

Industrial relations and social dialogue
Social dialogue and collective bargaining in the hospital sector during the COVID-19 pandemic



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Executive summary

Introduction

This report analyses the role of social dialogue and collective bargaining in addressing the challenges created or exacerbated by the COVID-19 pandemic in the hospital sector. It also explores whether existing social dialogue and collective bargaining practices and processes in the sector were adapted or changed to address these challenges.

The research comprises two parts. First, a literature review characterises and contextualises the structural features of the hospital sector at the time when the pandemic struck. This is followed by a qualitative analysis of information collected through the Network of Eurofound Correspondents.

Policy context

The health sector, and hospitals in particular, were severely strained by the COVID-19 pandemic while playing a key role in its containment. Most countries had to rapidly increase the surge capacity of their health systems. This was particularly challenging for countries already trying to cope with staff shortages or reduced hospital capacity. The pandemic response also required additional efforts from a healthcare workforce that had, to some extent, already experienced a deterioration in working conditions.

The health sector in the EU has undergone major restructuring over the last few decades, especially with the implementation of austerity policies in the aftermath of the 2007–2008 financial crisis. These policies have widened the gaps in employment prospects and opportunities between countries and have incentivised the international mobility of health workers. Healthcare reforms changed the sector's landscape, with the expansion of private healthcare provision and increased fragmentation of working conditions and interest representation in the sector. However, the EU strategic framework on health and safety at work 2021–2027 recognises the need for strong health and hospital sectors to ensure Member States' preparedness for future health crises.

Key findings

All EU Member States and Norway had to scale up their hospital capacity to some extent to meet the growing demand for healthcare services at short notice during the pandemic. Most adopted similar strategies to achieve this, including changing working time patterns, transferring staff between health facilities, mobilising private sector resources and recruiting foreign workers.

The implementation of these measures often required the adoption of emergency legislation, but the scale and scope of the social partners' involvement in crafting this legislation varied across Europe. Social dialogue and collective bargaining played a prominent role in addressing these challenges in countries with well-established social dialogue institutions and a long-standing tradition of cooperation between the social partners: Austria, Belgium, Denmark, Finland, Germany, Luxembourg, the Netherlands, Norway and Sweden. In countries where collective bargaining is comparatively less established, including Bulgaria, Cyprus, Czechia, Estonia and Malta, efforts to contain the pandemic also led to closer social partner collaboration.

In other countries, the social partners played a limited role in managing the pandemic response. This was the case in the countries most affected by the implementation of austerity measures in the health sector in the aftermath of the 2007–2008 financial crisis – namely Greece, Portugal and Spain. Their healthcare systems had not fully recovered from the staff cuts and pay freezes of that period. The governments of these countries enacted legislation without seeking the involvement of the social partners. Furthermore, in Hungary, government policies restricted the role of social dialogue and collective bargaining in the sector by redefining public doctors' contractual status, while in Lithuania, the government attempted to restrict unions' influence and the scope of collective bargaining.

Although no substantial changes were identified regarding social dialogue institutions and processes, the breadth of issues expanded beyond traditional employment and working conditions. The involvement of the social partners continued to be more significant in relation to issues that are traditionally within the remit of collective bargaining and social dialogue, such as wages and bonus payments. Nevertheless, there is evidence of their involvement in broader issues such as the adaptation of work organisation to secure greater capacity, the reallocation of staff and the protection of staff's health and safety. Although their involvement

was generally limited to information and consultation procedures, implementing these measures required the cooperation of the social partners, resulting in increased interactions at national, regional and local levels.

Finally, the pandemic highlighted or exacerbated some problems to which the social partners could not find joint solutions or that they only partially addressed. These include wage disparities between occupations and groups of workers, for example, which may have been aggravated by the uneven distribution of COVID-19-related bonuses or the inability to meet demands for wage increases in recognition of workers' efforts. The pandemic also exacerbated existing staff shortages and problems with staff retention, which are related to growing evidence of burnout associated with high stress levels and heavy workloads.

Policy pointers

- The pandemic demonstrated that countries with well-established social dialogue systems were better and more quickly able to develop responses. Beyond issues traditionally addressed through collective bargaining and social dialogue, the continued involvement of trade unions and employer organisations would be beneficial in addressing issues such as staff shortages and investment priorities that the pandemic brought into even sharper focus.
- Wage disparities have long existed in the health sector, but the pandemic exacerbated them. In many cases, the distribution of one-off COVID-19-related bonuses excluded non-medical staff and private sector workers, reinforcing existing wage inequalities in the sector. This generated tensions and conflicts that may jeopardise the sector's capacity to respond to future health crises. Social dialogue and collective bargaining could be more oriented towards addressing wage inequalities.
- Social dialogue and collective bargaining should also prioritise occupational safety and health issues. In an effort to ensure higher levels of staff retention, particular attention must be paid to the high prevalence of psychosocial risks and the risk of burnout.
- Measures to address the medium- to longer-term challenges facing the sector regarding recruitment, retention and crisis readiness must be developed within a broader context of adequate financial investment in the health sector. The social partners could contribute to finding balanced solutions to these problems, but their responses will be contingent on the fiscal policies adopted after the pandemic, which should avoid deepening existing problems in the sector.

Introduction

This report analyses the role of social dialogue and collective bargaining in addressing the challenges created or exacerbated by the COVID-19 pandemic in the hospital sector. It also explores whether existing social dialogue and collective bargaining processes at national level were adapted or changed in order to address these challenges.

The health sector, and the hospital sector in particular, was at the centre of efforts to manage the COVID-19 pandemic. Many countries were confronted with an urgent need to increase the surge capacity of their health workforce in order to deal with spiralling case numbers. This was particularly challenging for countries with staff shortages or reduced hospital capacity. It required additional efforts from a healthcare workforce that had already experienced a deterioration in working conditions prior to the pandemic.

The health sector in the EU has undergone major restructuring over the last few decades, especially through austerity policies implemented in the aftermath of the 2007–2008 financial crisis that curtailed public spending in order to reduce government debt. These policies have contributed to widening the gaps between countries in terms of employment prospects and opportunities and have incentivised the international mobility of health workers. Furthermore, healthcare reforms have changed the landscape of the sector, with the expansion of private healthcare, and increased the fragmentation of working conditions and the organisations representing the interests of workers and employers.

