



# Employment and industrial relations in the health care sector

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This report is available in electronic format only.

*This report presents the findings of a study that assessed the contributions of employers, trade unions and professional organisations in achieving the recruitment and retention of staff (other than doctors) in the health care sector as it battles to overcome the challenges of an ageing population, budgetary constraints and skills shortages. The study covers hospital-based, residential and home care provided in the public and private sectors in the EU27 countries (apart from Latvia and Finland) plus Norway. The report provides a summary of employment, expenditure and policy trends in the sector and identifies key social partner organisations. It examines collective bargaining and social dialogue and their contribution to addressing the challenges the sector faces, particularly in increasing its attractiveness as an employer for nurses and care workers by helping to improve their pay, working conditions and terms of employment.*

## Introduction

The health care sector is of increasing socio-economic significance in the context of an ageing population in Europe. By 2030, the population of working age in the EU could be reduced from the present 303 million to 280 million. This has implications not only for potential growth and the sustainability of pensions, but also for the funding of the health and social care sector and for the recruitment of workers to provide these services.

The health care sector consumes a high and often increasing share of gross domestic product (GDP) (5–11% in EU countries). Over 21.5 million people worked in the health and social work sectors in 2009. The workforce in the health care sector is dominated by women, with no less than 78% of workers being female.

Although demand for care workers and staff shortages are expected to grow, research shows that the sector often offers poor **working conditions** and remuneration compared to sectors requiring equivalent levels of skills and training. This has already led to significant **mobility of workers** within and outside the EU, and could serve to exacerbate skills shortages in the future.

Social partner organisations have an important role to play in shaping the attractiveness of the sector as a source of employment, but in many cases, they clearly do so within the constraints of public (or private) sector budgets, as well as within the framework of existing **collective bargaining** and **social dialogue** arrangements.

In order to assess the existing and potential contribution of employers and **trade unions** in ensuring recruitment and retention in this growth sector, this study aims to:

- provide a summary of key trends in the sector in relation to employment, health care expenditure and health care policy trends;
- outline the development of the sector and, in particular, the situation of nurses and care workers with regard to working conditions and terms of employment;
- describe industrial relations in the sector with regard to social partner organisations, collective bargaining and social dialogue both in the private and public sectors;
- map and analyse the contribution of social partners to addressing the challenges in the sector (such as working conditions, supply of qualified staff, ensuring greater gender equality, offering career opportunities, improving quality of care).

The sector covered by this study includes all health care activities including health care in hospitals, residential care and home care (for example, for elderly or disabled individuals), excluding childcare services. In terms of occupational coverage, the study focuses on nurses, midwives, skilled and unskilled care workers. It excludes doctors.

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The study covers hospital-based, residential and home care provided in both the public and private sectors. The latter includes ‘for profit’ as well as non-profit organisations such as care service providers funded by churches and non-governmental organisations (NGOs).

This report is based on contributions provided by the national centres of the [European Industrial Relations Observatory](#) (EIRO) network. It includes contributions from Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Germany, Greece, France, Hungary, Ireland, Italy, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, the UK and Norway. Latvia and Finland are not covered by the study as they did not yet have an EIRO centre at the time of writing.

## Health care sector context

The European health care sector has a critical role to play in the achievement of the goals of the [Europe 2020 strategy](#) by contributing to the overall health and well-being of the workforce and society as a whole. In addition, the health and social care sector is also an important employer, whose significance is likely to grow in the context of demographic change. As a result, health care employers are not only affected by trends towards an ageing population in terms of the rising demand this places on service delivery, but also in the context of emerging labour market shortages resulting from declining birth rates.

Expenditure on health care is also increasing as a result of ongoing advancements in medical science, making it possible to successfully treat and improve the prognoses for many conditions, which would previously have been unthinkable. Such developments have not only opened the door to more advanced (but often also expensive) treatments, but prolonging healthy life spans is also contributing to the number of individuals living to a very old age. This increases the potential to develop more complex ailments and raises the demand for long-term care services.

These developments are taking place at a time when health care funding systems are already coming under pressure from increasingly tight budgets, both for the public purse and for household expenditure, particularly in the context of the economic crisis.

This section summarises recent trends in expenditure on health care, employment and working conditions in the sector and in health care policy.

## Expenditure on health care

A number of factors are important when looking at overall expenditure on health care services and the funding of health care.

- Demand for health care is potentially open ended, particularly with advances in the development of medicines and medical technology. Thus there has always been a system of rationing, be it through a ‘gatekeeper’ system, financial restrictions, decision about the approval of drugs for widespread funding or indeed treatment decisions at the operational level.
- As a result of, but also exacerbated by, medical advances and demographic change, even where there have been significant increases in investment in the health care sector in recent years, it is not easy for such investment to keep pace with the rise in demand (GHK, 2008).

According to the most recent [Eurostat](#) data, health care expenditure in Europe ranges between 5.1% of GDP in Romania to 10.7% in France (Figure 1).

Figure 1: Health care expenditure as a percentage of GDP, 2003 and 2007

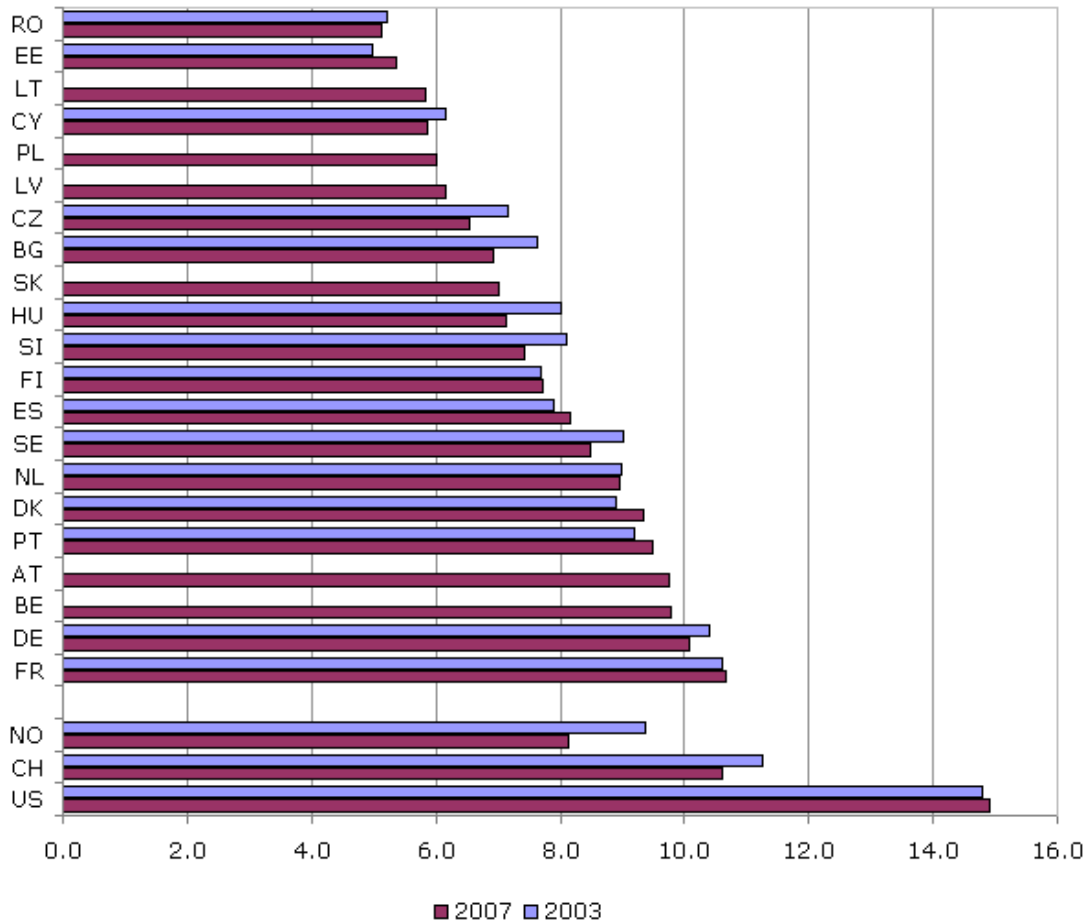


Figure 1: Health care expenditure as a percentage of GDP, 2003 and 2007

Notes: See Annex 1 for country codes and groups.

Data on health care expenditure are based largely on surveys and administrative (register) data sources in the different countries. They therefore reflect the country-specific way of organising health care and may not always be completely comparable. The database is based on cooperation between Eurostat, the Organisation for Economic Co-Operation and Development (OECD) and the World Health Organization (WHO), which have executed a joint questionnaire on health expenditure since 2005. The area covered consists of EU27 (excluding Greece, Ireland, Italy, Malta and the UK) plus Iceland, Japan, Norway, Switzerland and the USA.

The latest available data provided by Eurostat are for 2008 but 2007 figures are used as 2008 data are available only for a handful of countries. In the absence of statistics for 2007, 2006 figures are used for Latvia, Norway, Portugal, Slovakia and the USA.

Source: Eurostat, 2010

The most common method of funding health care in the EU is through a system of compulsory health insurance, usually funded through a system of **employer** and **employee** payroll

contributions, which is often complemented by some funding from general taxation. Only Denmark, Finland, Ireland, Malta, Portugal, Spain, Sweden and the UK have systems that are funded largely from general taxation (with some out-of-pocket payment for particular items and services).

In almost all cases, the share of private involvement in the health care sector is increasing, for example through a reduction in services covered by health insurance funds, more out-of-pocket payments, and an increase in private insurance and hospital care provision. Private, out-of-pocket payments play an increasingly important role in health care expenditure in Austria (28%), Bulgaria (45.5%), Hungary, Poland, Romania (all over 30%) and Spain (23%) (GHK, 2008).

For the reasons outlined above, per capita health care expenditure rose in all European countries between 2003 and 2007–2008 (most recent figures available) (Figure 2). Starting largely from a lower base and often requiring significant investment to improve health care infrastructure, the most significant increases are found in the eastern European Member States (for example, 171% in Romania).

Figure 2: Percentage change in total health care expenditure, 2003 to 2007–2008 (€ per capita)

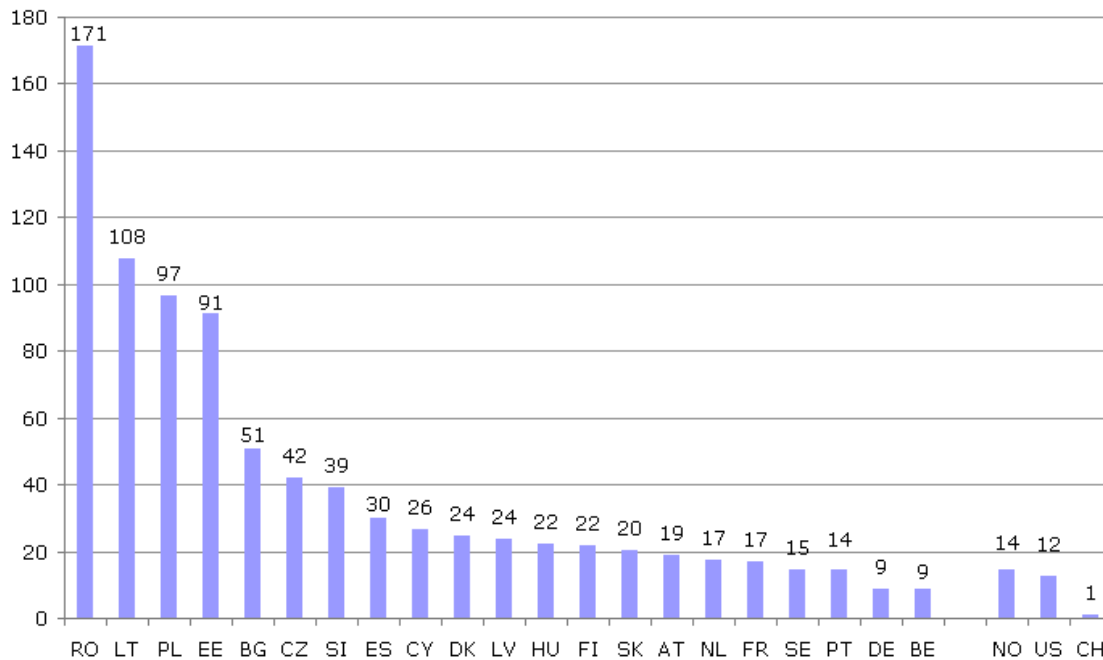


Figure 2: Percentage change in total health care expenditure, 2003 to 2007–2008 (€ per capita)

Note: 2008 figures used for AT, CY, LT, PL, RO, SI and SE; 2007 figures for BE, BG, CZ, CH, DK, DE, EE, ES, FI, FR, HU and NL; 2006 figures for LV, NO, PT, SK and US. 2005 figures for BE, LV and SK; 2004 figures for AT, LT and PL; 2003 figures for all other countries.

Source: Eurostat, 2010

Table 1 compares changes in hospital expenditure with resources for nursing and residential care facilities; in the majority of countries, expenditure on nursing and residential care facilities has seen a significantly higher increase. This appears in line with the trend towards an ageing population, but is by no means true for all countries.

