patient. The NHII paid for only services reported in particular ways and often changed the requirements, so that in numerous occasions services or medicines remained not paid by the institute and were covered by the hospital. Such shifts were perceived as negatively affecting the working lives of all categories and were expressed most strongly by doctors who considered it as underutilisation of their professional skills to fill in so many documents. The administrative personnel additionally complained from the frequent changes of the social security and other regulations of their work.

I. What makes the hospital different from this model [healthy organization]?

R. The bureaucracy has increased measurably. This means the documentation that the doctors are involved in. Filling out the records for the patients is a very, very slow process. We examine a patient for 10 minutes perhaps. To see if there are any broken bones, etc. I am talking specifically about orthopedic cases. And if this patient requires hospitalization, then the written work starts which takes about 20 minutes, half an hour. So, it's a bit slow and cumbersome process. Another thing which is unpleasant is when the doctor encounters the patient and explains what the NHII is. The doctor explains that insurance is needed and that some medicines are not covered by the insurance and the patient needs to pay for them. It is a real cacophony. This is what worries me. This way a doctor's valuable time is being lost instead of doing the job. The doctor explains things that are not part of his job. It's a sheer waste of time. Sometimes it takes us about 30 minutes of our working time to explain to the patient what the NHII does, what the patients' obligations are to this institute and the relationship between the NHII and the hospital.

Man, doctor

I. You mentioned that you have been working in this unit from the very beginning. Have you witnessed a lot of changes in the last years?

R. In 2000 the clinical paths were created. With them, a nurse's workload increased, the amount of written work required. Perhaps the Ministry of Health and this NHII required that we only write, and this is so much red tape. The NHII fines us if we don't do it. It is a big problem.

I. How much of your time is taken up by writing?

R. A big part. And the result is that there is no time for communication with the patient although this is a requirement for our profession. The feedback is of great importance. And now what it comes down to is that you go to the patient only to feed him and to make sure he is connected to the IV system. What communication can there be if you have to write at least an hour... This is my dream – that we have to write less and spend more time talking with the patients. We have a lot of elderly people and they need this. They tell me, 'Wait, dear, I need to tell you something.' They don't know that this prevents me from doing something else. But what can I do, I sit and listen. And then I have to go back to the writing. And you write and write...

Woman, nurse

- ***constant need for training of the personnel***

This was seen more as a challenge in a positive light than as a problem but was commented by all categories. The new equipment and developing medicine market made continuing training an imperative. The fact that the organisation was a university hospital was considered as an obligation to constantly improve the knowledge and skills of the personnel. The opening up of the borders and Bulgaria's joining the EU were cited as a resource in this aspect. The withdrawal of the state financing for residency (taking 5-6 years after university) was pointed as a barrier to younger people who cannot rely on parental financial support for their studies. The younger doctors in particular considered that the financial burden of gaining residency was becoming an acute problem for those without substantial parental support.

I. Other challenges?

R. Well, this constant training, qualification of the personnel in order to sustain the high level we currently have. This is simply a must. Without training and development of the personnel no results are possible. It is high time managers realized that you need to invest in people, in training and qualification.

I. Are there chiefs of clinics who are complaining that their personnel is taken away and the work is disrupted by the training?

R. No, there are none. Even a lot of the suggestions for training come from them. We have made the training plans in such a way that they don't interfere with the medical work. For example a lot of the training takes place in the clinics at the workplace. The training plans are created together by several colleagues in a team. Also, when a colleague sees a particular interesting case they share it with the trainees.

Woman, manager

I. Which are in your opinion the main challenges that the hospital is facing at the moment?

R. Well, the main challenge, and not only at the moment, but is a continuous challenge in the sphere of health care provision, is the raising of the profession qualifications. You learn new things, you implement new medical methods. You need to keep learning, because if you stop doing it, the results will not be good.

I. In what way do these challenges affect the quality of work?

R. They definitely affect it. For me, I dare say, that the positive challenges are more [than the negative]. The quality of work is related to knowledge. We learn more and more practical and theoretical skills. The quality of work is improved by our participation in international medical congresses, our links with colleagues all over Europe. There is an exchange happening both physical when we see each other and also electronically. There is no way all this doesn't affect one positively as well as one's quality of work. This is so because you see that you are developing. This is my personal view. After all, everyone has different views and different opportunities.