The health sector is intrinsic to the health and well-being of EU citizens and is a cornerstone of the Union's sustainability and social cohesion. Hospitals played a fundamental role during the pandemic and are likely to remain at the top of policymaking agendas as long as COVID-19 continues to have an impact and as governments seek to prepare the sector for similar future health crises. The EU strategic framework on health and safety at work 2021–2027 recognises that being prepared for any potential future health crises requires strong health and hospital sectors (European Commission, 2021).

Across the EU, governments and other institutions (such as public employment services) introduced diverse measures to cushion the potentially devastating impact of COVID-19 on economies, labour markets and societies. Worker representative organisations and employer organisations were also involved, although the role of social partner organisations in designing or influencing these measures varied across the EU27 (Eurofound, 2021a).

Some assessments of national pandemic responses have analysed the scope and scale of the involvement of the social partners and their impact (Eurofound, 2021a). Most have focused on national or cross-sectoral levels, analysing the involvement of the peak-level social partners in the design and implementation of responses, including recovery and resilience policy measures. The comparison of the features and outcomes of social partner responses developed at sectoral level has attracted much less attention. To address this gap, this report aims to explore the extent to which the social partners within the hospital sector participated in the development of measures to deal with the challenges arising from the COVID-19 pandemic. It presents an analysis of the main initiatives arising from social dialogue and collective bargaining in the hospital sector across the EU during the pandemic.

The report has two main chapters. Chapter 1 is based on a review of relevant literature describing the hospital sector. It contextualises the structural features of the sector that affect the development of social dialogue and collective bargaining and describes the key patterns of industrial relations in the sector in the EU. Chapter 2 examines the scale and scope of social dialogue and collective bargaining initiatives developed in the EU27 and Norway in response to the COVID-19 pandemic, including the views of the social partners on the content and an assessment of the outcomes of the initiatives. It is based on an analysis of 28 national contributions from the Network of Eurofound Correspondents collected between September and October 2021 (see Annex 1 for the questionnaire and Annex 2 for a list of the correspondents).

1 Mapping key sectoral characteristics

This chapter describes the structure of the hospital sector based on a literature review covering four main analytical dimensions. The first three contextualise features of the sector that are likely to affect the industrial relations' sectoral models (Bechter et al, 2012) and industrial actors' strategies (Keune and Pedaci, 2020).

The section 'General employment trends' describes the recent evolution of employment levels and workforce composition in the hospital sector, emphasising the incidence of non-standard forms of employment (part-time and temporary employment) across the EU and Norway. It examines two issues that affect workforce capacity: staff shortages and the increased reliance on international recruitment (Buchan et al, 2021a).

'Hospital governance: Decentralisation and privatisation' outlines the different forms of privatisation in the hospital sector and their implications for employment and working conditions. Considering the role of the public sector in healthcare systems, it focuses on the effects of decentralisation of hospital governance and changes in the financing of public hospitals. The joint effects of these developments have resulted in different forms of involvement of private operators in the provision of hospital care and increased fragmentation of employment and working conditions along public-private and territorial lines.

The section 'Working conditions before and during the COVID-19 pandemic' addresses various factors that frame the analysis of working conditions in the hospital sector during this period. It focuses on the psychosocial risks that frontline healthcare workers faced, which have been extensively reported in recent research publications (Eurofound, 2020a). Attention is given to the recent pay and working time developments – the two main dimensions more generally involved in recruitment and retention.

Finally, 'Industrial relations: Actors and institutions' provides an overview of the industrial relations landscape in the hospital sector across the EU, focusing on the fragmentation of social partner representativeness at national level and the differences in the structure and coverage of collective bargaining.

General employment trends

Before describing the main features of employment and working conditions in the hospital sector, it is worth considering some limitations of the available data.

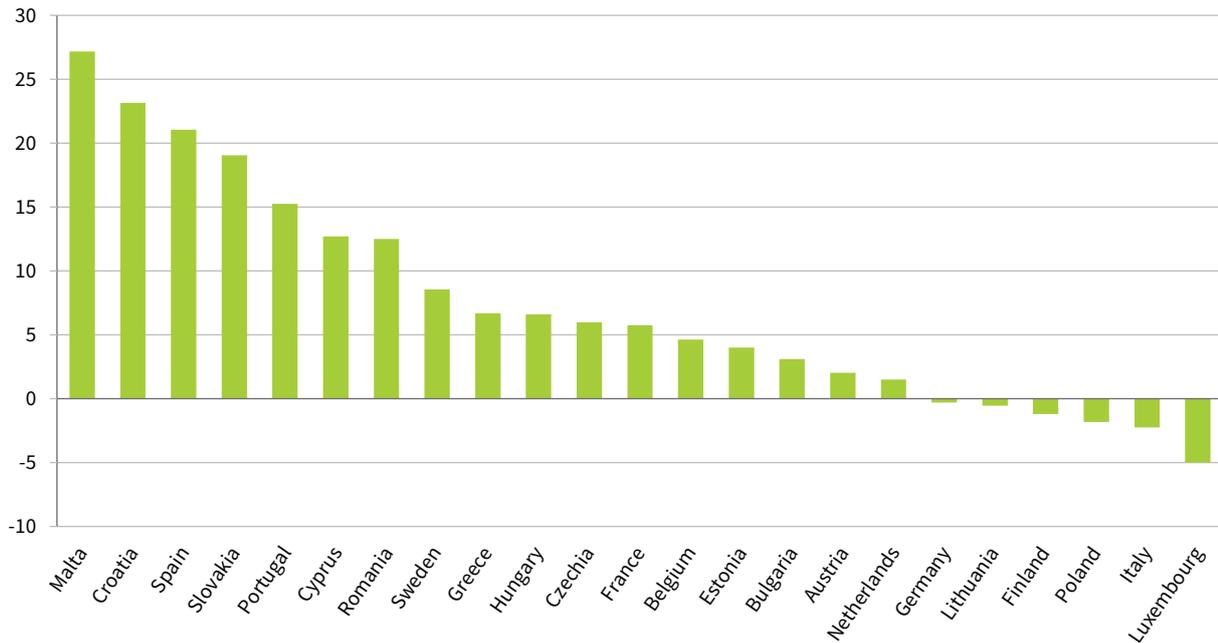
First, most national data pertain to professionals in the healthcare sector, not all of whom are employed by hospitals. According to Eurostat data, hospitals employ more than half of doctors in most EU Member States, but the share of doctors working in hospitals ranges from over four-fifths in France to around one-quarter in Belgium.