**Table 1: Health expenditure (€ per capita), 2003–2008**

	Total expenditure			Expenditure on hospitals			Expenditure on nursing and residential care facilities		
	2003	2008	Change	2003	2008	Change	2003	2008	Change
<b>AT</b>	2,819	3,354	19%	1,081	1,235	14%	216	242	12%
<b>BE</b>	2,838	3,084	9%	893	922	3%	300	342	14%
<b>BG</b>	173	261	51%	63	102	61%	1	2	54%
<b>CY</b>	1,003	1,269	26%	418	532	27%	25	32	28%
<b>CZ</b>	567	805	42%	260	365	41%	7	11	54%
<b>DE</b>	2,724	2,966	9%	810	880	9%	205	236	15%
<b>DK</b>	3,115	3,876	24%	1,383	1,792	30%	621	481	-22%
<b>EE</b>	319	610	91%	140	281	101%	4	15	296%
<b>ES</b>	1,471	1,911	30%	544	745	37%	68	100	48%
<b>FI</b>	2,153	2,620	22%	786	941	20%	195	223	14%
<b>FR</b>	2,725	3,183	17%	969	1129	17%	158	215	36%
<b>HU</b>	590	719	22%	218	240	10%	16	22	42%
<b>LT</b>	292	607	108%	105	225	114%	5	9	86%
<b>LV</b>	350	432	24%	141	178	26%	10	12	25%
<b>NL</b>	2,641	3,097	17%	955	1,141	19%	325	371	14%
<b>NO</b>	4,087	4,676	14%	1,553	1,784	15%	714	812	14%
<b>PL</b>	317	623	97%	97	215	122%	4	8	128%
<b>PT</b>	1,220	1395	14%	458	519	13%	21	24	18%
<b>RO</b>	126	343	171%	59	134	128%	1	7	570%
<b>SE</b>	2,772	3,174	15%	1,281	1,488	16%			
<b>SI</b>	1,045	1,451	39%	397	603	52%	50	77	56%
<b>SK</b>	<b>482</b>	<b>579</b>	<b>20%</b>	<b>135</b>	<b>157</b>	<b>16%</b>			

*Notes: Total expenditure covers: hospitals; nursing and residential care facilities; providers of ambulatory health care; retail sale and other providers of medical goods; provision and administration of public health programmes; and general health administration and insurance. Hospital expenditure consists of expenditure related to licensed establishments primarily engaged in providing medical, diagnostic and treatment services (which include physician, nursing and other health services to in-patients) and the specialised accommodation services required by in-patients. Nursing and residential care facilities cover establishments primarily engaged in providing residential care combined with either nursing, supervisory or other types of care as required by the residents.*

*For total expenditure: 2008 figures were used for AT, CY, LT, PL, RO, SI and SE; 2007 figures for BE, BG, CZ, CH, DK, DE, EE, ES, FI, FR, HU and NL; 2006 figures for LV, NO, PT, SK and US; 2005 figures for BE, LV and SK; 2004 figures for AT, LT and PL; 2003 figures for all other countries.*

*For hospitals: 2008 figures were used for CY, LT, PL, RO, SI and SE; 2007 figures for AT, BE, BG, CZ, CH, DK, DE, EE, ES, FI, FR, HU and NL; 2006 figures for LV, NO, PT, SK and US; 2005 figures for BE, LV and SK; 2004 figures for AT, LT and PL; 2003 figures for all other countries.*

*For nursing and care facilities: 2008 figures were used for CY, LT, PL, RO and SI; 2007 figures for AT, BE, BG, CZ, CH, DK, DE, EE, ES, FI, FR, HU and NL; 2006 figures for LV, NO, PT and US; 2005 figures for BE and LV; 2004 figures for AT, LT and PL; 2003 figures for all other countries.*

*Source: Eurostat, 2010*

## **Employment in the health care sector**

In 2009 over 21.5 million people worked in the health and social work sectors in EU27 (Table 2).

**Table 2: Employment in the ‘human health and social work activities’ sector (NACE Q), 2009 Q1**

<b>Country</b>	<b>Employment</b>
<b>AT</b>	379,400
<b>BE</b>	581,700
<b>BG</b>	159,400
<b>CY</b>	14,800
<b>CZ</b>	318,000
<b>DE</b>	4,537,400
<b>DK</b>	496,100
<b>EE</b>	33,000
<b>ES</b>	1,287,200
<b>FI</b>	387,300
<b>FR</b>	3,257,700
<b>EL</b>	229,400
<b>HU</b>	242,800

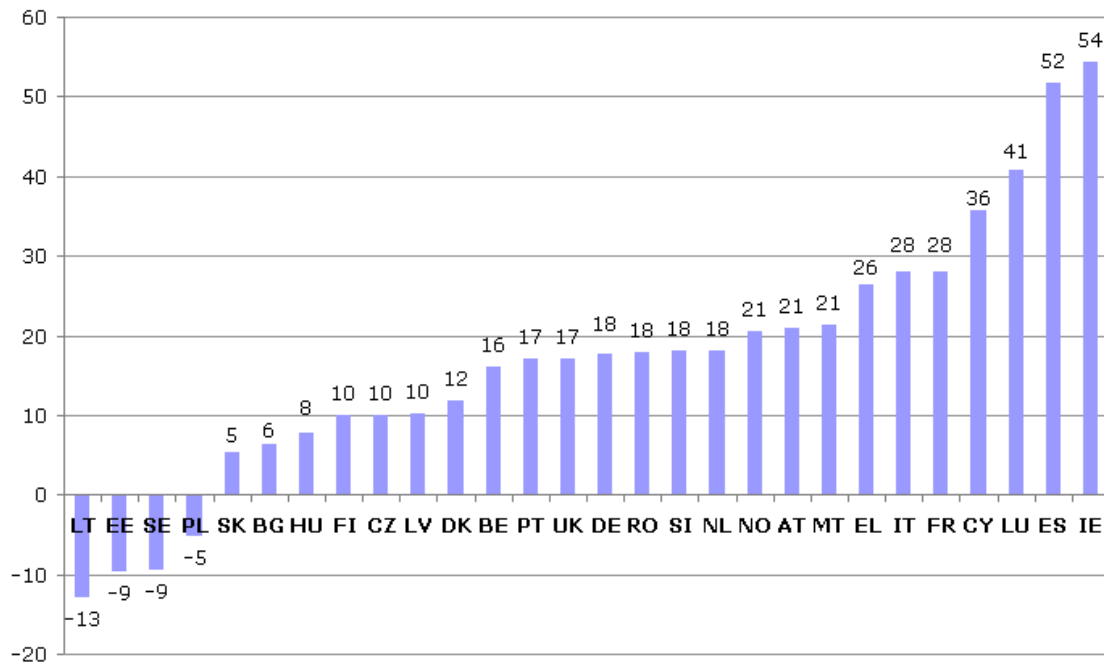
<b>Country</b>	<b>Employment</b>
<b>IE</b>	222,000
<b>IT</b>	1,680,400
<b>LT</b>	89,800
<b>LV</b>	48,300
<b>LU</b>	21,400
<b>MT</b>	11,100
<b>NL</b>	1,354,800
<b>PL</b>	894,700
<b>PT</b>	300,000
<b>RO</b>	382,300
<b>SE</b>	695,500
<b>SI</b>	52,800
<b>SK</b>	148,700
<b>UK</b>	3,740,500
<b>EU27</b>	<b>21,566,600</b>

*Source: Eurostat, Labour Force Survey [DS-073433-Employment by sex, age groups and economic activity (from 2008, NACE rev.2), (1000), data downloaded 18 March 2010]*

Employment in the sector largely increased over the last decade, although some countries witnessed a decline (Estonia, Lithuania, Poland and Sweden) (Figure 3). On the whole, employment in the sector in the EU15 grew more substantially than in the new EU Member States. Cyprus, Ireland, Luxembourg and Spain witnessed the most significant employment growth in the sector between 2001 and 2008.



Figure 3: Change (%) in employment in the 'health and social work' sector (NACE N), 2001–2008, Q2, EU27 and Norway



**Figure 3: Change (%) in employment in the 'health and social work' sector (NACE N) between 2001 and 2008, Q2, EU27 and Norway**

Notes: In the absence of the employment figure for 2008 Q2, the 2007 Q4 figure is used for BG, SE and SI, and the 2008 Q1 figure for PL.

Source: Eurostat, Labour Force Survey [Employment by sex, age groups and economic activity (1998-2008, NACE rev.1.1) (1000) (lfsq\_egana), data downloaded 8 August 2010], age group 15–64.

The workforce in the health care sector is dominated by women with no less than 78% of workers being female. This share rose marginally in the EU15 from 79% in 2000 to 80% in 2006. In the new Member States, there was a small decline in the share of women in employment in the sector from 81% in 2000 to 80% in 2006 (European Commission, 2009).

Education levels in the health and social care workforce tend to be medium or high, with 40% of workers having a high level of education. This is 13% higher than in the whole economy.

Around 43% of workers in the sector were aged 40 or younger in 2009. However, the share of young workers has decreased markedly since 2000 while the share of workers over 50 has increased, demonstrating an ageing workforce pattern reflecting an overall trend in the EU labour market. This means that the health and social care sector not only has to accommodate the demands of an ageing population, but it has to do so with an ageing workforce.

### Working conditions in health care

As outlined in a number of reports (Eurofound, 2006; GHK, 2008; Pillinger, 2010), low wages and difficult working conditions in the sector remain important factors contributing to labour and skill shortages in many specific parts of the health care system, occupations and regions.

According to the report prepared by Pillinger (2010) for the European Federation of Public Service Unions ([EPSU](#)), pay levels in the health care, childcare, elderly and other care sectors are

low compared with the national average for jobs requiring a similar level of qualifications. This is particularly true for relatively low-skilled care workers, particularly in residential care for the elderly, but also other low-qualified tasks in hospitals and other care environments.

Similarly, bearing in mind the predominance of women working in the sector, work organisation and working patterns are generally not seen to be conducive to encouraging recruitment and retention in the sector. Indeed, a report by the [European Foundation for the Improvement of Living and Working Conditions](#) (Eurofound) on *Employment in social care in Europe* (Eurofound, 2006) found that, in Germany, 80% of workers in the social care sector leave their jobs within five years. A significant number of women do not return to work in the sector following childbirth because of expressed difficulties in reconciling work and family life.

Another factor which is considered to militate against attracting more individuals to work (or stay) in the sector is a perceived lack of career opportunities – often despite significant investment in initial training.

Finally, the high levels of pressure of the job are associated with [stress at work](#) and sometimes the threat of [harassment and violence at work](#) (often from patients and their relatives), particularly in psychiatric care but also in care of the elderly. Coupled with a physically demanding [working environment](#) resulting from the nature of the tasks involved, as well as [shift work](#), this often leads to burnout and high staff turnover. The final section of this report examines the types of measures taken by social partners and other stakeholders to address some of these factors in order to increase recruitment and retention in the sector.

## **Key trends in health care policy**

The challenges facing the health care sector now and in the decades to come cannot be underestimated. The opposing demands of the need to contain costs and the increasing requirements of an ageing population are increasingly likely to require difficult decisions on how health care is funded and provided.

Financial pressures on the health care system are not new and ‘rationing’ of access and availability to certain treatments, drugs and services is an inevitable part of a service where demand is always going to outstrip supply. As indicated above, even within universal health care systems such ‘rationing’ takes place (whether it is obvious or not) in the form of decisions over which drugs to approve for use and the length of waiting times, down to individual clinical decisions on which treatments to offer. In insurance-based systems such processes can be more explicitly expressed in the types of treatments covered or the level of reimbursement provided. This need to make hard choices on service provision becomes all the more acute in the face of demographic change and advancements in medical science and treatment regimes.

Although the general trend is towards increasing healthy life expectancy, the conditions suffered in older age have become more complex while simultaneously becoming more treatable. This means that, while individuals are keen to extend the period they can live more or less independently in their own home, they require ever more skilled individuals to support them in times of serious ill-health. This has inevitable implications for the planning of provision, and the shape and skills of the health care workforce.

These changes are also occurring at a time of increasingly tight public budgets, in particular in the aftermath of the economic crisis. Many countries and individual health care providers are struggling with cutbacks in public expenditure. While some are striving to mitigate the negative effect on public investment in the health care sector, it is clear that shrinking budgets will in many cases affect services and employment in the sector, with a number of countries already announcing recruitment freezes and pay cuts or pay restraint. Significant issues with staff recruitment and retention, skill shortages and outward [migration](#) are also making it difficult to meet the increasing demand for services across the EU and serve to highlight that the fact that the

attractiveness of the sector remains relatively low and must be addressed if skilled staff are to be available as demand increases.

It is difficult to generalise key trends in the variety of health care systems across Europe as countries seek to accommodate these challenges. However, a number of prevalent themes have emerged which include trends towards the decentralisation, liberalisation and in some cases privatisation of provision. Legislative changes have sought to increase patient rights and to limit emerging challenges related to [undeclared work](#) in the provision of long-term care. There is also increasingly a shift away from hospital to community-based care for a range of client groups. The official goal of such reforms is to:

- meet client demands;
- provide better and more personalised care;
- improve working conditions;
- create more and better jobs;
- enhance the attractiveness of the sector.

In a number of countries, efforts have also been made to establish and improve systems to fund long-term care.

### *Decentralisation*

A key trend has been towards the decentralisation of provision and decision-making, offering greater autonomy to local hospitals and care providers over the services they offer, the running of these services and, in many cases, the remuneration of their staff. These steps have generally been taken to provide services more closely linked to the requirements of the locality, but results have not always been positive. The countries currently affected by the trend in decentralisation include Norway, Romania, Slovakia and the UK.

- In Norway, the health care system has historically been decentralised to the municipalities and the county municipalities. However in 2002, due to major reforms, the hospitals were organised as four independent enterprises (regional health authorities). As a result, the independent health authorities now have employer responsibilities in addition to being responsible for their own finances.
- In Romania there are plans to decentralise health care services in respect of both structure and decision-making by moving them from the umbrella of the Ministry of Health ([MS](#)) to the local public administration bodies.
- Slovakia has also undergone major reforms, and during the period 1998–2006, deregulated and decentralised health care providers. However, the reforms produced discrepancies in pay and working conditions, which has led to staff shortages in some areas.
- In the UK, a key policy and structural shift has occurred in the publicly managed part of the sector within the last five years with the transformation of many National Health Service ([NHS](#)) hospitals into Foundation trusts. Foundation trust status provides local management with greater autonomy with regard to the management of their funds, and the negotiation of the pay and conditions of employees.

### *Liberalisation and privatisation*

Liberalisation and privatisation is a controversial issue, and in some countries, it is viewed as an answer to addressing failed systems and increasing the quality of care. The countries affected by this trend include Belgium, Cyprus, the Czech Republic, France, Germany, Greece, Italy, the Netherlands, Norway, Poland, Slovenia and Spain.

Opponents of moves towards greater privatisation of public provision raise concerns that privatisation is endangering a universal and more equitable system. Liberalisation has created complex issues in some countries.

The most important change that has occurred in the Swedish health care system during the past five years is undoubtedly the liberalisation of the primary health care services, including geriatric care. In 2009, Parliament passed a new law that enabled the public to choose between public and private primary health care. A key challenge for the Swedish health care sector will be how to handle the liberalisation of the primary health care services, while preserving the tax-funded welfare system. In Slovakia, the health care reforms implemented between 1998 and 2006 also liberalised the system, aiming at greater competition and the expectation of resulting service improvements.

In Belgium, private provision is growing in response to the unmet requirements of an ageing population. This growing demand is also expecting higher quality standards, especially among the growing group of wealthier people who have private health insurance in addition to the compulsory statutory health insurance. Belgium has also witnessed an increase in private-for-profit establishments and, more recently, the appearance of foreign conglomerates. This includes the establishment of public-private partnerships in building infrastructure and the outsourcing of non-critical business functions to private companies. The expansion of public-private partnerships in infrastructure investment has also been a feature of reforms in the UK, where many new hospitals have been constructed with the assistance of private finance.