Man, doctor

R. My job description is a resident at the clinic for facial surgery. In other words I am specializing while working together at the same rate with everyone else – we have shifts, we perform operations. At the same time we train until the program for specialization in this area of surgery finishes. At the same time we don't get any money at all for our work. This is how the training system in Bulgaria works right now. On the one hand, they admit the need for constantly improving one's qualifications, on the other – they don't give any money for this process. There are almost no such positions paid by the state. We [trainees] are all here through private programs and we specialize by paying ourselves for everything. It would be good if at least we got some money back from what we have earned by working.

Man, doctor

- *rising expectations from patients*

The staff widely shared a conviction that patients now demanded much more from the hospital – not only the best medicines and the best procedures but greater attention by the personnel and also better living conditions in the hospital and the latter are still lagging far behind their expectations. There was no mention about patients considering themselves medically competent and insisting on more information about the treatment or interfering with doctor's diagnosis. Rather doctors and nurses complained that the patients did not have enough information about the legal changes in health care and health insurance in particular, that patients did not care about healthy life styles, did not respect doctors and nurses enough and did not value their work. Many of the interviewees shared stories about aggressive behaviour of patients and their relatives. Several doctors expressed the opinion that the well off patients visited private clinics while the state hospital was used by those lower in the social ladder and with limited financial and cultural capital.

I. How do the patients treat you? You mentioned some negative experiences... Can you elaborate on that?

R. Yes, we have some negative experiences especially recently.

I. Why is that?

R. Possibly because of the media [coverage of the doctors' strike]. On the one hand there is a report of how we support our colleagues from the 'Pirogov' hospital who are on strike and then the next story is about gypsies selling their blood contaminated with Hepatitis C with the knowledge of the doctors. And the report goes further showing reporters running after doctors with cameras asking them if they knew that the blood was contaminated, why they took it, whether it was legal and so on. This way, first they give people the idea that we are flush with money and we are corrupted and we work only if a bribe is involved, all of which is of course completely false. They consider us to be part of the mafia, wearing the white medical uniform, which is very denigrating when people don't know what it is to be a doctor. They don't know what it is not being able to sleep because you keep thinking whether someone has died or not, whether you did the correct thing when you told them to go home. People go home, have a beer and don't realize that our job is such that you can't stop thinking about it. You go home and you start searching the Internet. You have to be very good because all the time there are new treatments being discovered and human lives are involved. It is not like in business whether you have made the deal, here there is no taking back what you have done, there is no spare part that you can exchange it with.

Woman, doctor

...

R. We don't feel secure at the workplace. There have been cases when patients come who are drunk, want to fight, scream and insult us. We don't have any security here. Well, we do have some security people, but they have obviously let these patients in already. I think that at the entrance of the hospital there need to be people to screen the incoming patients. Very often it happens that whole crowds get in at the same time. One patient comes, who has been hit on the head, blood is rushing from the wound and behind him there are 20 more people who are coming with him and are screaming, crying, pulling their hair. It is a real tragedy. In my office they come 7-8 people together with the patient and the patient himself is sometimes anxious and hyper. This makes him be rude, to behave disrespectfully. And you are tired and all this is too much. So, that is why I think there should be someone to screen people. Professionals I mean. So that they can say, 'Stop. This is the patient. Only one or two people can come with him and no more.'

Man, doctor

...

R. In Bulgaria is like in Uruguay. In Uruguay there are 3 million people – 3 million referees of the national football team. Everyone is very competent. In Bulgaria we have the same story but with the health care provision. We are 8 million people and we all can give an opinion about how the minister is not doing his job well, how the doctor is not doing his job well, how the ambulance driver is not doing his job well. What we should do is perform one's own duties.

Man, doctor

...

I. Are the patients satisfied with the medical care they receive? What is your opinion?

R. Most of them are satisfied. I don't know how representative a sample are the patients who come here to us. I am saying this because I notice that there is a differentiation between our patients here and the general contingent of patients. I have not seen a person with a higher social status coming here. I can only guess where such people go to have themselves treated. These who have the highest social status go abroad, I have acquaintances who do this. I work with all kinds of people and know all kinds of people. Those with a middle social status go to private clinics. My wife, when she was to give birth to our second child, I decided not to take her here. After all, she is special to me. She went to the private family clinic in Plovdiv. So for us, the doctors who work at the state hospitals, we get patients with the lowest social status and lowest educational level. So what does it matter to talk about whether they are satisfied or not? When there is such a differentiation it is very difficult to analyze whether the patients are satisfied.