Second, those in non-healthcare occupations working in hospitals are not specifically covered in Eurostat's healthcare resources statistics, which makes it difficult to obtain a comprehensive and accurate characterisation of employment. Most definitions of the hospital workforce do not consider ancillary occupations such as administrative, cleaning or waste management staff to be part of the hospital workforce. The definition is limited to healthcare occupations, mainly nurses and doctors. Data from the European Union Labour Force Survey (EU-LFS) on the hospital sector (NACE 86.1) can help to bridge the gap. According to estimates for 2020, clerical support workers represented 5% of EU27 hospital employment, while the share of staff in elementary occupations (such as cleaners and launderers) was around 6%. However, this figure might underestimate actual employment because these activities are frequently outsourced and subcontracted to third companies.

Evolution and composition of employment

Overall, there has been a general increase in employment levels in hospitals in EU Member States, as shown in Figure 1, with the exceptions of Germany, Lithuania, Finland, Poland, Italy and Luxembourg. Employment levels in Malta, Croatia, Spain and Slovakia have increased more than those in other countries with data available.

Figure 1: Change in employment in the hospital sector (%), EU Member States, 2015–2020

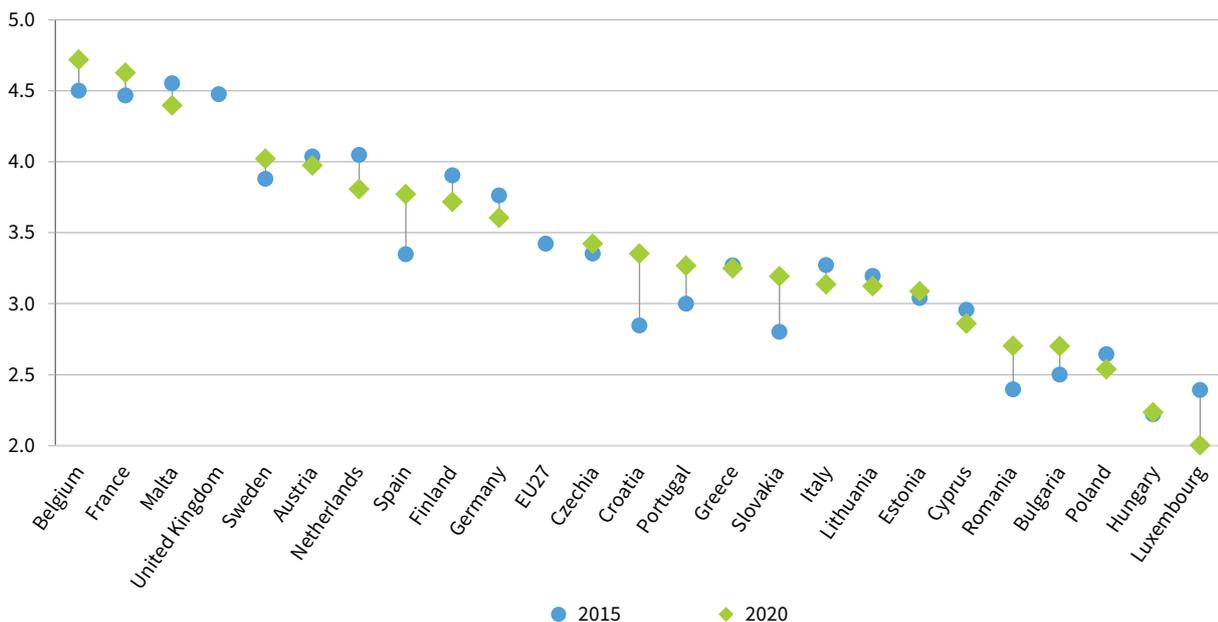


Notes: Covers employed persons 15 years old and over in the hospital sector (NACE 86.1). Only countries for which data are available are shown. The reference year for Belgium and Bulgaria is 2019–2020, as data for 2015 are not available.
Source: EU-LFS

There is wide variation in hospitals’ share of employment out of total employment across countries (Figure 2). According to EU-LFS data, the share of hospital employment remained stable between 2015 and 2020 in most EU Member States, with the

exceptions of Finland, Luxembourg and the Netherlands, where it fell considerably. Overall, in Luxembourg and central and eastern European countries (especially Hungary, Poland, Bulgaria and Romania), the share of employment in hospitals is

Figure 2: Share of hospital employment out of total employment (%), EU Member States and the United Kingdom, 2015 and 2020