In Germany, the number of public hospitals is declining while private provision is increasing. Cuts in public funding by the federal states (*Länder*) and the 2002 change to a case-based flat-base remuneration system resulted in a wave of privatisations of formerly public hospitals. In Greece, private hospitals are increasing their market share compared with public hospitals, mainly because of the perceived shortcomings of the public health care system. Private sector hospital services focus on niche markets selecting mainly 'lucrative', short-stay surgical procedures. Reforms have also been implemented in Romania, enabling the establishment of private medical facilities.

In Cyprus, the private sector experienced a significant growth spurt around the mid-2000s. More recently, however, employment in this market segment has been declining and the number of private hospitals also fallen due to stricter regulation of the operation of private hospitals. France is experiencing a blurring frontier between the private and the public health sectors due to the contractualisation of care activities to private clinics that contribute to public health service provision and to the reform of hospitals' funding that brought the public sector closer to the private sector, establishing the remuneration according to the activity. Portugal has seen some experiences with the private management of public hospitals.

The Netherlands introduced the Health Care Insurance Act to reform the health care structure into a system of regulated competition. In 1998, Poland tried to introduce an act to restructure public hospitals into joint stock companies. However, this initiative was vetoed and the government introduced 'plan B' which allowed local authorities to apply for money to pay back the debts of public hospitals. As a result, hospitals have been transformed into joint stock companies.

### ***Shift to community-based care***

Many countries have seen an expansion of community-based care, allowing individuals to access health care support in the home or in expanded health care facilities in their locality rather than utilising hospital facilities. This particularly applies in relation to the care of older citizens (thus meeting their demand for greater independence), but is also true for some mental health and primary health care services.

In Cyprus, the Czech Republic, France, Ireland, Italy and Malta, there has been a shift towards community-based care and away from hospital treatment. For some countries, this transformation is due to the changing nature of care, and in others it is directed at cost saving measures or increasing the quality of provision.

In the Czech Republic, hospitalisations are decreasing and outpatient care is increasing, resulting in greater family involvement. In Italy, hospital care has also been decreasing and community care increasing since the 1990s in order to contain health costs due to a large public debt.

A key trend in the health care sector in Ireland is the expansion of primary care services and development of primary care team networks, which includes a shift to community-based care. National policy in Ireland is currently striving to develop appropriate home and community care for older people, with an aim of no more than 4% of people over age 65 using residential care.

In Malta, the public policy on long-term care is directed towards keeping people in their own community setting. In Cyprus, the community care sector has grown along with the growth in the public and private sectors.

France is also experiencing an increase in the provision of care at home (for example, home hospitalisation and nurses providing care provision at home). Between 2003 and 2007, the number of health care establishments participating in a partnership relating to home care provision nearly doubled to 60.8%.

## **Views of social partner organisations**

Trade unions and employer organisations have responded to and have influenced these key trends in a number of ways, depending on their level of involvement in [tripartite concertation](#), tripartite or bipartite bargaining at different levels. (See the next section for information about social partner organisations in the health care sector.)

The emphasis of their interventions and the focus of expressed views have been on the shape of reforms, ensuring the attractiveness of the sector, and the need to ensure that quality jobs can be created to meet additional demands in an increasingly difficult budgetary environment.

The majority of trade unions have expressed concern about trends towards the liberalisation and privatisation of health care provision. These concerns largely relate to the equity of provision, but also reflect uncertainty about the impact of such moves on wages, and terms and conditions of workers in the sector. While trade unions are in dialogue with employers and the government in Denmark, Slovenia and Sweden about the precise shape of reforms in order to ensure equitable, high quality outcomes, in other countries there is graver concern about the impact of planned liberalisation and privatisation on the sector.

Employer organisations tend to be more supportive of reforms. In Poland, for example, employer organisations generally support the far-reaching privatisation of health care services accompanied by the regulations which grant equal access of private and public service providers to contracts with the National Health Fund and the introduction of private health insurance.

While employer organisations are generally supportive of more private sector provision, they are also concerned that budgetary stringency will restrict the expansion of such public-private partnerships. In the UK, NHS employers have generally supported decentralisation and the financially viable setting of terms and conditions. Similarly, Swedish employers in the sector have also generally been supportive of government reforms.

In Italy, trade unions are concerned that cost containment policies will lead to a creeping privatisation of Italy's national health service. In the Netherlands, unions are concerned about the effects of the implementation of competition in the health care sector. They believe that market regulation has not led to more efficiency and better allocation of resources in the sector. However, employers in the Netherlands stress the advantages of entrepreneurship and

competition in health care, and believe it creates more diversity between health care providers. On the other hand, they are aware of the ‘war on talent’ that is going to develop in the sector as a result of the growing demand for qualified personnel. According to the employers, this growing demand is the result both of the ageing working population as well as because health care is a growth market.

Many trade unions are concerned with staffing issues and believe that the sector remains unattractive to new job entrants and returners, largely because of poor pay and conditions. Pay is seen to be a critical factor in attracting workers to the sector, and the number of disputes concerned with pay (see the final section of this report) underlines the efforts by trade unions to tackle low pay in order to help recruit and retain staff. Pay parity between (and within) the public and private sector is also an increasingly important issue as the organisation of the sector and wage bargaining becomes increasingly decentralised.

Employers in many countries are keener to preserve or ensure greater local **flexibility** in setting wages and terms and conditions in order to be able to respond to local circumstances. However, in a significant number of countries, employers’ interests are either (partly) represented by the government or are constrained by the limited availability of public finances that control wage setting, irrespective of their views regarding requirements to attract/retain more workers in the sector.

Trade unions and some employers also emphasise the importance of improving **work-life balance** measures in a sector so dominated by female workers. Of similar importance is the need to continuously update the skills and capacities of the workforce to ensure they remain up-to-date with advancements in medical technology, patient care and work organisation. This has led to negotiations in many countries over regular access to **lifelong learning** opportunities. For instance, in the Netherlands, five (of the six) employer organisations in the sector have constructed a ‘Labour Market Agenda 2015’. In this they address ways to tackle the labour market problems including effective and efficient **vocational training**, and the attractiveness of the sector.

Staffing issues are a significant concern for social partners in the context of increasing demand for health and social care resulting from demographic trends and ongoing improvements in medical technology, procedures and pharmaceuticals. Therefore, there are concerns about current and future skills shortages in the sector. In order to tackle the problem of underfunding in Austria, private sector trade unions have requested a ‘social billion’ (€1 billion) for the health care sector in order to create 20,000 new jobs to address labour shortages in the sector. The French General Confederation of Labour (**CGT**) also supports an ambitious policy of training and recruitment in order to create about 100,000 jobs in public hospitals to improve the working conditions and status of existing jobs, thereby increasing the quality of care.

In Belgium, trade unions are united in their view that more jobs will be needed in the health care sector to cope with the pressure placed on the systems by the trends mentioned above. They argue that increasing the number of open-ended jobs will help to decrease workload in areas where staff are overstretched. At the same time, the unions are keen to see less recourse being made to use of **temporary agency work** and **fixed-term work**. Employers favour measures that would reduce the administrative burdens on front-line staff and the development of measures which support the retention of older workers in the sector. The health sector trade unions in Romania are also concerned about workload and argue that it is the loss of personnel through migration to other labour markets that has led to labour and staff shortages, and the overburdening of the remaining medical staff.

In some countries a recruitment freeze has created challenges. For instance, Irish health care unions have been critical of the Government moratorium on staff recruitment and promotion



across the public sector. The Irish Health Service Executive ([HSE](#)) is generally more supportive of government initiatives and policy in this sector.

## Social partner organisations

This section provides an overview of trade unions and employer organisations in the health care sector. It should be read in conjunction with Annexes 2 and 3, which provide an overview of all bodies representing employees and employers in this sector. The analysis is based on the responses of EIRO national correspondents and it must be borne in mind that fully comparable information is not available for all unions and employer organisations in the sector.

The section begins by setting out some of the specifics relating to industrial relations in the sector. These are largely influenced by:

- the essential nature of the services being provided;
- the organisation and funding of health care services (for example, public and private provision and the particular role of the state as provider in many countries).

## Specifics related to industrial relations in the health care sector

Overall, social partner organisations in the health care sector enjoy the same rights as trade unions and employer representatives in other sectors. These are generally laid down constitutionally or in labour law. Freedom of association is guaranteed in all countries studied.

With one exception, the same applies to the right to engage in collective bargaining. This exception relates to Germany, where religious health care organisations are not involved in collective bargaining. To be more specific, in Germany, around 34% of care in hospitals, 16% of care in rehabilitation clinics, 55% of residential care and 38% of outpatient care is provided by a range of charitable organisations (data from the [Federal Statistical Office](#)). Health care workers employed by some of the religious charities (Protestant and Catholic charity organisations) are not covered by federal [labour law](#) or the Works Constitution Act but by [ecclesiastical labour law](#). Under this law, employment terms and conditions (*Arbeitsvertragsrichtlinien*, AVR) are set by commissions consisting of employee and employer representatives. Consequently, there is no collective bargaining with unions in the health care sector covering Protestant and Catholic health care organisations.

### *Limited rights to industrial action*

The health care sector displays a number of specificities regarding the [right to strike](#), largely resulting from the fact that in many European countries the health care sector is classified as an ‘essential service’. These provisions highlight the inherent bargaining strength of trade unions in the health care sector through the potential to cause disruption to vital services, but also demonstrate the limitations to their ability to fully withdraw labour. Information in the final section of this report on recent strike actions in the sector demonstrates how this instrument has been used by trade unions over the years to enforce improvements in pay and working conditions.

In just over half of the countries studied (Belgium, the Czech Republic, France, Germany, Greece, Hungary, Italy, Lithuania, Luxembourg, Malta, Poland, Romania and Slovenia), the health care sector is subject to specific rules or regulations regarding the right to take collective action. Legislative measures restricting strike action in the health care sector usually govern the maintenance of an emergency (or ‘vital’) level of service. Because the health care sector is classified an essential services sector in a number of countries, often only restricted/partial strikes can go ahead (for example, in Belgium, the Czech Republic, Estonia, Greece, Hungary, Ireland, Italy, Malta, Romania and Slovenia).

The procedures which must be fulfilled in order to take strike action are usually governed by law. In the health care sector, these do not only relate, for example, to requirements such as giving advance notice or carrying out ballots, but also stipulate the 'vital' or emergency level of service that must be maintained during periods of strike action. For example, in the Czech Republic, the legislation on collective bargaining (Act no. 2/1991 Coll.) stipulates that a strike of health or social care workers is illegal if it endangers lives. In practice, this means that emergency care must always be available during a strike or other form of industrial action. Similarly, in Belgium, the health care sector requires the provision of minimum 'essential services' in cases of strike action, which are governed by the 1948 Essential Services Act. Joint committees of employers and employees decide on critical service needs and how they can be met during the strike. The state intervenes only when the parties are unable to agree. In Greece, the obligation to run a minimum level of emergency service during a strike applies to the health sector in a similar way to other emergency services (fire, police, etc.). In Malta, the Supplementary Provision of the 2002 Employment and Industrial Relations Act stipulates the number and occupational profile of the personnel required to run health care services during strikes. In Romania, it is the responsibility of the leaders of strikes to ensure that at least a third of normal duties are carried out during strikes.

Ireland is the only country studied where a voluntary form of regulation is in place. A voluntary code of practice governing industrial dispute procedures in essential services was agreed in 2003. Similar to legal provisions in other countries, it commits the parties to any disputes to maintaining an emergency level of service.

As indicated above, regulations often specify the notice period for any potential strike in the health care sector. This applies, for example, to Belgium, France, Italy, Lithuania and Slovenia. The notice period ranges from five days in France to ten days in Slovenia, and two weeks in Belgium and Lithuania. For example, it is the 1948 Essential Services Act in Belgium which states that a collective industrial action must be announced two weeks in advance. In Lithuania, the notice period for a strike is twice as long in the health care sector than in most other sectors (14 versus seven days).

Rules regarding the right to strike are the same for nurses and care workers in public and private health care establishments in most of the countries studied. The situation is, however, different in France and Luxembourg. In France, health care professionals in public establishments or private ones providing public health services (PSPH) must give notice of a strike five days in advance. A minimum service must also be maintained, which means that an employer can order employees to stay at work. At the same time, nurses and care workers in private establishments can call a strike without notice and the employer has no right to require workers to stay at work (to provide a minimum level of service) during a strike. Legislation regarding the right to strike is also stricter in the public than in the private health care sector in Luxembourg.

In Germany, restrictions on the right to strike are applicable only to health care workers in specific third sector organisations. Carers working for the Red Cross do not have employee status (they are considered to be members, rather than employees, of the organisation) and hence they are not allowed to go on strike. In a similar manner, industrial action is prohibited in Protestant and Catholic charity organisations as they are covered by the ecclesiastical labour law rather than federal labour law or the Works Constitution Act. In Lithuania, the Labour Code prohibits strike action in first aid services.

There are no specifics in relation to the right to strike for employees in the health care sector in Norway. However, strikes have often been stopped by compulsory arbitration due to the danger they could pose to life and health. For example, early in 2010, a strike among nurses in Norwegian private nursing homes was ended after 10 days by compulsory arbitration. In the same year, nurses' strikes in state-owned hospitals and among municipal employees (involving all unions including unions organising health and care sector employees) ended with a new



agreement after negotiations were resumed after a five-day strike in hospitals and a two-week strike in the municipal sector.

Health professionals in Bulgaria and Cyprus had no right to strike until recently. In Bulgaria, the legislation regarding industrial action was modified in 2006, and in Cyprus, the restriction regarding the right to strike in essential services (including hospitals) was abolished through an agreement between the social partners in 2004 ([CY0404103F](#)).

## Trade unions in the health care sector

### *Number of trade unions*

A multitude of trade unions is active in representing workers in the health care sector in most of the countries studied, with the exception of Slovakia (Table 3). In many cases this is because different trade unions represent specific occupational groups with their own particular interests. However, in some countries, trade union pluralism is also a feature of the industrial relations system. The highest number of trade unions representing workers in the sector can be found in Belgium (8), Germany (9), Hungary (10), Portugal (10) and UK (12). They are followed by Cyprus and Spain with six unions each. Health care professionals are represented by only one trade union in Slovakia and by two unions in the Czech Republic, Lithuania and Luxembourg. Other countries with a comparatively low number of unions active in the sector are Denmark, Estonia, Malta and the Netherlands.