Man, doctor

...

R. Patients' demands keep rising, and no one is considering that the doctor is also human and he can be tired or have personal problems at home.

I. And what creates this problem in your opinion?

R. I think this problem arises because in my view Bulgarians are used to receive medical care without paying for it. At school everything is paid by the state, though the teachers are not exactly in our position. I mean they can make additional money by giving private lessons whereas the nurse here works hard and then goes home dead tired...

Woman, nurse

The interviewees also mentioned as challenges the emotional stress from a patient's death, the need for making fast decisions with high precision, the feeling of great responsibility, the aggressiveness of some patients or their relatives, and the positive feelings from patients' gratitude.

Future challenges

All interviewees were rather optimistic that the financial problems would be solved in the near future if the reforms were continued by the government. They also expected that work intensity and rising patients' demands would continue and that this was inevitable in a market economy. The three most commonly anticipated challenges in the near future were the emigration of medical personnel, the competition from private clinics in Bulgaria and the technological and organisational innovation.

1. Emigration abroad

Many interviewees commented that they worried about the emigration of doctors and more so of nurses to better paid jobs abroad or in private clinics in Bulgaria. In practice, there was more talk about emigration than real numbers of employees leaving the hospital (2 doctors and 5 nurses) but the trend might exacerbate in the future according to some of our respondents. They saw the following reasons for emigration: low salaries, few opportunities for rising qualifications and gaining residency. However, there

were opposite opinions that the emigration wave would gradually subside down together with the improvement of the financial situation of the health sector in Bulgaria.

R. In five years there will be no doctors in Bulgaria if the salaries do not change. All of them would go abroad.

Woman, doctor

I. What do you consider would be the main challenges in the future?

R. Well, I think the main challenge in the future would be the emigration of employees. It turns out that many of our doctors and nurses started to look for better work conditions in other countries after Bulgaria joined the EU. To put it frankly, we already have a problem with the lack of candidates. Whereas last year we had a list of nurses, sanitary workers and doctors waiting to be employed, at the moment if someone leaves there is no such list. This means that we will have to start being the active side of the hiring process and to search for people in order to employ them.

Woman, chief accountant

...

R. Emigration of doctors will not occur. In Western Europe and the USA there are many, many requirements in order to become a practicing physician. I have colleagues who left for the USA. They managed to get their diplomas recognized only as a general practitioner. You need to be fluent in the language. Also, our doctors go to the Arab countries, or in Africa, where until now they were receiving somewhat higher salaries. But I think now that this outgoing wave has stopped because overall good salaries can be earned here, too. Besides, who wants to risk their lives, as the case of our medics in Libya, just for 200 dollars more. I have heard that in Kuwait the salary ranges between 900 to 1000 dollars. But even then there is no point of going anymore, because you can earn this money in Bulgaria as a doctor. I think that it is more likely that doctors would be coming to Bulgaria. We already are working here with colleagues from Libya, from the African countries, from Greece. These are people who have been training here and before that studied in medical schools here. I think this is wonderful... exchange of ideas between young people, knowledge of the culture of different nations... In this way you learn a lot. It is good, definitely good. You realize who you are, who these people are. You realize you are all people. These are the main positive things.

Man, doctor

I. Do you expect the emigration of qualified employees to keep increasing?

R. Most definitely. Even now there are a lot of people leaving. Another much worse trend is the lack of medical candidates because not enough students have been accepted. That's it, I don't see any improvement in the next 10-15 years. This is because these older colleagues who already work in our specialty would retire sooner or later or would not be able to work any more. There is not a single intern accepted for three years now. I think now in Bulgaria we are about 45 people who specialize in facial surgery. The median age is about 63 years old or something like that. Under 40 there are only two, and under 35 is only one colleague who just joined this subfield. The demand for such qualifications is just beginning to increase. And this would continue because no students are trained in this at the moment.

I. What are the reasons for this?

R. State bureaucracy. It has been three years since they have been trying and failing to write a single medical code.

Man, doctor

2. Competition from private hospitals in the country

Some doctors anticipated rising competition from private clinics in the country. They pointed at the fact that even now the private sector attracted many well-paying patients with better living conditions in the hospital wards and modern medical equipment. The more serious cases like bad burns or heart failures concentrated in the state hospital which imposed a heavier burden on it and further diminished its financial competitiveness. There were other opinions though, particularly among the administrative staff that there was no ground for such a fear and pointed that the hospital had roughly ten percent of the health market in the whole country, that it had well trained personnel and modern equipment and the prestige of being a university hospital.