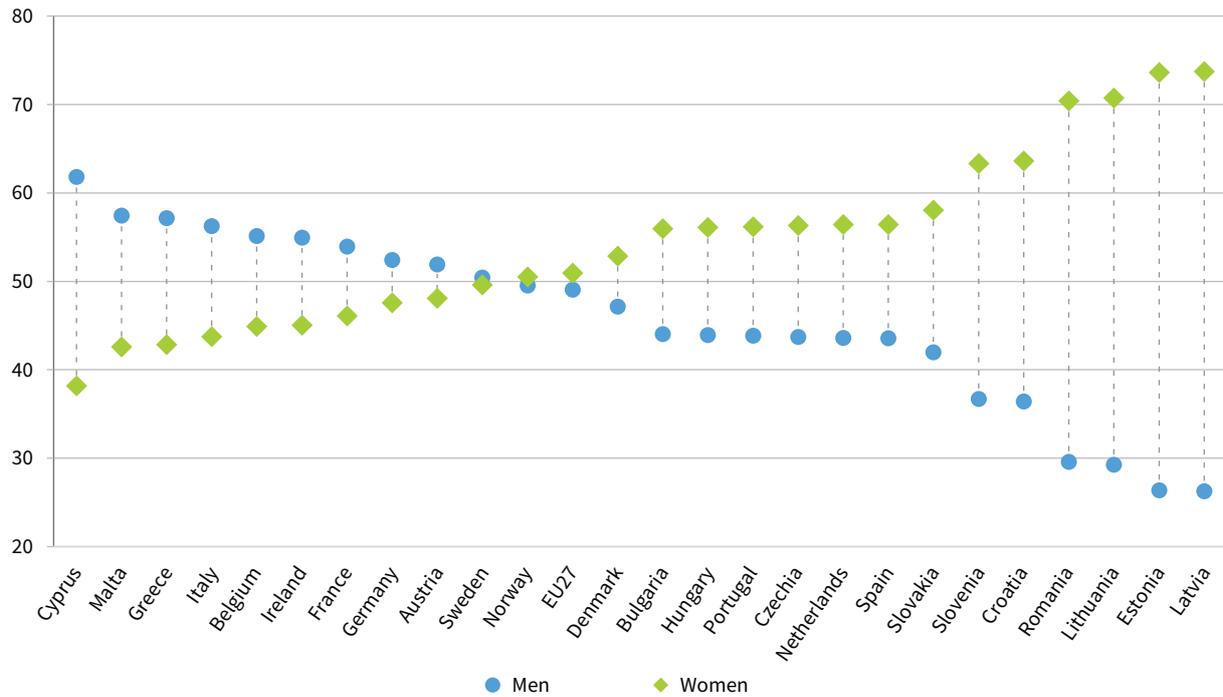
Notes: Covers employed persons 15 years old and over in the hospital sector (NACE 86.1). Only countries for which data are available are shown. The reference year for Belgium and Bulgaria is 2019, as data for 2015 are not available.
Source: EU-LFS

below the EU average. The countries with the largest shares of employment in hospitals are Belgium, France and Malta.

The composition of the health workforce differs significantly by age and gender across countries,

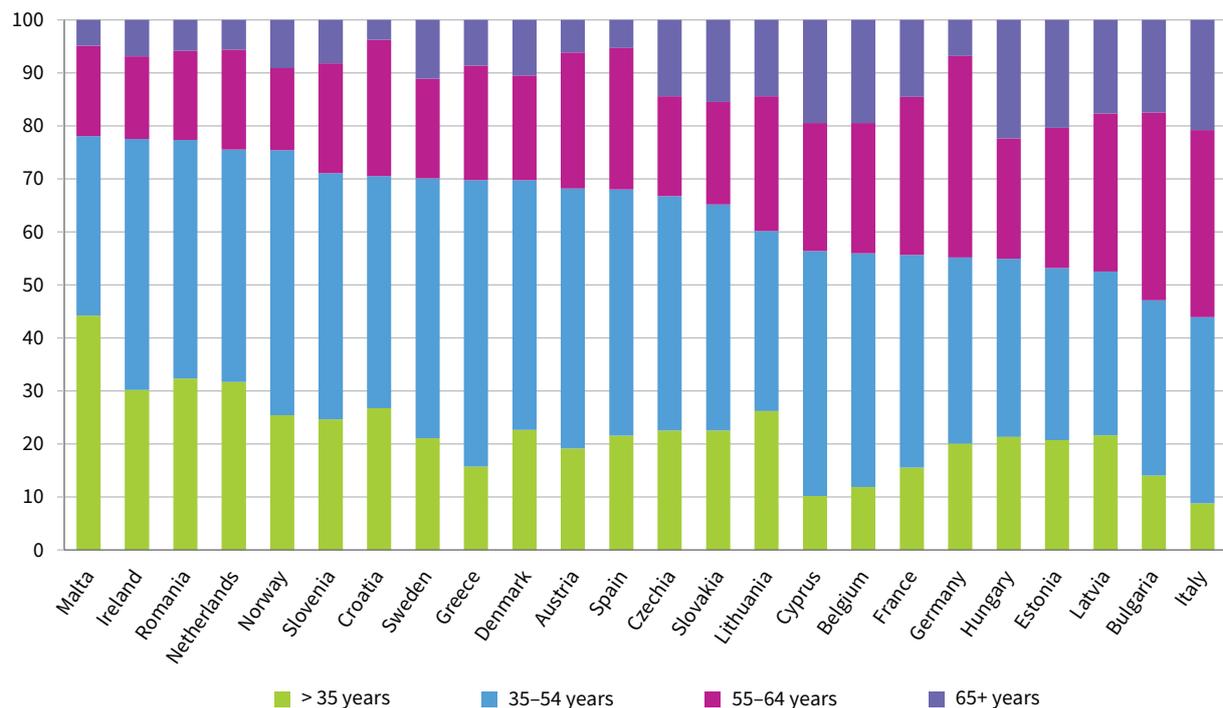
particularly within the medical profession (Figures 3 and 4). In most Member States, a higher share of women than men work in the sector as a result of the rising numbers of women in the medical profession over the last decade. The Baltic states and Romania have the

Figure 3: Breakdown of hospital doctors by gender (%), EU Member States and Norway, 2019



Notes: Only countries for which data are available are shown. For Denmark and Sweden, the latest data available (2018) have been used. Source: Eurostat, Healthcare personnel statistics

Figure 4: Breakdown of hospital doctors by age (%), EU Member States and Norway, 2019



Notes: Only countries for which data are available are shown. For Denmark and Sweden, the latest data available (2018) have been used. Source: Eurostat, Healthcare personnel statistics

largest shares of female doctors (around 70% of the total), while the gender distribution is more balanced in the rest of the Member States. Male doctors clearly outnumber female doctors in only six countries (Cyprus, Malta, Greece, Italy, Belgium and Ireland), and the difference in shares is typically smaller than it is when female doctors outnumber male doctors.

The gradual ageing of the health workforce has severe implications for EU health systems, with a large share of doctors employed by hospitals being close to retirement. This is reflected in the share of doctors aged 55 years and over in many EU countries. In eight (Latvia, Estonia, Hungary, Germany, France, Belgium, Cyprus and Lithuania), between 40% and 47% of doctors are in this age group, as are more than half of all doctors in Bulgaria (53%) and Italy (56%). In the remaining Member States for which data are available, the share of this age group in the total number of doctors is between 22% and 35%.