Health care sector unions can be categorised into two broad groups:

- general, cross-sectoral unions whose membership reaches other sectors beyond health care;
- specialist unions representing only the workforce in the health care sector or specific occupations.

General unions are involved in representing nurses and health care professionals in at least 15 countries. In four of these countries (Austria, Belgium, Italy and Luxembourg) only general unions are active in the health care sector and no specialist unions represent particular occupational groups of workers.

In eight countries, particularly in eastern European Member States, specific unions for the health care sector or for specific occupations have emerged (Czech Republic, Estonia, Greece, Lithuania, Poland, Romania, Slovakia and Slovenia). These often include unions representing, in particular, nurses and midwives.

**Table 3: Trade unions in the health care sector, 2010**

	No. of unions	No. of unions for specific sector	Public vs. private	Participation in collective bargaining
<b>AT</b>	4	0	Separate unions for public and private sector workers: two private and two public sector unions	Both private sector unions involved in collective bargaining
<b>BE</b>	8	0	Separate unions for public and private sector workers: five private and three public sector unions	All involved in collective bargaining
<b>BG</b>	4	2	All represent public sector	All involved in collective

	No. of unions	No. of unions for specific sector	Public vs. private	Participation in collective bargaining
			employees only	bargaining
<b>CY</b>	6	1	Separate unions for public and private sector workers: two private and four public sector unions	At least four out of six involved in collective bargaining (no information is available for two unions)
<b>CZ</b>	2	2	–	All involved in collective bargaining
<b>DE</b>	9	2	Public, public/private and third sector unions	All apart from one involved in collective bargaining
<b>DK</b>	3	2	Same unions for public and private sector workers	All involved in collective bargaining
<b>EE</b>	3	3	Same unions for public and private sector workers	All involved in collective bargaining
<b>EL</b>	4	4	Both public and private sector unions	Two out of four involved in collective bargaining
<b>ES</b>	6	3	All apart from one (public) represent both public and private sector workers.	All involved in collective bargaining
<b>FR</b>	5	4	Same unions for public and private sector workers	At least four out of five involved in collective bargaining (no information is available for one union)
<b>HU</b>	10	6	At least one union specific to the public sector, others represent public and private sector workers.	All involved in collective bargaining but at local level
<b>IE</b>	5	2	Unions representing both public and private sector workers and public sector workers only	All involved in collective bargaining
<b>IT</b>	5	0	At least three public sector unions	All involved in collective bargaining
<b>LT</b>	2	2	Same unions for public and private sector workers	All involved in collective bargaining
<b>LU</b>	2	0	Same unions for public and private sector workers	All involved in collective bargaining
<b>MT</b>	3	1	Same unions for public and private sector workers	All involved in collective bargaining
<b>NL</b>	3	1	Same unions for public and	All involved in collective

	No. of unions	No. of unions for specific sector	Public vs. private	Participation in collective bargaining
			private sector workers	bargaining
<b>NO</b>	4	2	Same unions for public and private sector workers	–
<b>PL</b>	5	5	Limited almost exclusively to public sector workers	All involved in collective bargaining
<b>PT</b>	10	4	Most unions represent workers in both public and private establishments.	All involved in collective bargaining.
<b>RO</b>	4	4	Same unions for public and private sector workers	All involved in collective bargaining
<b>SE</b>	4	1	Most unions represent both public and private sector workers.	All involved in collective bargaining
<b>SI</b>	4	4	–	All involved in collective bargaining
<b>SK</b>	1	1	Limited almost exclusively to public sector workers	All involved in collective bargaining
<b>UK</b>	12	At least 8	Most unions represent both public and private sector workers.	All involved in collective bargaining

*Notes: – = information not available.*

*Comparable information was not available for all trade unions. This means, for example, that the actual number of health sector specific unions can be higher in some cases than indicated.*

*Source: EIRO national reports on industrial relations in the health care sector, 2010*

### ***Public and private sector representation***

Countries differ considerably in terms of how employees in the public and private health care sectors are represented.

Health care sector workers are represented by separate unions for private and public sector workers in Austria and Belgium. But in at least 13 countries (Denmark, Estonia, France, Ireland, Lithuania, Luxembourg, Malta, Netherlands, Norway, Portugal, Romania, Spain, Sweden and the UK), a unified system of union representation dominates. Unions in these countries typically represent health care professionals from both the public and private parts of the sector. However, these unions tend to have a higher number of members from public operators as it tends to be more difficult to reach and recruit nurses and care workers working in private health care establishments (for example, Ireland, Malta, Sweden and the UK).

In some of these countries (such as Ireland, Portugal, Spain and Sweden), while most unions represent both public and private sector employees, one or two specific unions have also emerged that represent public sector workers only.

In Bulgaria, Poland and Slovakia, trade union representation in the health care sector is almost exclusively limited to public sector employees and the private health care sector remains essentially non-unionised.

In the majority of the countries studied, all trade unions participate in collective bargaining. The two public sector unions for health care professionals in Austria and the two recently formed health care federations in Greece do not take part in collective bargaining.

Otherwise, most unions take part in company, sector and/or cross-sectoral bargaining, depending on the dominant level of collective bargaining in the country (see final section of this report).

### ***Reorganisation of the structure of trade unions***

The trade union structure has remained stable over the past five years in most of the study countries.

Changes in the organisational structure of trade unions has been most widespread in Austria, but mergers between health care sector unions have also taken place in Malta and the UK, while splits have occurred in Greece and Poland. Brand new unions have been established in Romania and Slovenia, and one German health care sector trade union disbanded in 2009 due to a continuous decline in membership.

The mergers in Austria, Malta and the UK have mainly involved larger cross-sectoral unions with some health care sector representation. In Austria, a merger between three (mainly) blue-collar unions created the [vida](#) trade union in 2006. The union represents employees in a range of occupations, including truck and engine drivers, waiters and nurses. It has some 150,000 members of which 7,000 are nurses. Further mergers, caused primarily by a decline in membership and subsequent financial instability, took place in 2007 between other cross-sectoral unions active in the health care sector. These mergers resulted in the formation of two ([GPA-djp](#) and [GdG-KMSfB](#)) of the other three active unions in the health care sector.

In the UK, one major merger occurred in 2007 where Amicus and TGWU merged to become [Unite the Union](#). Unite is the UK's biggest union with over 1,600,000 members and has about 100,000 members in the health sector.

New unions have been established over the past five years in Romania and Slovenia. The Central National Trade Union of Health and Social Care (*Centrala Națională Sindicală din Sănătate și Asistență Socială*) was formed in Romania and very recently a trade union called FLORENCE was established in Slovenia which represents about 200 nurses. The main reason for establishing FLORENCE was dissatisfaction with the work of [SDZNS](#) (the main union representing nurses in Slovenia) which was, in the nurses' opinion, neglecting the promises made by the government to equalise the terms and conditions of nurses with higher vocational qualifications with those holding university degrees.

Following splits between unions, health care professionals in Greece and Poland have set up new unions. For example, the National Confederation of Trade Unions for Health Workers ([OKZZPOZ](#)) was formed in Poland following a split from a regional structure of a larger federation of health and social care professionals ([FZZPOZiS](#)).

### ***Rivalries between unions in the sector***

Overall, relations between trade unions within the same sector are characterised by cooperation. EIRO correspondents have reported some rivalries in about a third of the countries covered by this study. These rivalries were considered serious in three countries.

The good cooperation in most of the countries studied is fostered by the fact that clear boundaries exist in many of them between the occupational and organisational domains covered by different unions. Furthermore, competition between unions is reduced when the public authorities consult

all the unions on relevant public policy issues and where the unions represent similar views and standpoints. The spirit of cooperation between unions can also be strengthened by the rules governing national trade union confederations that stipulate strict rules and procedures regarding competition to represent members.

There is some degree of competition between health sector unions in Belgium, the Czech Republic, Estonia, France, Greece, Norway, Portugal and Slovenia. Rivalry is more apparent in countries such as Germany, Italy and Malta. Despite the rivalry, many unions still tend to collaborate on matters concerning collective bargaining, professional development of nurses and carers, and public policy consultations.

In many cases the rivalry is local and based on competition over members (for example, Belgium, Estonia, Malta, Norway and Slovenia). This is particularly true for countries where the domains of health sector unions overlap such as in France. In Belgium, local level competition exists between different health care sector unions in both the public and private sectors. However, the unions are unified in their approach to collective bargaining, public policy consultations and the implementation of policy priorities.

A conflict has emerged in Germany where two unions have a disagreement over a new collective framework agreement for the public part of the sector ([DE0607019I](#), [DE0503203F](#)). Rivalry is apparent between the United Services Union ([ver.di](#)) and Marburger Bund ([MB](#)), a trade union representing medical doctors. In 2005, MB decided to opt out of a bargaining alliance with ver.di because it believed that better terms and conditions could be achieved for staff through separate negotiations. Ver.di criticised MB for this move and insisted on its right to negotiate for all staff in the health care service.

Rivalry is also clear in Italy and Malta. In Italy, competition exists between the three traditional union confederations and the more contemporary confederations, which claim to defend workers' interests more genuinely. However, all representative unions signed the last collective agreements. In Malta, competition stems from power struggles between unions over members and the rivalry tends to be particularly fierce among public sector unions. Various disputes have taken place between public health care unions; the General Workers' Union ([GWU](#)) and the Union of United Workers ([UHM](#)). These unions have a more cooperative relationship with the emerging professional associations in the sector than with one another.

## **Relationship between unions and new emerging professional organisations**

As indicated above, the relationship between traditional trade union organisations and new professional associations of health care workers varies from one European country to another. Professional organisations tend to be established to further the interests of a particular occupational group in matters going beyond wages, terms and conditions. Although trade unions collaborate well in many countries with such professional associations on matters of common interest, this relationship is more difficult for example in Estonia, France, Italy and Poland.

France has seen strong opposition against the recent law that established a professional association for nurses. Nurses dislike being made to pay a fee to this association and the unions have questioned the representativeness of the association; the protests against the new association have culminated in strikes calling for its closure. In Italy, the overlap between the activities of unions and professional associations has caused occasional conflicts. In Estonia, the competition between unions representing nurses emerged when the professional association of nurses (Estonian Nurses Union, [EÖL](#)) transformed its organisational status into a trade union. This means that nurses are now represented by two dedicated unions.

## Employer organisations in the health care sector

### *Number of employer organisations*

In many countries, employers' interests are represented by several organisations, often depending on the precise nature of health care provision, financing and industrial relations traditions. By far the largest number of representative organisations can be found in Belgium (13), followed by Greece and Italy with 10 employers organisations per country (Table 4). Six or more organisations are present in Austria, the Czech Republic, Denmark, the Netherlands, Poland and Spain. Hungary is not far behind with five representative organisations. Two representative bodies can be found in Cyprus, Ireland and Portugal. Three smaller Member States (Estonia, Lithuania and Malta) have a single organisation representing health care providers.

The low number of employer organisations in, for example, Cyprus is explained by the fact that the ministry in charge of health handles most of the bargaining in the public part of the sector. This is also the case in Greece and Romania. In Belgium, the high number of employer organisations partly reflects the regional structure of the country (Walloon and Flanders).

**Table 4: Employer organisations in the health care sector, 2010**

	Total number	Number specific to the health care sector *	Organisational domain: public, private, private, third sector	Participation in collective bargaining
<b>AT</b>	7	5	Four third sector, two private and one for public sector employer organisation	All involved in collective bargaining except one public sector organisation
<b>BE</b>	14	13	Private, public and third sector organisations	All involved in collective bargaining
<b>BG</b>	4	2	Separate private and public employer organisations	All involved in collective bargaining
<b>CY</b>	2	1	All private	All involved in collective bargaining
<b>CZ</b>	6	6	Some private (membership not clear for all)	None involved in collective bargaining
<b>DE</b>	5	2	Two public, two private and one third sector organisation	–
<b>DK</b>	6	2	Three private, two public and one third sector organisation	All involved in collective bargaining
<b>EE</b>	1	1	–	All involved in collective bargaining
<b>ES</b>	6	6	–	All involved in collective bargaining (no information available for all)

	<b>Total number</b>	<b>Number specific to the health care sector *</b>	<b>Organisational domain: public, private, private, third sector</b>	<b>Participation in collective bargaining</b>
				organisations)
<b>FR</b>	3	3	One public, one private and one mixed (private/third sector) organisation	All involved in collective bargaining
<b>EL</b>	10	10	All private	All involved in collective bargaining except one
<b>HU</b>	5	5	–	All involved in collective bargaining
<b>IE</b>	2	1	One private and one mixed (public and private)	All involved in collective bargaining
<b>IT</b>	10	6	Six third sector, three private and one public employer organisation	All involved in collective bargaining
<b>LT</b>	1	1	Mixed public and private representation	All involved in collective bargaining
<b>LU</b>	4	2	Mixed	All involved in collective bargaining
<b>MT</b>	1	0	Mixed (public and private) representation	None involved in collective bargaining
<b>NL</b>	6	6	–	All involved in collective bargaining
<b>NO</b>	4	0	Public and private sector employer organisations	All involved in collective bargaining (no information available for all organisations)
<b>PL</b>	6	4	Four private and two mixed public and private sector organisations	None involved in collective bargaining
<b>PT</b>	2	2	Private sector organisations	None involved in collective bargaining
<b>RO</b>	5	1	Public and private (3) employer organisations	All involved in collective bargaining
<b>SK</b>	4	4	Public and private (2) employer organisations	All involved in collective bargaining
<b>SI</b>	3	3	Mixed (public and private sector) organisations	Only one involved in collective bargaining

	Total number	Number specific to the health care sector *	Organisational domain: public, private, private, third sector	Participation in collective bargaining
<b>SE</b>	5	1	Two private, one public, one mixed (private/public) and one third sector organisation	All involved in collective bargaining
<b>UK</b>	4	4	Public	–

Notes: – = information not available.

\* In some cases, the actual number of health care sector specific employer organisations can be higher. Due to the lack of information for all organisations, it was not possible to determine the domain of all organisations.

Source: EIRO national reports on industrial relations in the health care sector, 2010

### *Public, private and third sector representation*

In contrast to trade unions where many organisations cover employees of both the public and the private parts of the sector, representation of employers is more likely to be split according to the nature of provision (public, private and third sector) (Table 4).

Separate employer organisations for public and private providers exist, for example, in Austria, Belgium, Bulgaria, Denmark, France, Germany, Ireland, Italy, Norway, Poland, Romania, Slovakia and Sweden. However, there are also some employer organisations representing both public and private sector providers in Ireland, Lithuania, Luxembourg, Poland, Slovenia and Sweden.