I. Which would be the main challenges in the future?

R. In the future we would have to overcome the competition, because in the future the hospitals would start to widen their work spheres. The private ones will no longer be very narrowly specialized, they would serve different profiles. In the private organization the equipment and the personnel are without doubt at a much higher level. We would have to keep our level and to fight this. This is one of the main challenges – being competitive on the health care market.

Woman, head nurse

3. Introduction of new technologies and the corresponding organisational change

New hospital software products, E-health services, quality assessment criteria were also mentioned as future challenges. The anticipated consequences of Bulgaria's membership in the European Union were also commented upon by our interviewees as affecting their quality of work and life in a positive direction – better information, better opportunities to work collaboratively and to compare your work to others, better equipment, more law and order in the profession and in society.

I. And in the end a couple of questions about the future. If we think about 5-10 years into the future, which would you consider to be the main challenges?

R. Implementing the new technologies, keeping pace with the different hi-tech developments in our sphere. Specifically in the field of burns, we keep and nurture for a long time these tissue cultures which are used for patients with a very high level of burns. These are patients which have very little places on their bodies that we can use as a donor. Thus with such a development you use this new tissue culture and you operate and there where you have to put a new skin, what you do is you simply sprinkle and the new cells develop like plants, in a manner of speaking. In this respect we are unique. The private clinics cannot develop such research. Of course, every new development creates a risk for some patients, but at the same time it is a hope for the rest of the patients whom you can save afterwards.

These things with the new type of bandages, the new synthetic antibiotics are all very wonderful things.

Doctor, head of a department

I. How do you see the future challenges facing your organization?

R. Well, challenges always exist and will continue to exist. We will always have a goal, something new that we will aim at. In terms of equipment, for instance,...all the time we are applying for financing through these additional programs and through the European Union, because it is a very expensive equipment that our specialists work with and in some of the clinics it is morally outdated. We are looking for new equipment, but we can't buy a new one for every unit all of a sudden, we cannot satisfy the need completely. Yes, so these are the challenges. We want more money to flow into the hospital, for these flows to increase, in order to be able to buy equipment, to participate in different programs. For example the hospital won a project for energy efficiency and they would finance the change of the windows and window frames in the entire hospital. So this is a big expense that our hospital will be able to save money on.

Woman, manager

Conclusions

We started the healthy organisation study in Bulgaria at a time when the radical social transformation gave rise to a lively public debate about what it means for companies to be economically efficient and competitive on the market and what the necessary resources are for achieving such a goal. The fact that we studied a state university hospital also made our interviewees more sensitive toward quality of life issues. In comparison, in the private bank which we studied three years earlier there was little consideration about issues other than economic consideration or as one of the interviewees put it, *'there is no private employer caring about their employees'* (Kovacheva and Matev, 2005). Our employees were well versed in the changes of the legal regulations not only of the medical profession, but also on financial matters. In their argumentation they often used comparisons between state and private sector organizations, as many of them held second jobs or have worked previously in private companies. Germany, the UK, France, Western Europe, the USA, Africa and Asia were also used as points of reference. The European Union had a positive image of influencing the quality of work and quality of life in the country toward an improvement.

The university hospital had the public prestige of an efficient organization and a good employer. Both the management and the employees were positive toward the idea of the dual agenda and some even considered that their organization was very close to being a healthy organization. However, our study showed that workplace efficiency had a much higher priority of the organization than the concern for the quality of work and the quality of life of the employees. Most interviewees shared the conviction about an automatic link between high efficiency, high pay and high quality of life and there were no workplace policies developed to help the employees balance between work and wider life. Among the challenges in the current situation and the near future economic considerations were clearly dominant. The organizational culture was also dominated by values such as professional efficiency, orientation toward improving skills and standards and full devotion to the profession. There was little sensitivity about gender equity and a high acceptance of the traditional gender division of labour in the home but also in

the organization. In particular childcare was seen as primarily a mother's responsibility, women doctors as lacking enough professional devotion when having children and men were more visible in managerial positions in the hospital. The initial analysis of the emerging themes revealed that the organization needed to challenge these assumptions if it was to accept the dual agenda as its strategy for meeting the challenges of further social transformation in the country and the global competition.

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