Figure 5 provides an overview of the composition of the health workforce by professional profile, highlighting significant differences in the ratio of nurses and midwives to doctors across countries. Bearing in mind the limited direct comparability of countries' records,

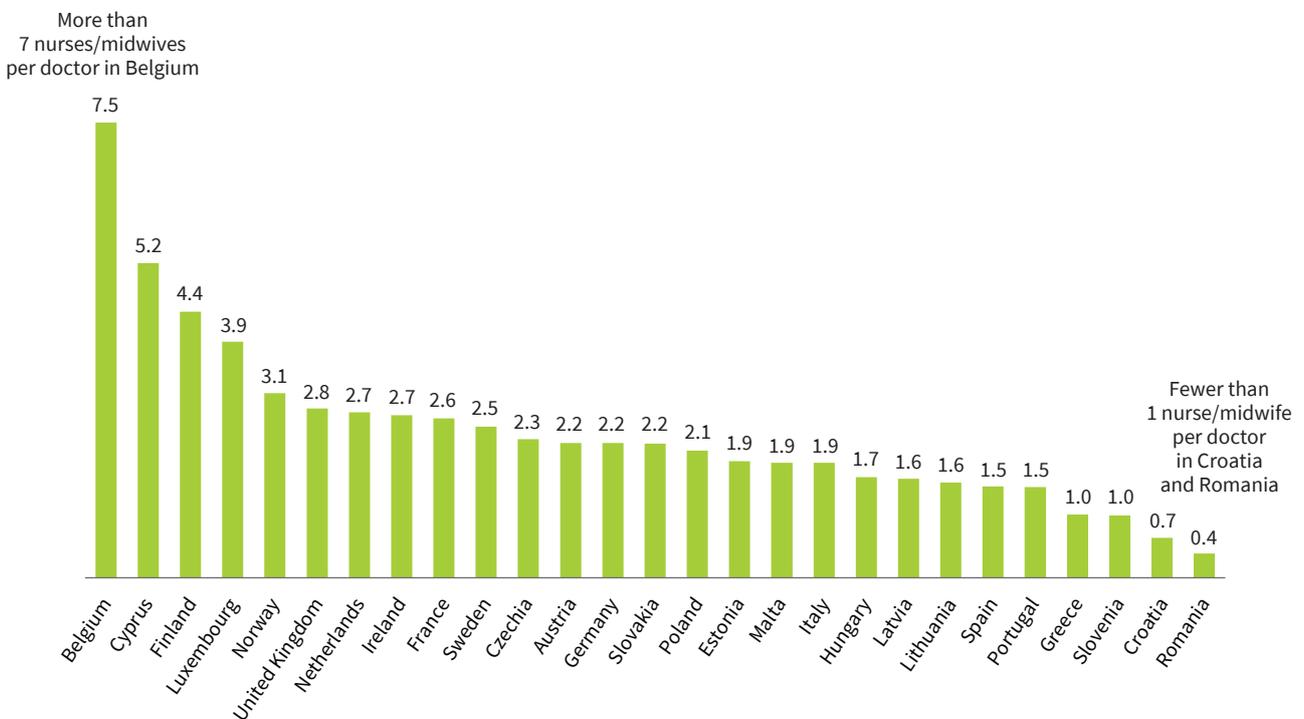
the ratio of nurses to doctors working in hospitals varies greatly, reflecting differences in the division of labour between health professionals of different qualification levels (Pavolini and Kuhlmann, 2016). The ratio is particularly high in Belgium, with more than seven nurses and midwives for every doctor, whereas in Croatia and Romania the ratio is less than one, with more than two doctors for every nurse or midwife.

Several countries facing staff shortages (such as Finland, France, Greece and the Netherlands) are shifting tasks and responsibilities from doctors to nurses by providing upskilling programmes for nurses, and healthcare assistants now undertake some of the tasks of nurses and midwives. Such initiatives may lead to improved efficiency and the development of new professions and career pathways in the health sector (Kuhlmann et al, 2018; SEPEN, 2021).

Non-standard forms of employment

Research on the evolution of employment conditions in the health sector points to a general trend towards diversification and fragmentation of employment relationships due to the spread of non-standard forms of employment among health workers (nurses, doctors and care assistants) over the first decade of the 2000s

Figure 5: Ratio of nurses and midwives to doctors in hospitals (full-time equivalents), EU Member States, Norway and the United Kingdom, 2019 or most recent data available