In the private sector, employer organisations tend to represent either private hospitals or private residential care facilities.

In the public sector, employers' interests are often represented by the respective ministry of health, particularly if the majority of health care is state provided and funded. As described in more detail in the next section, this can have a crucial impact on collective bargaining. This is especially true for health care employees in the public sector who have the status of civil servants, as they often have their terms and conditions fixed in legislation (rather than by collective agreement).

Separate organisations for third sector employers (especially providers run by churches and religious organisations) exist for example in Austria, Belgium, Denmark, France, Germany, Italy and Spain.

General and specialist employer organisations exist in parallel in half of the countries studied. General employer organisations represent the interests of employers beyond the health care sector (of either the public or private sector), whereas specialist employers focus solely on representing health care establishments. General employer organisations are often found in the public sector, especially in countries where employers essentially represent the employer interests of all regional or municipal public services (such as in Denmark, Finland or Sweden).

Employer organisations specifically representing providers in the health care sector have been reported in 10 countries (the Czech Republic, Estonia, France, Greece, Lithuania, the Netherlands, Slovakia, Slovenia, Spain and the UK). Specific organisations can represent public providers, or indeed the state health care system, as is the case with [NHS Employers](#) in the UK, or the French Hospital Federation ([FHF](#)), but they can also be found among private providers as



is the case in the Czech Republic and Greece where they represent, for instance, private hospitals, private clinics or private nursing homes.

In the majority of countries, all employer organisations participate in collective bargaining. Exceptions are the Czech Republic, Malta and Poland where employer organisations in the health care sector do not participate in collective bargaining and agreements are reached at establishment level. In some other countries (for example, Austria, Greece and Slovenia), all but one take part in bargaining either at cross-sector, sector or local level. Where employer organisations are not involved in collective bargaining, it is generally because they are not mandated to do so by their members, and their activities are limited to representing the interests of their members in social dialogue or providing advice on bargaining outcomes reached at the local level.

On the whole, employer organisations in the eastern European Member States tend to have a shorter tradition and are organisationally and economically weaker. In many cases they are involved in collective bargaining only at local level.

### ***Reorganisation of the structure of employer organisations***

After some years of rapid change in the representation of employers (particularly in the 12 new EU Member States following accession in 2004 and 2007), the landscape for employer organisations in the health care sector has remained relatively stable over the last five years. Relatively few reorganisations have taken place. Over half of the countries studied (15) witnessed no major reorganisations, while 10 have experienced some degree of reorganisation over the past five years. Mergers, splits or other forms of restructuring have taken place in Belgium, Denmark, Germany, Ireland, Italy, the Netherlands, Poland, Slovakia, Spain and Sweden.

Structural reforms of the health care sector or the reallocation of responsibilities between the state, regions and local authorities have led to reorganisation in the health care sector in Belgium, Denmark, Ireland and Slovakia. In Denmark, the setting for employer organisations has been adjusted to take into account of the change in prerogatives between the state, regions and municipalities (the health care sector is now the responsibility of the regions and municipalities). In Ireland, the Irish Government disbanded the public health boards in 2005. They were reorganised into the HSE, which took over full operational responsibility for running Ireland's public hospital and other health care services. In Slovakia, health care reforms have brought new roles for larger, state-owned hospital (as opposed to small and private hospitals). As a consequence, the association representing hospitals was split into two organisations in 2006.

Employer organisations have merged in Germany, the Netherlands and Sweden. In Germany, a new employer association of private care providers was established in 2009. [Arbeitgeberverband Pflege](#) was established by eight companies involved in health care services and the federal association of providers of private social services ([bpa](#)) to establish a body which could conclude a sectoral agreement with the German Trade and Industry Employees' Association ([DHV](#)) and the health trade union, [medsonet](#). In Sweden, the Swedish Association of Local Authorities and Regions ([SALAR](#)) was created in 2007 after a merger of the municipality and county associations, and [ActiZ](#) was created in the Netherlands as a result of a merger of two smaller employer organisations in the sector. ActiZ represents nursing homes, homes for the elderly and providers of home care, youth health care and maternity care.

Employer organisations have split into smaller units in Italy and Slovakia. For example, in Italy, the reorganisation of the federation of national cooperatives, [Legacoop](#), which took place in 2005, resulted in the creation of a specific employer organisation for social and health care cooperatives.

A new, informal umbrella organisation for employers in the health care sector was established in Poland in 2006. The Healthy Health Corporation ([Korporacja Zdrowe Zdrowie](#)) represents three employer federations and some individual employers in the sector.

### *Rivalries between employer organisations in the sector*

On the whole, there is less competition between employer organisations than trade unions in the sector, as demarcation between organisations is fairly clear, reducing competition over members. Some degree of rivalry was reported by EIRO correspondents only between employer associations in Austria, Denmark, Germany, Spain and Sweden. The most important examples are Austria and Spain. In Austria, many different collective agreements cover pay and working conditions of health sector workers, causing rivalry between employer organisations in the sector. Two employer organisations, the Association of Health Companies ([FVG](#)) and the Association of Private Hospitals in Austria ([VPÖ](#)) also compete over the right to conclude collective agreements. The conflicting interests and priorities of some Spanish employer organisations in the sector have created a climate of hostility between different organisations. Some employer representatives have also questioned the representatives of other employer organisations involved in collective bargaining in the sector.

## **Collective bargaining, social dialogue and industrial action in the sector**

For the purposes of this study, a distinction is made between collective bargaining and social dialogue, with collective bargaining referring to bipartite negotiations between employers and trade unions on wages, and [terms and conditions of employment](#), taking place at different levels. Social dialogue on the other hand is taken to refer to a range of bipartite and tripartite information, consultation and negotiating arrangements not related to the terms and conditions of employment. This includes tripartite concertation, which refers to institutionalised arrangements (usually at national level) that allow social partner organisations to be consulted by government on a wide range of policy issues.

This section begins by examining the structure and nature of collective bargaining in the health care sector, its coverage, and the possibility of extending collective agreements and any derogations or opt-outs that can be applied. The second part focuses on social dialogue structures, processes and issues discussed within such fora in the health care sector. The final section examines industrial action in the health care sector over the past five years.

## **Collective bargaining**

### *Structure and level of collective bargaining*

In most European countries, the structure of collective bargaining in the health care sector is conditioned by the nature, funding and organisation of health care provision (the mix of public, private and voluntary provision and the level of responsibility for managing the service – national government, municipalities, voluntary organisations at different levels, etc.). The most significant distinction in the level and nature of bargaining can be found between public and private sector providers.

### *Setting wages and terms and conditions in the public sector*

In the public sector, wage setting tends to be centralised either at national or regional level. Negotiations on salaries and terms and conditions can depend on the status of the employee (civil servant or employee under the standard labour code). The terms and conditions of civil servants are usually laid down in legislation (for example, in Cyprus, France and Greece), whereas

settlements for other public sector workers are negotiated between the government and public service trade unions. However, this is not the only reason for the complexity of bargaining arrangements in the public sector. Differences can also be found in the nature of the parties taking part in bargaining processes, whether these are bipartite or indeed tripartite (involving employer organisations and the state as well as the unions), the level of bargaining (national or regional) and the level of detail covered by collective bargaining at central level – and, as a result, the extent of local leeway to further shape pay and conditions.

The precise shape of collective bargaining in the public sector is also influenced by:

- particular responsibilities for health care provision in different countries;
- the level of local autonomy provided (in addition to national bargaining);
- the strength and maturity of employer organisations in the sector.

In the public sector, these factors tend to be paramount to general industrial relations traditions, although they clearly do have an influence. (See [TN0611028S](#) for an overview on industrial relations in the broad public sector.)

In Belgium, Lithuania and Portugal, for example, negotiations take place between trade unions and the state as employer. In Belgium, the federal structure of the state means that national agreements have to be translated into agreements at regional level. In Lithuania, the outcome of such centralised bargaining does not take the shape of a collective agreement, but of legislation on the general financial perspectives which set the framework for further negotiations at local level. In Portugal, negotiations take place, but decisions can ultimately be taken by the government unilaterally.

Collective bargaining between trade unions and public authorities at regional level takes place in the public sector in Austria, Denmark, Finland, Germany, Spain and Sweden. In Austria, these negotiations are directly between the trade unions and the *Länder*. In Germany, these negotiations are carried out by the Confederation of Municipal Employers' Associations ([VKA](#)) and [TdL](#) (the employer organisation for the *Länder*) for the health care providers in their purview (although these negotiations no longer cover all regions). In Spain, public service bargaining for the health care sector is the responsibility of the autonomous regions. In the Nordic countries, bargaining is also carried out at regional level, with local or regional authority employers.

In Ireland, Italy, Luxembourg, the Netherlands, Slovakia and the UK, bargaining in the public sector is between national employer organisations and trade unions. In Estonia, an agreement has been signed between the national employer organisation in the sector and the trade unions on a minimum wage.

In countries where public service provision is paramount, bargaining at this level often has a guiding function, with private sector settlements shadowing public sector deals. Public sector bargaining is generally constrained by overall public spending plans or the level of public insurance levies. Like the trend in health care policy, there has been a move towards the decentralisation of management which has meant that, even in the public sector, more and more local autonomy is being granted to further shape collective bargaining outcomes.

### ***Setting wages and terms and conditions in the private sector***

Many private providers only bargain at the local level, although there are some exceptions to this rule in cases where there are strong private sector employer organisations engaging in multi-employer bargaining. Multi-employer bargaining at national level takes place in Austria, Belgium, Finland, France and Slovakia. However, bargaining in the private sector is entirely decentralised in the majority of member states in eastern Europe (for example, in the Czech Republic, Hungary, Poland and Romania), as well as in Cyprus, Germany, Greece, Malta and the UK.

In Austria, the sectoral agreement concluded between the Professional Association of Employers for Health Care and Social Workers ([BAGS](#)) and the trade unions, GPA-djp and vida on behalf of employees, represents the only sector-wide collective agreement covering the whole health care and care sector including work with the disabled, children and youth welfare and the provision of labour market policy services.

In Belgium, collective bargaining in the private sector takes place in joint committees. Separate committees exist for health care providers and care providers. Although negotiation and consultation in the public sector must take place between trade unions and the government which can lead to agreements and protocols, these have no legal standing and the government can act unilaterally. Bargaining is carried out in three committees (Committee A covering all public sector workers at federal level, Committee B which contains 15 different sectoral bargaining committees and Committee C where protocols are negotiated for workers in different provincial and local administrations). In the last 10 years, there has been greater coordination of collective bargaining between the private and public sectors with agreements being negotiated for five-year periods covering the public and private (not-for-profit) sector.

In the Spanish private sector there are:

- two collective agreements at national sectoral level:
  1. one covering all workers in retirement homes, day care centres, night care centres, sheltered accommodation and those who provide home care,
  2. one for individuals working in facilities dedicated to the diagnosis, treatment and rehabilitation of patients suffering from physical, mental and sensory disabilities);
- 19 multi-employer agreements;
- 45 single employer agreements.

In many countries, these trends are in line with national industrial relations traditions (examples include Austria, Belgium, France, Finland and the UK), but in other cases the situation of a private health care sector is more unusual (for example, in Slovakia, where private sector bargaining often tends to take place at the local level, and in Germany, where private sector bargaining is more centralised in many other sectors).

### ***Coverage of collective agreements***

Overall, the coverage of collective agreements of workers in the health care sector is very high. This is particularly true for the public sector, where 100% of workers are generally covered by a single agreement. This applies to Austria, Belgium, Cyprus, Denmark, France, Ireland, Italy, Lithuania, Malta, Romania, Sweden, Slovenia and the UK. Significantly, Austria, Belgium (private sector), Estonia, Spain, France and the Netherlands provide the opportunity to extend multi-employer agreements to employers not affiliated to the relevant organisations. In Austria this has been done in relation to two collective agreements (one at national and one at regional level). In Estonia, this extension only applies to minimum wages.

In Belgium, collective bargaining coverage in the private sector is also high because of the compulsory affiliation to the employer organisation. In Denmark, private sector coverage is also close to 100%. In a number of countries, however, private sector collective bargaining coverage is considerably lower than in the public sector because of the more fragmented nature of bargaining. This is the case in Cyprus (30%), Spain (40%), Italy, Lithuania (20%), Malta (under 13%) and the UK (40%). In some cases, these figures are difficult to ascertain and therefore reflect estimates. In Bulgaria, coverage in the health care sector is particularly low at an estimated 28%, and in Poland, an even lower 5% coverage is estimated among nurses. In Estonia, minimum wage provisions cover 88% of employees, with other terms and conditions having lower coverage levels.

## *Derogations and opt-out rules applying to sectoral agreements*

The majority of countries do not have any **derogation** or **opt-out** rules applying to sectoral agreements in relation to pay and conditions; this does not apply to working time, where the use of opt-out rules is quite prevalent.

The most important example in this area can be found in Germany. According to an annual survey for the German Hospital Institute (DKI), [Krankenhaus-Barometer 2008 \(in German, 5Mb PDF\)](#), 9% of all German hospitals were covered at the time of the study by an ‘emergency collective agreement’ deviating from the concluded agreement as a means of securing profitability and jobs. An additional 3% planned for the bargaining of an ‘emergency agreement’. Around 98% of collective agreements contained an opt-out provision from statutory working time regulations in 2008. However, under a 2009 amendment of the Posted Workers Act, it is not necessary to extend a multi-employer agreement in order to set a minimum wage covering health care workers. In May 2010, the Federal Labour Ministry approved an hourly minimum wage covering assistant care workers (see box).

### **National minimum wage for care workers in Germany**

A new national minimum wages for care workers came into force in Germany on 1 August 2010. The employees covered are entitled to an hourly minimum wage of €8.50 in western Germany (including Berlin) and €7.50 in eastern Germany. These rates will increase with effect from 1 January 2012 to €8.75 in western Germany and €7.75 in eastern Germany.

The sectoral national minimum wages were declared generally binding under the Posted Workers Act (*Arbeitnehmer-Entsendegesetz*, AEntG) by a decree of the Federal Ministry of Labour ([BMAS](#)). This means that the rates apply to all employees in Germany working in the occupations concerned regardless of the country of origin of their employer. The rates also cover agency workers hired out to employers in the care sector. Of the approximately 810,000 workers in the sector, 520,000–560,000 care workers in ambulatory and stationary ‘basic care’ (*Grundpflege*) are covered by the decree, which will expire on 31 December 2014.

The minimum wages apply to care facilities and care providers that provide services under the provisions of the Social Security Code XI (*Sozialgesetzbuch XI*, SGB XI). This act regulates the compulsory long-term care insurance (*Pflegeversicherung*) which is one pillar of the German social security system. SGB XI defines as ‘basic care’ services directed at supporting patients in the fields of body care, feeding and mobility. Not covered by the minimum wages are hospitals and care providers offering predominantly health care nursing services. The minimum wages do not apply to caregivers directly employed by private households.

For more information see [DE1008019I](#).

## **Social dialogue**

### *Overview*

Formal or informal tripartite or bipartite social dialogue takes place at national, sectoral or regional level in all countries covered by the study with the exception of Cyprus, Greece, Malta and Slovenia. The extent to which this is institutionalised and the range of subjects covered varies significantly from country to country. Important elements include participation in the running of health insurance systems, involvement in health policy planning and, more importantly, the contributions made by employer and trade union organisations as well as the planning of training curricula. In a number of these dialogues, stakeholders other than the social partners are also represented, including NGOs and other public and private interest organisations. Table 5 provides an overview of the different fora for social dialogue in the health care sector.

**Table 5: Nature and content of social dialogue in the health care sector**

Country	National, regional or local	Tripartite or bipartite	Other stakeholders involved	Topics covered
Austria	All levels	Both BAGS only involved in lobbying activities	No information available	All relevant subject areas
Belgium	All levels	Both	Sickness funds, Order of physicians, occupational bodies, hospital associations, pharmaceutical companies, etc.	Health care policy, including manpower planning for the sector Social insurance policy Management of sickness funds Qualifications development Improvements in administration in the hospital sector Professional conduct Management of sectoral funds for training and planning of training
Bulgaria	National and regional	Tripartite	Municipalities	Issues affecting the sector
Czech Republic	National and regional	Tripartite and bipartite		Reform and financing of health care system At regional level exchange of information on developments and working conditions in the sector
Germany	National and regional	Tripartite and bipartite	Regional government	50:50 representation on boards of statutory health insurers National round tables on care and 2009 establishment of wage

Country	National, regional or local	Tripartite or bipartite	Other stakeholders involved	Topics covered
				commission Care commission at regional level
Denmark	National	Bipartite		Vocational and training and health and safety
Estonia	National	Tripartite		Qualifications, wages, health care funding
Spain	National (with regional representation)	Tripartite	Autonomous communities, private health care companies	Health care planning Tripartite consultant committee contributes to law making
France	National	Tripartite	Organisations representing health care users	Created in 2006, the National Health Care Conference is consulted by government on public health care issues; other consultative bodies on training and pensions
Ireland	National	Bipartite Tripartite		Health Services National Partnership (employer/trade union body). Forum aims to change best practice, promote partnership and develop training  Health Service National Joint Council not only responsible for collective bargaining, but also other matters of common concern are discussed.
Italy	National, regional	Both		Rather weak consultation bodies established at various levels. Do not deal with industrial relations issues

Country	National, regional or local	Tripartite or bipartite	Other stakeholders involved	Topics covered
Lithuania	National	Tripartite	Other societal groups	Compulsory Health Insurance Council
Netherlands	National	Bipartite		Education and development funds and pension funds
Norway	National	Bipartite		Continuous dialogue on health care issues
Poland	National Regional	Tripartite		Tripartite Health Care Team established in 2005  Regional social dialogue bodies can also cover health care issues
Portugal	There is no institutionalised social dialogue in the health sector.			
Romania	National	Tripartite		Committee for Social Dialogue has representatives from health care sector
Sweden	Local	Bipartite		Workplace committees
Slovakia	National	Tripartite and bipartite		Regulation of health care provision, health care reform and financing
UK	National	Bipartite (government involvement as employer in a national health services framework)		NHS Staff Council also discusses wider working conditions, sector skills councils on vocational training development

*Source: Responses of EIRO national experts on industrial relations in the health care sector, 2010*

Tripartite social dialogue is far more developed than bipartite dialogue. This is particularly (though by no means exclusively) true for the central and eastern European countries where



employers organisations often are less well-established and the state continues to play an important role in social dialogue (and in some cases in collective bargaining) arrangements.

### *Nature and content of social dialogue*

In line with strong social dialogue traditions, it is notable that bipartite dialogue alone is far more prevalent in the Nordic countries than elsewhere (with perhaps the exception of the Netherlands). In the UK, the NHS Staff Council deals with other matters affecting working conditions in the sector as well as pay and terms and conditions. In countries like Austria, Belgium and Germany, bipartite dialogue is also strong, but goes hand-in-hand with rather institutionalised tripartite dialogue at national and regional level. Bipartite social dialogue is significantly less well-developed in many of the new Member States.

Bipartite dialogue can either focus on very specific local issues (as in Sweden), certain topics of joint concern such as vocational education and training (as in Denmark), or can be more wide-ranging looking at all the different aspects of health care policy and delivery (as in Norway).

Tripartite discussions between national governments and social partners in the sector are relatively common. They rarely constitute a form of joint decision-making, but rather take the form of a consultative process. Notable exceptions are the National Council for Hospital Facilities in Belgium, which advises the Minister of Social Affairs and Public Health on hospital planning, accreditation and financing, and has a considerable influence. The other example is the institutionalised consultative process in Spain which led to the conclusion of some of the most important agreements in the country in the health care sector in recent years:

- ‘Agreement for the Improvement and Development of the Social Protection System’ in 2001;
- ‘Agreement on Competitiveness, Employment and Social Cohesion’ in 2004;
- ‘Agreement on the Protective Action of Care for Dependent Persons’ in 2005.

Other well-established, permanent tripartite dialogue processes involving discussions on the future of health care policy, reform and service planning exist in Bulgaria, the Czech Republic, France, Ireland, Poland, Portugal, Slovenia and Slovakia. In Bulgaria, Municipal Councils for Tripartite Cooperation discuss municipal health care budgets and structural health care reform, and have control over the implementation of collective agreements. Similarly, in the Czech Republic, the Council of Economic and Social Agreement of the Czech Republic ([RHSD](#)), discusses health care finance and reform. In France, the National Health Conference ([CNS](#)), established in 2006, provides a forum for discussion on health matters though not only social partners are involved and organisations representing health care users are also included. This body is consulted by the government about public health objectives and it may suggest improvements to the system.

In a number of cases, the cooperation is highly institutionalised and forms part of the management of statutory health or social insurance, sickness or pension funds (as is the case in Belgium, Germany, Lithuania and the Netherlands).

A particular focus on sector skills among bipartite and tripartite social dialogue bodies can be found in Belgium (through the steering of a sectoral fund for training), Denmark (Industrial Committee for the pedagogic assistant and the social and health care training programmes), Estonia (Estonian Qualifications Authority) and Ireland.

## Industrial action

The majority of European countries have experienced industrial action in the health care sector over the past five years. Actions taken have varied, depending on the country and the context, from full strike action (withdrawal of labour) to more restricted forms of protest such as demonstrations and ‘work-to-rule’. In some countries, the level of industrial action within the sector is relatively low compared with many other sectors and other areas of the public sector in particular. This is the case, for example, in Austria, Luxembourg and the UK. At the same time, a relatively high number of strikes and protests have taken place within the sector in countries such as the Czech Republic, France, Ireland, Poland, Slovakia and Spain; such strikes have focused primarily on pay disputes.

### *Strikes*

Strike action has taken place in the health care sectors all across Europe from the north of Europe (for example, Denmark, Norway and Sweden) to the south (for example, Cyprus, Greece, Italy and Spain), and from the eastern/central European Member States (for example, Bulgaria, Czech Republic, Slovakia and Slovenia) to the western European ones (for example, Belgium, France, Ireland, Germany).

In some cases, industrial action has been the result of disputes affecting either the whole public sector or the health sector as a whole. Public sector disputes over pay involving, but going beyond the health care sector, took place in Ireland and Romania. Pay was also at the heart of a health care sector dispute in Lithuania in 2005. Portugal witnessed a strike in the health care sector in 2010 which resulted in a completely revised collective agreement for nurses in private hospitals ([PT10010491](#)). In many cases industrial action is, however, specific to certain occupational segments of the health care sector. A number of countries, such as Germany, report an increase in the number of company/workplace level disputes, which can be attributed to the increasing decentralisation of the health care system. Industrial action has affected both the private and public health care system.

Only four (Austria, Estonia, Lithuania and Luxembourg) out of 24 countries reviewed (no information was available for the Netherlands) reported no strike action in the health care sector over the last five years. In Luxembourg, it is rare that disagreements in the sector lead to strike action as an ongoing dialogue exists between social partners and health policymaking is centred around a tripartite approach. In Lithuania, a planned strike was called off as the labour code requires that the immediate (vital) needs of society are met in case of a strike of medical workers; in this case, the threat of a strike was sufficient to lead the government and trade unions to settle the pay dispute. Similarly, threats of strike action provided sufficient impulse for the relevant parties in Austria and Estonia to reach agreement before industrial action took place.

Disputes over pay were at the heart of most industrial action taken in the past five years. This has been the case, for example, in Bulgaria, Denmark, Greece, Ireland, Italy, Norway, Portugal, Slovakia, Slovenia, Sweden and Romania. As an example, wage disputes caused over two-thirds of strikes in Romania between 2005 and 2009. In Spain, 43 disputes over pay led to strikes in 2009 alone.

Other key factors triggering strikes in the health care sector concern disputes over staffing levels and working hours.

With regards to staffing levels, public sector nursing staff in Greece have taken strike action over the past five years to demand salary increases, improvements in working conditions, and staff increases. As a result, the Minister of Health announced in March 2010 that 3,000 new nurses would be recruited by 2012. In Cyprus, the Federation of Government, Military and Civil Service Workers ([OEKDY](#)), affiliated to the Federation of Private Sector Workers ([SEK](#)), and PASYEK,

affiliated to the Pancyprian Federation of Labour ([PEO](#)), organised a 12-hour strike in 2009 demanding that public sector hospitals fill vacant care assistant posts. This demand was subsequently met by the hospitals.

In relation to working hours, thousands of nurses in several German municipal hospitals went on a strike in 2006 in protest against demands from employers to increase weekly working hours ([DE0605019I](#)). Other triggers have included:

- demands to create an organisation for nurses (for example, France);
- opposition to government health care policies (for example, the Czech Republic);
- health care expenditure, including cuts to services (for example, Ireland and Poland);
- reform of the staff pension system (for example, France);
- lack of training leading to care workers being asked to carry out tasks they are not qualified to do (for example, Slovenia);
- employers failing to meet the conditions of collective agreements (for example, Malta).

Strikes in the sector have ranged from one hour or one day warning strikes (for example, Bulgaria, Cyprus, Ireland, Malta and Slovenia) to work stoppages lasting from 11 days (for example, Norway) to eight weeks (for example, Denmark). The largest number of working days lost due to strike action occurred in Denmark in 2008 when a strike among nurses lasted 43 working days ([DK0804029I](#)). In this dispute, over 1.8 million working days were lost. While some strikes were settled between management and the workers, others required the intervention of independent mediators to help reach an agreement.

Although disputes remain unresolved in some cases, it is clear that many strikes have contributed to increases in wages, in particular, for nurses and care assistants. In the case of Lithuania, the wage increases achieved reached double digits, though the sector is still considered to be a low-paid one in many countries. Other outcomes have also been achieved. For example, the 2008 eight-week nurses' strike in Denmark led to a Wage Commission being set up to look at the wage systems and differences within the public sector.

In a number of countries, threats of strikes were used during collective bargaining rounds, or to protest against employers not meeting previously agreed obligations. Most notably, the threat of strike action in Lithuania led to the government agreeing a 20% pay increase for doctors and nurses.

### *Protests and demonstrations*

Between 2005 and 2010, protests and demonstrations as a means of industrial action were carried out in at least eight Member States. The protests ranged from meetings with government representatives (for example, Poland) to one-day high profile demonstrations (for example, Belgium), and protests involving hundreds of nurses and care workers camping in front of government buildings for several weeks (for example, Poland, [PL0707019I](#)).

Most of these demonstrations were organised by unions and workers to protest against low wages in the sector, though in the case of Belgium the purpose of the recent demonstrations has been to illustrate the need to reach an all encompassing collective agreement for the whole not-for-profit sector. Health care workers have been at the forefront of these demonstrations, their aim being to reach a new agreement in autumn 2010.

In Luxembourg, large-scale demonstrations were organised in 2006 and 2008 to protest against the career path framework and inequality in salary scales for nurses. Workers also carried out a protest against a merger of specialist hospitals in the city of Brno in the Czech Republic.

Some of the demonstrations have led to demands being met. For example, in Bulgaria, protest meetings were organised by the unions in 2007 to dispute low wages that had not been increased

since 2003. As a result of the meetings and an associated strike, an agreement was reached with the government to increase wages by 30%. In Luxembourg, the action of a trade union, the National Association of Nurses of Luxembourg ([ANIL](#)), resulted in the opening of negotiations to amend the law on nurses' training.

### *Work-to-rule*

Examples of industrial action where employees have resorted to working strictly according to the legal terms of their contract of employment (work-to-rule) can be found within the health care sectors in Ireland and Malta. For example, in 2007 nearly 40,000 Irish nurses took part in industrial action over pay and working hours. The two unions involved were the Irish Nurses and Midwives Organisation ([INMO](#)) and the Psychiatric Nurses Association of Ireland ([PNA](#)). The dispute involved a nationwide work-to-rule and a series of short work stoppage. The dispute ended when nurses voted to accept a proposal which included the introduction of a 37.5-hour week, an independent commission to examine how a 35-hour week might be achieved, and a bridge back to benchmarking/social partnership. Another incidence of work-to-rule in Ireland took place between January and June 2010 following pay cuts imposed on all public sector workers in the 2009 budget.

### *Other industrial action*

Malta has recorded several, short incidences of care staff refusing to take on additional duties. The dispute was caused by staff shortages, insufficient provision of staff meals, and increases in workload for longer periods than originally agreed upon.

Sit-in strikes, hunger strikes and marches have been organised by workers and their representatives in a number of individual hospitals across Poland as a way of demanding pay increases for nurses.

## **Contribution of collective bargaining and social dialogue to addressing the challenges facing the sector**

As demand for health and social care services increases in the context of an ageing population, the issue of recruiting and retaining workers attains growing significance. Similarly, the rise in relatively healthy life expectancy with individuals expecting to live at home longer, coupled with the increasing complexity of conditions arising with older age, requires the health care workforce not only to work differently, but also to update their skills and competencies more regularly. In facing these changes, it is important to bear in mind the current predominance of women in the workforce, who often combine their career with family life.