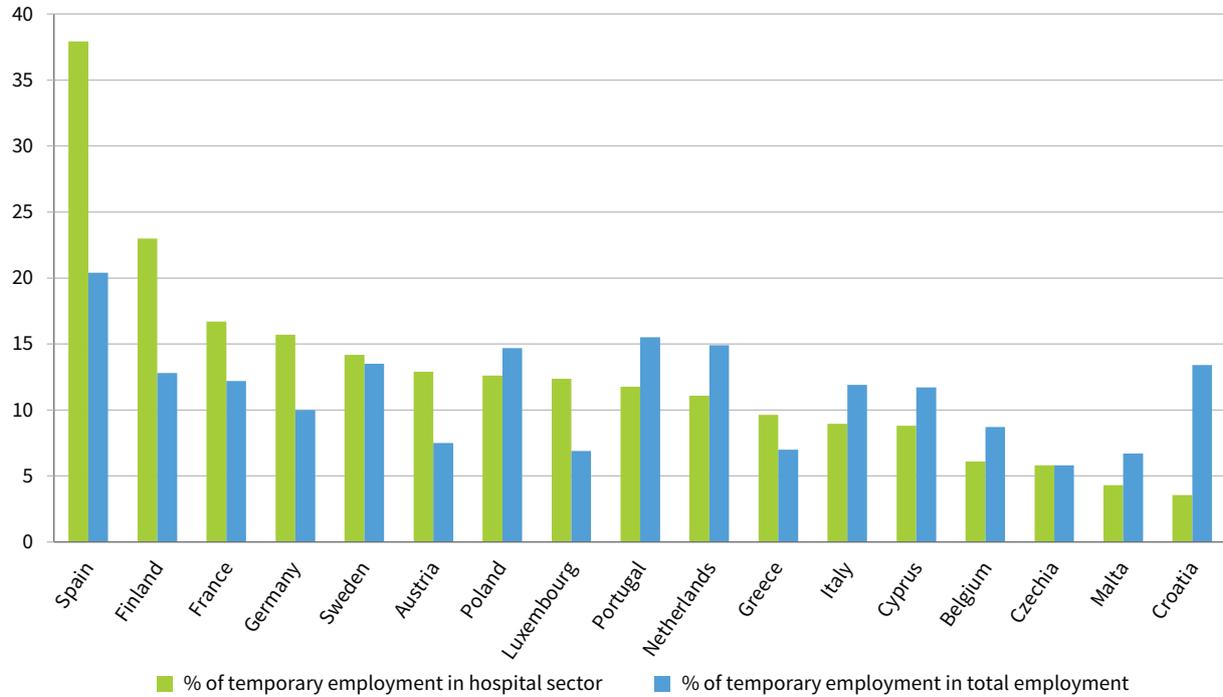


Notes: Only countries for which data are available are shown. Data for Italy, Portugal, Romania and Spain refer to total employment (full-time equivalents not available). Data for Finland, Luxembourg, Poland and Sweden refer to practising nurses and/or practising doctors.
Source: Eurostat, Healthcare personnel statistics; authors' calculations

(Pavolini and Kuhlmann, 2016). According to recent estimates based on the EU-LFS annual data for the hospital sector, temporary employment is most significant in Spain, Finland, France and Germany,

whereas part-time employment is the more prevalent form of flexible employment in the Netherlands, Belgium, Germany and Luxembourg (Figures 6 and 7).

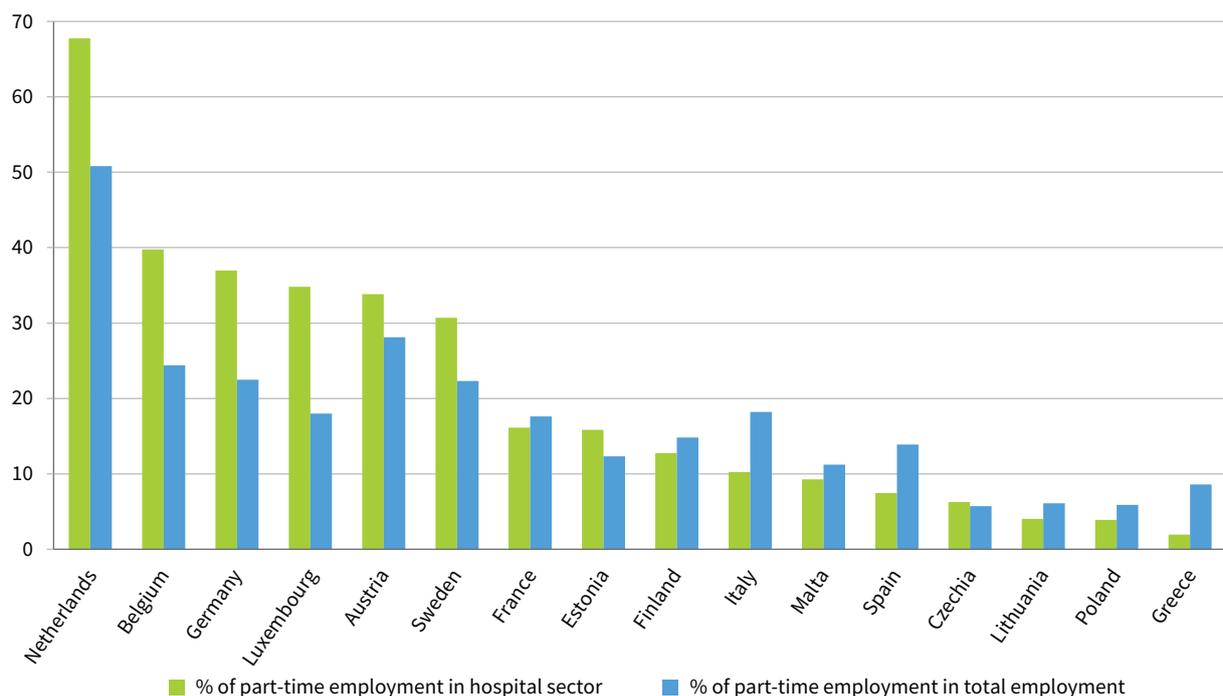
Figure 6: Share of temporary employment in hospital sector and in total employment (%), EU Member States, 2020



Notes: Only countries for which reliable data are available are shown. The data for Croatia, Luxembourg and Malta should be interpreted with caution, however, due to low reliability.

Source: EU-LFS

Figure 7: Share of part-time employment in hospital sector and in total employment (%), EU Member States, 2020



Notes: Only countries for which reliable data are available are shown. The data for Greece, Lithuania, Malta and Poland should be interpreted with caution, however, due to low reliability.

Source: EU-LFS

Although these data do not include a breakdown by professional profile, previous evidence based on the EU-LFS suggests that, compared with the general labour market, part-time employment is higher among nurses and care assistants but less widespread among doctors. By contrast, temporary contracts are less typical among nurses and are particularly common among doctors in Germany and Sweden (Pavolini and Kuhlmann, 2016). In Spain, the recent rise in temporary employment for many skilled professionals is mostly a result of hiring restrictions adopted in 2010 as part of austerity programmes, meaning that many doctors are in interim positions until permanent posts become available. Crucially, none of the legal limits on the use of temporary contracts applies in public hospitals (Molina and Godino, 2020).

Staff shortages and international mobility

Despite the general increase in employment levels in the hospital sector in most EU countries over the last decade, there are growing concerns about the prospect of staff shortages resulting from a widening gap between the fast-growing demand for healthcare services – boosted by population ageing – and the available workforce capacity. In an attempt to address shortages, healthcare systems in Europe increasingly depend on international recruitment of health professionals, which, in turn, tends to aggravate shortages in the professionals' countries of origin.

Recent analysis by Williams et al (2020a) of the mobility patterns of foreign-trained health workers from 2010 and 2018 shows that the share of foreign-trained nurses and doctors rose faster than the total number of nurses and doctors in most of the countries studied, with rising east-west and south-north intra-Europe mobility driving this movement.¹ Furthermore, these findings show that some countries (Belgium, Germany and Ireland) are acting as both source and destination countries, whereas other countries face major outflows of health professionals (Ireland, Italy, Portugal and Romania).