This serves to highlight the need for relevant stakeholders, including importantly the social partners, to address some of the factors limiting the attractiveness of the sector such as poor working conditions and remuneration.

At European level, the European social partners in the sector, EPSU and the European Hospital and Healthcare Employers' Association ([Hospeem](#)), have prioritised some of these issues as part of their [2008–2010 work programme](#). Among other things, this work programme commits EPSU and Hospeem to:

- develop policies and instruments to support sustainable workforce management within the hospital sector in the EU;
- promote the application of equality principles and legislation;
- further explore how the organisation of health care systems influences work organisation in the hospital sector.

The work programme emphasises the importance of capacity building among national social partner organisations to help them address such issues, as well as the exchange of information on good practice.

The remainder of this section looks at initiatives taken by social partners in an effort to address the main challenges facing the sector. This includes actions taken at national and regional level, either through national, regional or local sectoral bargaining or other social dialogue initiatives taken at bipartite or tripartite level. The national reports highlight the need for initiatives in this area to focus on improving:

- wages and terms and conditions;
- access to ongoing training and career opportunities;
- work–life balance measures;
- gender equality and equal pay;
- health and safety;
- working conditions for older workers;
- integration of migrant workers.

## **Improvements in wages and terms and conditions**

### *Wage negotiations*

A recent report commissioned by EPSU (Pillinger, 2010) examined:

- pay levels in health care, child, elderly and other dependent care in eight EU countries (Belgium, Estonia, Finland, Germany, Ireland, Latvia, Sweden and the UK) compared with average wages in the public and private sectors;
- the extent of the pay gap and its relationship with the national gender pay gap.

The report found that, in the countries surveyed, workers in these sectors generally earn wages below the national average. The wages of unqualified or low-qualified staff are often at the minimum wage or basic collectively agreed level, whereas well-qualified workers earn below the average for their country for an equivalent qualification level. In addition, the report found severe gender disparities, a high incidence of precarious contracts, irregular working hours and few career opportunities. It argues that these combined factors often contribute to difficulties in relation to the recruitment and retention of workers in the sector. Additional difficulties relate to work organisation and working patterns which can be difficult to reconcile with family life. For some cross-border regions in the EU, retention difficulties can also be related to increasing workforce mobility to higher wage countries.

EIRO correspondents from just under half the EU countries report that multi-employer collective bargaining has contributed to improving the wages of health and social care workers over the last five years. In a further four countries, the national reports provide examples of local agreements which aimed to increase pay (though the incidence of such local agreements overall may be significantly higher and may have been under-reported as local agreements were not the focus of this study). As outlined above, in many cases this has only been achieved following the threat, or actual implementation, of strike action.

In a number of agreements, particular emphasis was placed on improving the remuneration of low-skilled, particularly low-paid workers in the sector where there was often a high rate of staff turnover. In the private health care sector in Austria, the most important collective agreement was the one reached in 2004 between BAGS (employer organisation) and GPA-djp and vida (trade unions). For the first time, this agreement provided for standard pay with an automatic bi-annual increase in remuneration and annual adjustments for inflation for all workers in the sector.

Following the extension order implemented in 2006, over 80,000 employees now fall under this collective agreement. Also in Austria, the cross-sectoral social partners concluded an agreement on the introduction of a minimum wage (currently €1,000 per month) for full-time workers in all sectors. This agreement, which came into force in 2009, goes beyond health care but clearly benefits many workers in the sector.

In 2004, the Health Service Branch of the Services, Industrial, Professional and Technical Union ([SIPTU](#)) and the Health Service Employers in Ireland negotiated a national pay agreement which improved the pay and conditions of over 12,000 home helps nationally.

In Sweden, the creation of the ‘low income pool’ agreed by the Swedish Municipal Workers’ Union ([Kommunal](#)), SALAR and the Federation for Municipal and Private Organisations ([PACTA](#)) ensures that larger wage increases are guaranteed for low income workers in the sector (this example is further elaborated in the section on gender equality below).

In Belgium, Bulgaria, Lithuania and Poland, agreements have been reached to improve the pay and conditions of certain categories of workers in the health and social care sector. A multi-annual, cross-industry agreement reached in Belgium to cover the period 2005–2010 provided for a significant increase in wage supplements for night shift workers. The same agreement also extended the employment protection previously only available to white-collar workers to all care workers. In Poland, social partners influenced the passage of a law (Wedel Act) in 2006, which allowed for financial resources allocated to service providers to be used to increase wages. The law stipulates that 30% of these resources must be spent on wage increases for medical staff. A 30% increase in wages for social care workers was achieved in a tripartite agreement in Bulgaria between the government, the Confederation of Labour ‘Podrepa’ ([CL Podrepa](#)) and the Federation of Independent Trade Unions of Government and Organisations ([KNSB](#)). Similarly a collective agreement in Lithuania dating back to 2005 provided for a 20% wage increase for doctors and nurses in the health care sector, although according to the trade union representatives, this 20% increase was only shared evenly between all employees in establishments with strong union representation, which was not the case in other establishments.

A number of agreements negotiated at sectoral or local level specifically aim to attract care workers back to the sector who had left either on extended periods of maternity and parental leave or to work in another country. An agreement in Malta ensures that nurses and midwives leaving the sector remain on a ‘reserve list’. Should they wish to return, this ensures that they can have their previous service accumulated, which is then reflected in their salary and calculation of total length of service (for example, for pension provision).

In Slovakia, a number of hospitals are indirectly increasing pay by subsidising housing in order to encourage workers who had gone to work abroad (often to the Czech Republic, where pay is higher) to return home.

The [Agenda for Change](#) agreement reached by the sectoral social partners in the UK in 2004 is the most wide ranging reform of NHS pay in recent years. It largely aims at greater transparency in pay scales and is based on detailed job evaluations and classifications, which also seek to make it easier for workers to progress between grades. Efforts are also under way to achieve greater parity between the salaries of health and social care staff in the private and public sector. The latter is also the aim of a sectoral collective agreement reached in Cyprus in December 2009.

A number of collective agreements have gone further than addressing wages and have also sought to improve wider terms and conditions. The box below provides an example of such a more wide-ranging agreement.



### **Tackling the challenges in health care through tripartite social dialogue in Belgium**

One example of how tripartite social dialogue has been used in Belgium is the multi-annual plan to make nursing care more attractive in Belgium (2008–2011) drawn up by the Federal Minister of Social Affairs and Health after consultation with the social partners. The plan targets hospitals, nursing in elderly care and home care. Four areas of action are defined.

1. Easing workload and stress for the nursing staff
  - Implementing the 2005–2010 Social Agreement: one extra full-time nurse or auxiliary per 30 hospital beds can be used by hospitals to create a moving team of nurses to help counter lack of personnel in nursing teams.
  - Relaunching ‘Training project 600’: auxiliary nurses (non-graduate care workers) have the opportunity to upgrade their nursing skills and to obtain a graduate nurses degree. It is aimed at people who know the job and are motivated to do it, but just need help to study. This form of horizontal promotion is organised by giving the employer an additional auxiliary nurse salary, so that they can engage someone else to carry out the job while the auxiliary studies. The target is to support 350 auxiliaries a year.
2. Qualifications and lifelong learning
  - Hospitals will get a gradual increase in funding for nurses’ training (€1 million in 2009, a 7.5% increase). A new accreditation scheme will be implemented for nurses working in residential homes for older people and for nurses in home care services. The scheme provides for a higher rate of reimbursement for some services by the public authorities to the care provider on condition that a continuous training programme is run.
  - Further specialisation and differentiation of nursing needs will be organised and recognised in the way hospitals are financed (refunded by the specific care they provide to patients). Hospitals will also receive a budget to hire (or promote) more specialised nurses (geriatrics, oncology, paediatrics).
3. Specific increases in remuneration
  - Better payment for working at unsocial hours: an extra bonus per hour will be given for services in the early morning (between 06.00 and 07.00) or evening (19.00–22.00).
  - Increasing the pay rewarded for basic specialties and special competences: a 5–10% pay increase will be introduced for officially recognised expertise and specialisation, combined with a current practicing of this expertise in the sector.
  - Nursing executives: the rewarding of executive tasks will be further improved first by extending the so-called *complément fonctionnel* (extra bonus for managerial activities) and then by granting a pay level compatible with relevant legal training requirements.
4. Promotion campaign
  - Campaigns to promote becoming a nurse will be run.

### ***Terms and conditions***

While pay is clearly an important factor in an individual’s decision whether or not to enter and remain in the sector, other terms and conditions also have an important role to play. This section excludes **health and safety** considerations, which have been a key topic in collective bargaining (see next section), but looks exclusively at wider terms and working conditions including pension entitlements, working hours and job security which can also serve to shape the attractiveness of a sector and which are the subject of collective bargaining in many countries.

The Irish agreement raising wages for home helps also includes provision for an increase in holiday entitlements (to 23 days). It also covers improvements in pension provision, and grievance and disciplinary procedures for workers in this sector. Another sectoral agreement covering nurses in Ireland reduced weekly working hours to 37.5 (nurses' demands had been for a 35-hour week).

A sectoral agreement for nurses working in residential care centres for the mentally ill in Poland provides for enhanced pension rights facilitating early retirement for those who wish to take it. In Germany, an agreement in the public health care sector (*TVöD-Pflege*) introduced the first partial retirement scheme in the sector. The facility is restricted to 2.5% of the staff of an establishment. The agreement also calls on employers to offer employment to apprentices for at least 12 months following the completion of their apprenticeship.

One theme of collective bargaining in several countries (France, Italy, Norway, Spain and Sweden) has been to increase the number of full-time and open-ended jobs in the health care sector. One example is that the new main agreement (HÖK10) in Sweden signed by Kommunal and SALAR/PACTA, which established bipartite committees with the task of increasing the number of full-time employment contracts. These committees will map out the different working time agreements/schemes, local agreements and policies in order to work out where additional staffing may be required.

In Belgium, the 2005–2010 Social Agreement allows for one additional full-time nurse or auxiliary to be recruited per 30 hospital beds. This additional capacity can be used by hospitals to create a moving team of nurses in order to help counter staff shortages in nursing teams (see box).

In Norway, both employer and employee organisations agree that the share of part-time employment is too high within health care occupations, but at sectoral level, it seems difficult to find and agree on effective measures to reduce the high part-time rate (which is largely due to the high share of female workers needing to combine work with family responsibilities). However, different types of initiatives and projects have been tried out at a local level. A number of female-dominated unions are asking for stricter legislation (demanding that employees be given the right to full-time positions), but the employer side does not want this kind of legislation to be implemented (see [NO0412102F](#), [NO0506102F](#)).

Collective bargaining at the sectoral level in Spain has promoted stable recruitment. Article 15 of the Fifth Agreement of Care Service for Dependent Persons and Development for the Promotion of Personal Autonomy determines that, as of the 1st January 2008, 80% of the staff working for companies affected by the agreement must have open-ended contracts. In the case of new companies, this percentage must reach 50% by the end of the first year and 80% by the end of the second year. Article 15 of the 12th Collective Agreement of Care Centres and Services for the Disabled establishes that no more than 15% of recruited staff can have temporary contracts.

Many of the examples mentioned above relate to agreements negotiated prior to the onset of the economic crisis and its knock-on effect on public budgets. Although they appear to paint a picture of efforts being undertaken in many countries to improve wages as well as terms and conditions in the sector, it is not yet possible to assess the impact of greater budgetary stringency on public sector wages in health and social care (which often act as a yardstick of private sector settlements).

### **Addressing risk factors at work, including health risks and violence**

In line with Directive 89/391/EEC and implementing national legislation, all employers are obliged to carry out risk assessments at the workplace and to take reasonable steps to reduce any health and safety risks workers may be exposed to while carrying out their duties. Such risk factors in the health care sector are wide ranging, depending on the exact nature of the working environment, and have led to the agreement of additional European sectoral legislative provisions



(most recently the agreement between EPSU and Hospeem on sharps injuries, see [EU1003059I](#)), as well as national legislation, collective agreements and policies aimed at protecting medical and care workers' physical and mental health in the workplace.

As well as regulating the security of the work environment through collective agreement, social dialogue at the tripartite and bipartite level has also contributed strongly to increased awareness of stress, violence and occupational health risks. This dialogue has echoed the autonomous framework agreements reached at European level between [BUSINESSEUROPE](#), the European Association of Craft, Small and Medium-sized Enterprises ([UEAPME](#)), the European Trade Union Confederation ([ETUC](#)) and the European Centre of Employers and Enterprises providing Public Services ([CEEP](#)) on violence and harassment in the workplace (2007, [EU0705019I](#)) and on stress in the workplace (2004, [EU0410206F](#)).

In Sweden, a national framework agreement was negotiated in 2005 to facilitate social dialogue and collective bargaining on occupational health and the working environment.

A national public sector agreement was reached in France in November 2009 which addresses occupational risks and prevention tools, and offers enhanced rights with regard to compensation for work-related accidents and ill-health. The agreement covers psycho-social risks for the first time.

In Slovenia, one of the most important successes of the health care social dialogue has been the inclusion of the issues of violence and stress in the workplace in the collective agreement covering nurses and other care staff. The agreement provides for joint measures to prevent all forms of discrimination, and physical and psychological violence and harassment in the health care sector. Likewise tripartite social dialogue by the Sectoral Council for Tripartite Cooperation in Health Care in Bulgaria led to the inclusion of these issues in the sectoral collective agreement.

In Slovakia, collective bargaining has resulted in provisions for additional pay for employees exposed to the risk of infection in public care homes – an extra €30 a month under the agreement between the Slovak Trade Union of Health Care and Social Services ([SOZZaSS](#)) and the Association of Slovak Hospitals ([ANS](#)).

In Spain, the Fifth Agreement of Care Service for Dependent Persons and Development for the Promotion of Personal Autonomy provides paid time off work for certain medical examinations and specifically refers to assistance to be provided for workers suffering from drug addiction.

The collective agreement at the dispensary Doctor Marko Markov in Varna, Bulgaria, provides a wide range of measures as regards health and safety at work, including the employer's obligation to inform trade unions about risks as well as measures to reduce and control risk factors. For employees who work in a hazardous environment, the employer must provide free food and beverages during night shifts and all workers must be issued with working clothes and [protective equipment](#).

Targeting private care providers, in Germany, the employers' liability insurance association for health services and charities ([BGW](#)) provides a product line of measures to monitor health risks and job satisfaction of care staff and to improve working organisation at establishment level.

### **Local-level joint initiatives in France and the UK**

In France, a local hospital in the area of Paris with around 700 employees was confronted with violence between care workers and patients that led to high levels of staff absence. A specific committee in charge of monitoring psycho-social risks was created which implemented specific training targeted on these risks. On the committee were union representatives and members of management and occupational medicine experts. The aim of this approach is to monitor closely psycho-social risks in the establishment in order to find ad hoc solutions to reduce exposure and preserve employees' health.

In the UK, the Cambridgeshire and Peterborough NHS Foundation Trust works with employees suffering from problems related to mental health issues. The Trust has formulated policies designed to aid employees suffering from these types of problems and specifically provides them with ongoing training, support and advice. The Trust has also compiled a series of 'success stories' of individual employees who have managed their problems successfully and promotes these success stories to the rest of the organisation.

In Norway, the government set up a tripartite committee in 2009 to study the factors influencing sickness absence in the health care sector. In Cyprus, the trade unions have called for measures to address stress at work to be tackled in the next cross-sectoral collective agreement.

### **Improvement of gender equality**

Gender equality considerations are particularly relevant in a sector dominated by female employment. In a societal context where women continue to carry out most of the childcare and domestic responsibilities, effective work–life balance measures have a key role to play in assisting the recruitment and retention of workers in the sector. This can include measures aimed at increasing leave provisions for fathers, potentially enabling women to return to the labour market sooner. This was the goal of a national level cross-sectoral collective agreement reached in Denmark in 2008, which ensured the provision of six weeks' non-transferable parental leave for fathers.

Similarly, equal pay considerations are highly relevant and affect pay negotiations not only in the health and social care sector, but also in relation to comparisons with counterparts in the wider public (and to some extent also private) sector workforce.

In Sweden, the 2007 bargaining round introduced new gender equality measures in collective bargaining with the introduction of so called 'equality pools'. The Swedish Trade Union Confederation ([LO](#)) proposed increasing the pay of female workers relative to male workers in order to improve wage equality. The solution meant that Kommunal, among others, signed agreements where such pools were integrated. The pools were commonly structured such that sectors where there was a predominance of female workers would receive higher wage increases than those where male workers dominate. Assistant nurses benefitted the most from the new pool, but questions were soon raised as to the real impact for the majority of female workers. The Manufacturing and Industrial Workers' Union ([IF Metall](#)) argued that the pools were too biased towards female-dominated sectors, resulting in female workers in male-dominated sectors being relatively worse off as a result of the new method. LO and its unions have now reformed the equality pool into a 'low income pool', which simply gives larger wage increases to low income workers among whom female workers are overrepresented. As indicated above, this solution was incorporated in the latest agreement (HÖK10) between Kommunal, SALAR and PACTA.

In Cyprus, trade unions have called for work–life balance measures to be discussed as part of the renewal of national collective agreements. Particular emphasis is being placed on the provision of childcare facilities within (or close to) workplaces.

In the UK, the NHS ‘Improving Working Lives’ agenda seeks to work towards more family friendly work environments, with NHS trusts being able to seek different levels of accreditation for work–life balance policies and their implementation.

As many work–life balance measures are implemented at establishment level, it is possible that many such initiatives were not covered by this study. Nonetheless, it is surprising to find relatively few initiatives being taken in this area given their importance for a predominantly female workforce. In terms of initiatives dealing with work organisation and work rostering, this could be due to the nature of the service (and its round-the-clock requirements). It could also reflect an existing staff shortage situation which makes it more difficult to offer flexibility, thus leading to a situation where new rostering mechanisms cannot be introduced because of a lack of staff.

### **Improvement of access to career development/lifelong learning**

In recent years, EU policy has increasingly emphasised the importance of access to lifelong learning in order to ensure the **employability** and **adaptability** of the workforce. In the health care sector, this is no less relevant than in manufacturing or other knowledge-intensive sectors as knowledge of medical procedures and techniques, pharmaceutical products and care regimes continuously improves and needs to be updated. Lifelong learning also provides the opportunity for individual development and career advancement, also critical to the attractiveness of a sector or occupation.

Collective bargaining and social dialogue have contributed to improved access to training in at least half of the countries under review (Austria, Belgium, Bulgaria, Cyprus, France, Ireland, Malta, Slovakia, Slovenia, Spain and Sweden). It has particularly helped individuals to become qualified to take a step up the occupational ladder (for example, to allow care assistants to train as qualified nurses in Austria, Belgium, Ireland and Malta). Most of the measures are taken at sectoral level and often relate to a specific number of training days, the introduction of a training subsidy or the availability of interest-free loans for further study.

In Slovenia, collective bargaining has regulated work organisation in such a way to allow for additional training time for staff. For example, there is now a special right for nurses to 30 minutes’ daily preparation time (this is meant to be used for additional professional training). The collective agreement also guarantees between seven and 20 paid days of professional training per year.

The Spanish First Agreement of Care Service for Dependent Persons and Development for the Promotion of Personal Autonomy, which applies to care workers in the private sector in Spain, includes the right to carry out courses that will improve their professional skills. The priority of such training is determined by the Sectoral Training Commission, made up in equal parts by members of the organisations which endorse the agreement. The 12th Agreement of Care Centres and Services for the Disabled in Spain specifies that all employees must be given the right to access 30 hours of training annually during working hours.

Recent rounds of collective bargaining in Sweden have retained measures implemented in previous agreements that supported training. This includes, for example, an entitlement to attend a certain number of courses, conference or educational measures during working hours on full pay. Paragraph seven of the agreement also states that, for training less than seven days in length, workers should receive supplementary pay for the inconvenient working hours they would have worked had they been at work.

On the recommendation of the arbitrator assisting in the settling of a dispute between SOZZaSS and ANS, a contribution of €30 per month to lifelong learning for all health care personnel was included in the collective agreement. A similar provision also applies to university hospitals affiliated to the Association of University Hospitals of the Slovak Republic (AFN SR).

The Irish social dialogue agreement, 'Towards 2016', includes a commitment towards training and upskilling health care assistants (though many aspects of this agreement have now been put on hold as a result of the economic crisis). A new qualification developed as a result of the agreement enables health care assistants to support nurses in the delivery of patient care. In addition, a dedicated SKILL (Securing Knowledge Intra-Life-Long Learning) project to enhance the role of support staff in delivering quality patient care started in 2006. The project addresses the training needs and aspirations of home helps and other support workers.

The 'Conversion Course' in Malta, whose syllabus was established by the Maltese Union of Midwives and Nurses ([MUMN](#)) and the government, is another initiative derived from social dialogue in the public sector intended to assist nursing assistants enhance their knowledge base. Before Malta's accession to the European Union in May 2004, there were two levels of nurses in the public sector who were awarded different salaries for the different duties performed. Once Malta became a member of the EU, the Conversion Course was offered to nurses in the lower level (essentially nursing assistants), giving them the opportunity to further their knowledge and at the same time augment their pay. The 'Training Project 600' programme also aims at upskilling non-graduate care workers in Belgium (see box above).

### **Measures dealing with migration and labour mobility**

Labour shortages have already led to a number of national health care systems and health care providers to turn to other EU countries and beyond in order to recruit qualified staff. This has already led to significant shortages among doctors and highly skilled nurses in a number of countries and regions.

For instance, Cyprus, the Czech Republic and the UK are among countries actively recruiting foreign nurses. In the UK, the NHS has held a number of international recruitment fairs in recent years, particularly in Asia. In the Czech Republic, there are efforts to recruit nurses from Romania, the Ukraine and Vietnam. From 2003 to 2007, the Ministry of Health in Cyprus aimed to entice nurses from Greece by offering an attractive package providing incentives such as good pay, transportation expenses (two visits to Greece per year) and relocation expenses.

In 2008, the European level social partners EPSU and Hospeem adopted a European Code of Conduct on Ethical Recruitment which calls on Member States to ensure that recruitment is not targeted at countries experiencing skill shortages domestically. In addition, it calls for equal rights for migrant workers in access to pay and terms and conditions, as well as the provision of assistance with the integration of migrant workers. Emphasis is placed on ensuring that migrant workers returning home after a period of time are equipped to enhance the labour market and health care system of their home country. At the same time the code emphasises that foreign recruitment should not be used in lieu of efforts to train and recruit workers at the local level and should not serve to depress domestic wages.

The question of labour mobility among nurses and the recruitment of foreign nurses was a particular issue in six national reports (Cyprus, the Czech Republic, Romania, Slovakia, Slovenia and the UK). The report from Austria highlighted the recruitment of (often unregistered) home carers as an additional issue. In light of the European Code of Conduct, it is interesting to note that none of the national reports identified ethical recruitment as an issue discussed in collective bargaining or social dialogue at national level (although there were some single employer initiatives in this regard).

In Austria, where demographic trends have led to an increasing demand for home-based long-term care, there has been an expansion in the use of undeclared workers from abroad to help take care of elderly people. In response, legislation has been passed to regulate the provision of care in private households. In tandem, an amnesty has been granted for formerly illegally employed care workers in private households and their employers, encouraging official registration of such

workers with the authorities. Italy has similarly witnessed a regularisation of informal carers (largely foreign women) providing care to elderly people.

In Cyprus, a substantial number of nurses from other countries who do not speak Greek are employed particularly in the private sector. To address this problem, a special provision was introduced in 2009 under which all nurses must meet the language criteria of the Nursing and Midwifery Council (a body that checks nurses' qualifications). In this context, special programmes for teaching Greek, designed especially for nurses, have come into operation at the local level.

In the Czech Republic and Slovakia, there has been a trend of Czech nurses leaving to work in western European countries offering higher salaries. Slovakia has also seen a movement of nurses to the Czech Republic. Some efforts are being made in both countries to seek to retain nurses, for example by offering housing allowances in the larger cities. The trade union, SOZZaSS, claims it has successfully used the migration of nurses and care personnel as an argument in multi-employer bargaining to agree wage increases in order to avoid further migration.

In order to integrate new migrant nurses into the workforce in the UK, at the local level many NHS trusts issue migrant workers with welcome packs, help them find accommodation, and support them with any issues related to language capacity.

Bearing in mind the efforts of the European social partners to highlight the issue of the transnational migration of health care staff (and the conclusion of a code of conduct on ethical recruitment), it is surprising that relatively few initiatives appear to have been taken at national level first to manage migration and to ensure it does not result in 'beggar thy neighbour' policies, but more importantly to integrate migrant workers fully into the organisation and the local community. As migration tends to be concentrated in particular areas, it is possible that such initiatives are highly localised at establishment level and therefore could not be captured for the study.

## Commentary

The challenges facing the health care sector as a result of the opposing pressures of rising demand in the context of greater budgetary stringency are undeniable and likely to exacerbate. In general, this is taking place in an environment of increasing labour shortages and skills gaps in the sector (though there is some evidence that the economic crisis has encouraged more school leavers and young graduates who have lost their jobs in other sectors to look towards the health and social care sector for career opportunities).

Social partners both at European and national level have recognised that the attractiveness of the sector needs to be improved to ensure high quality care and medical treatment in the future. This is not only linked to wages and favourable terms and conditions, but also to the ability to continuously improve and enhance skills and to develop career opportunities.

A number of the features of interest organisation, collective bargaining and social dialogue contribute to the ability to take effective steps in this area. On the positive side, organisational density in the sector is rather high (particularly in the public sector), and the same is true for coverage of collective agreements. The tradition and practice of tripartite concertation and dialogue are both relatively strong, which is particularly important in countries where public spending is paramount in the funding of health care provision (the improvement of terms and conditions relies on the availability of funding). Bipartite dialogue is less well developed, but has already led to a number of positive results at the national, regional and local level.

On the other hand, the plurality of employer and trade union organisations and the increasing trends towards the decentralisation of decision-making and the liberalisation or privatisation of provision could limit the development of sustainable solutions to make the sector more attractive. For example, it could increase to greater local and regional competition for staff (including across borders), making recruitment and retention more difficult in certain areas, organisations or occupations. Overall, increasing budget stringency, which has already expressed itself in wage and recruitment freezes in a number of countries, is going to make it more difficult to address some of the factors affecting the attractiveness of the sector.

On the whole, collective bargaining and social dialogue have already contributed to improving wages, terms and conditions, health and safety, equal opportunities, and training and lifelong opportunities in a number of countries. This review has shown that, in just under half the countries studied, collective bargaining has helped to increase wages, particularly among low-skilled and low-paid workers. Action has also been undertaken in a number of countries to seek to attract leavers back into the sector (for example, by taking account of all years of service in calculating salary and other service-related terms and conditions). Recruitment from abroad is becoming more commonplace in a number of countries. National and local level action in this area has focused on the successful integration of migrant workers into the workforce as well as into the local community. However, based on the information gathered for this study, it remains surprising that effects in this area appear rather limited.

In light of the dominance of female workers in the sector, measures to increase equal opportunities (for example, through job evaluation) and to ease the reconciliation of work and family life are of paramount importance. Some work has been done in this area, although perhaps not as much as might be warranted given the importance of the issue.

The health and safety measures implemented have focused more and more on the psycho-social risks associated with work in the sector, including stress and violence and harassment, and including acts perpetrated by patients and relatives.

Increasing emphasis is being placed on strengthening vocational training, lifelong learning opportunities and career pathways, including through the availability of funds, annual entitlements to training, and the clarification of pathways for career advancement.

Regrettably, the information currently available provides little evidence of the impact of such measures on recruitment and retention in the sector and more research is required to evaluate the impact of such measures and share good practice. The European level social dialogue has an important role to play in this process. The existing working group on recruitment and retention and skills development provides good opportunities to exchange such information and learn from best practice. Finally the implementation and monitoring of European level texts on ethical recruitment, sharps injuries and the current discussions on third party violence could and should lead to relevant national initiatives being identified.

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## Annex 1: Country groups and codes

### Country groups

- EU15** 15 EU Member States before May 2004 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom)
- NMS** 12 New Member States that joined the EU in May 2004 (Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia) and in January 2007 (Bulgaria and Romania)
- EU27** 27 EU Member States, comprising the EU15 and the 12 new Member States

### Country codes

Country code	Country name
AT	Austria
BE	Belgium
BG	Bulgaria
CH	Switzerland
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
HU	Hungary
IE	Ireland
IT	Italy
LT	Lithuania
LU	Luxembourg
LV	Latvia
MT	Malta
NL	Netherlands
NO	Norway
PL	Poland
PT	Portugal



<b>Country code</b>	<b>Country name</b>
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
UK	United Kingdom
US	United States

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