These two issues – staff shortages and reliance on foreign-trained staff – are at the forefront of national agendas responding to the COVID-19 health crisis, with many governments resorting to emergency recruitment strategies for retaining and scaling up workforce capacity during the pandemic, such as targeting migrant health workers or mobilising private sector workforce capacity (Winkelmann et al, 2021). However, research has shown that existing staff shortages are the result of various factors on both the demand and supply sides of the labour market.

On the demand side, a critical factor is the impact of economic recessions or, more specifically, the implementation of austerity packages in the management of the consequences of the 2007–2008 financial crisis. Cuts to public spending translated into employment and salary freezes and reduced employment opportunities in a sector that is highly dependent on public financing. Studies of the 2008–2012 economic crisis in Europe provided evidence of employment and salary freezes in the public health sectors in Greece, Ireland, Portugal and Spain. In contrast, studies of the recession in Australia, Canada and the United States presented evidence of increases in employment levels for healthcare professionals, particularly for nurses. This difference suggests that employment opportunities in the health sector decrease in countries with mostly publicly funded health systems during economic recessions. By contrast, in countries with a more consolidated non-public sector, private hospitals may continue hiring to capitalise on the increased demand for health services, even if this results in unstable employment conditions and risks increasing inequalities in access to health services (Russo et al, 2021).

On the supply side, the main factors concern workers' reactions to the impact of economic recessions. Austerity in Europe appeared to reduce overall employment opportunities, and nurses chose migration and other 'exit options' as their main coping strategy (Russo et al, 2021). Work intensification due to understaffing, wage freezes or cuts and reduced employment opportunities caused by austerity measures have resulted in growing levels of job-related stress and burnout, coupled with increasing numbers of health workers intending to leave their jobs.

Nurses reported problems related to understaffing and plans to leave the profession in a large-scale survey ($N = 33,659$) conducted in 488 hospitals in 12 European countries over the period 2007–2013. More than one-quarter of nurses were dissatisfied with their jobs, although there were significant differences across countries and in the sources of dissatisfaction, which included, for example, reduced wages and scarce opportunities for career advancement. Nonetheless, between 20% and 50% of nurses reported an intention to leave their jobs in the following year, most of whom (20–40% of the total) indicated that they would seek a job outside nursing (Aiken et al, 2013).

Staff shortages appear to be one of the major challenges faced in 18 out of 28 European countries (SEPEN, 2021, p. 35). The ageing of the health workforce is a relevant factor in current projections of

¹ The study considers a sample of European countries that are traditionally receiving countries for foreign-trained doctors and nurses and have comprehensive data on health professionals' mobility patterns. Eight countries are covered in the analysis of foreign-trained physicians (Austria, Belgium, France, Germany, Ireland, Norway, Switzerland and the UK) and five countries in the analysis of foreign-trained nurses (Belgium, France, Norway, Switzerland and the UK) (Williams et al, 2020a).

employment in the sector, and this is reflected in the high share of workers close to retirement age in many EU countries. Some studies claim the gradual ageing of nurses indicates the diminishing attractiveness of the profession among younger workers, particularly in the countries with the lowest nurse density rates, for example Poland. The increasing qualification requirements for nurses over the last decade, along with inadequate wages, are deterring young, qualified staff from entering the hospital sector. There is an increased interest in nursing abroad, mostly from young, single nurses with foreign language skills (Marć et al, 2019).

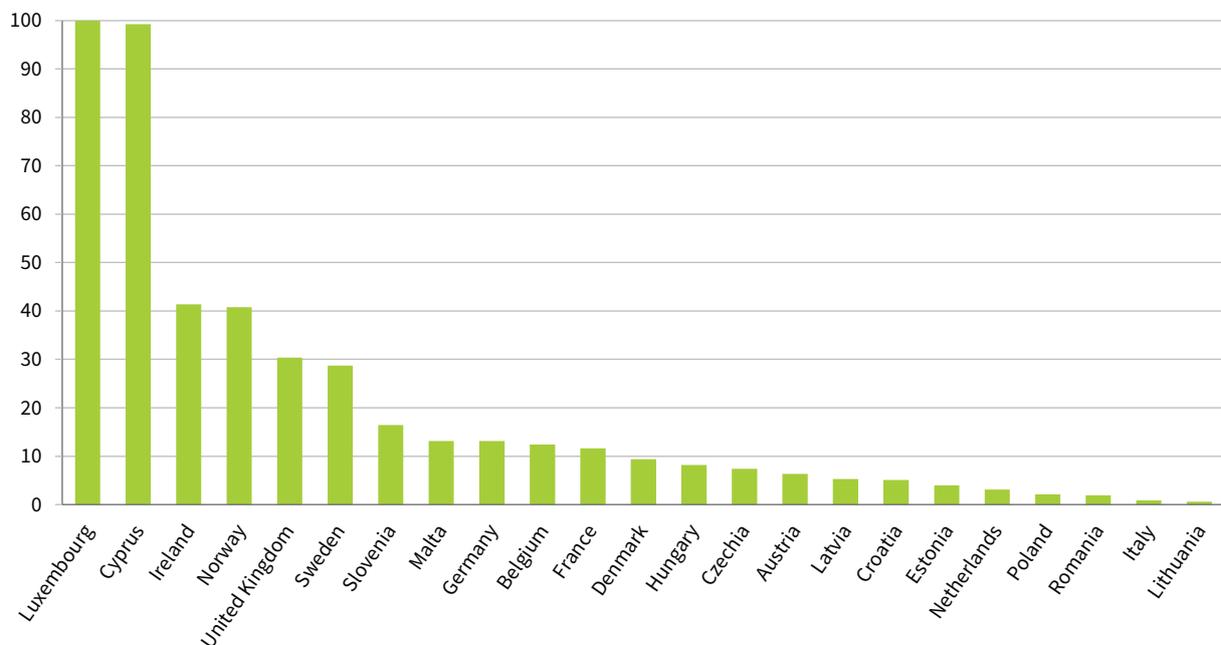
The share of foreign-trained health professionals in a country has become the main indicator of staff shortages (Drennan and Ross, 2019). As shown in Figures 8 and 9, doctors are among the most in-demand health professionals. Cyprus and Luxembourg are highly dependent on foreign-trained doctors because of their lack of training capacity, but the shares of foreign-trained doctors have increased in many other European countries too. Foreign-trained doctors comprise over one-quarter of doctors working in Ireland, Norway and Sweden, while the shares are almost negligible in some central and eastern European countries (Estonia, Lithuania, Poland and Romania),

the Netherlands and Italy. Note that a large number of foreign-trained doctors in Norway and Sweden are actually native professionals who studied abroad (OECD, 2019a).

Foreign-trained nurses form a smaller proportion of the health workforce in most of the countries with data available, although they account for the largest number of professionals in absolute terms. The United Kingdom and Germany appear to be the main destination countries for nurses. Norway also shows a large share of foreign-trained nurses, but many of these nurses are natives (OECD, 2019a).

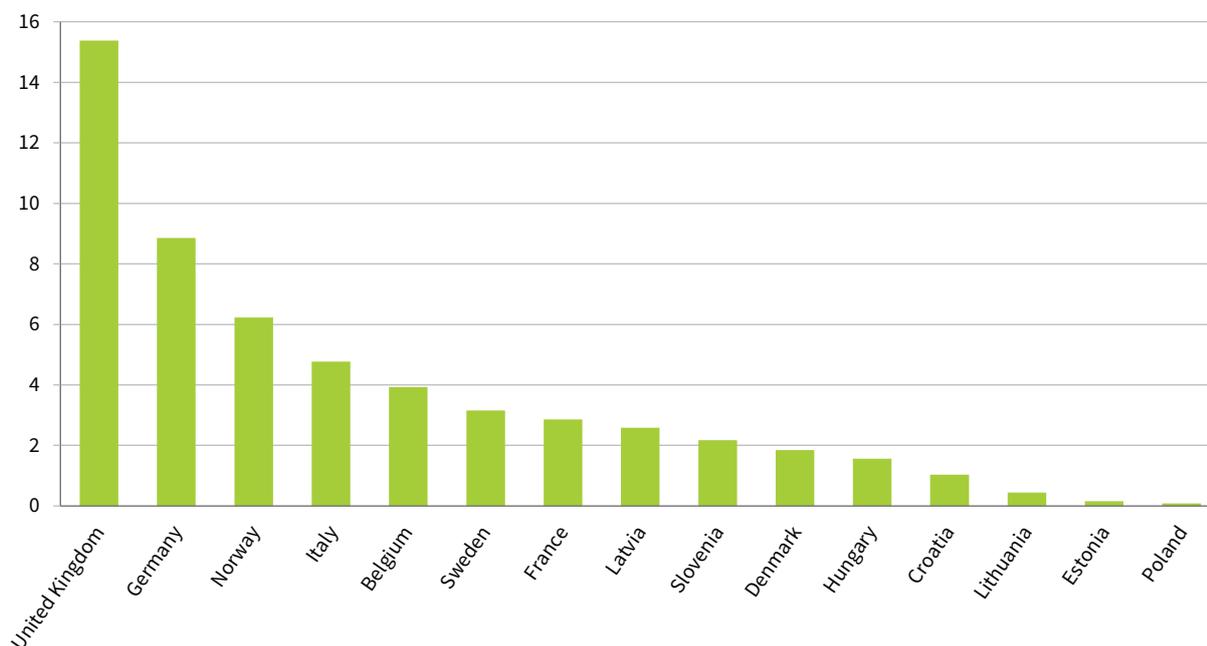
The migration and international mobility of health professionals is a cyclical process that intensified in the last decade as a result of the economic crisis and widening inequalities in employment and income opportunities across the EU (Kuhlmann et al, 2018). The mobility of health professionals is contingent on various factors. First, Directive 2005/36/EC on the recognition of professional qualifications facilitated migration within the EU. Data on requests for diploma recognition to practise abroad are often used as proxies for estimating 'intentions to leave' a given country. However, these requests do not necessarily entail actual mobility and can therefore lead to misestimation of actual migration flows (Wismar et al, 2011).

Figure 8: Share of foreign-trained doctors in country (%), EU Member States, Norway and the United Kingdom, 2019



Notes: Only countries for which data are available are shown. The latest data available for Denmark, the Netherlands and Sweden are from 2018.

Source: Eurostat, Healthcare personnel statistics

Figure 9: Share of foreign-trained nurses in country (%), EU Member States, Norway and the United Kingdom, 2019

Notes: Only countries for which data are available are shown. The latest data available for Denmark and Sweden are from 2018.

Source: Eurostat, Healthcare personnel statistics

Second, in some countries, mobility has been linked to the effects of austerity policies. The rise in the mobility of nurses trained in Ireland and Spain was mostly concentrated in the years of public spending cutbacks. Research conducted in Spain showed that the increase in nurses' intentions to migrate recorded between 2010 and 2014 was preceded by a period of significant economic growth in which the extension of part-time contracts allowed more nurses to remain employed in the country (Galbany-Estragués and Nelson, 2016, 2018).

Third, mobility from central and eastern European to western European countries substantially increased in the years following EU enlargement (2004–2007) but subsequently decreased, although remaining higher than before accession. Evidence shows that these mobility flows are driven by the prospect of higher income opportunities that are mostly temporary, such as weekend work and short-term contracts for several weeks or months, especially in the homecare and long-term care sectors (Wismar et al, 2011; Stan and Erne, 2021). However, there is also a non-negligible share of highly skilled doctors seeking to establish themselves in their host country as a means of professional development (Žuk et al, 2019; Becker and Teney, 2020).

Labour mobility has implications for the hospital sector in both source and destination countries. High-mobility outflows may cause or aggravate territorial imbalances, leaving many communities in rural areas undersupplied. Some studies have also explored the implications of

increased migration for industrial relations in the hospital sector. One key question is whether increased emigration will strengthen unions' calls for improved wages and general working conditions (Stan and Erne, 2016). Many EU countries undertake different initiatives to attract candidates to the health sector. Policies aiming to improve the working conditions of health professionals are crucial for attracting and retaining health workers. These policies consist of raising wages, along with programmes aimed at improving health professionals' work environment, autonomy, job flexibility and work–life balance through childcare support, flexible working hours, part-time contracts and parental leave (SEPEN, 2021).

The COVID-19 pandemic highlighted long-standing issues in health systems across the EU. Ensuring sufficient numbers of health workers to meet the growing demand for hospital care was a challenge during the pandemic because of pre-existing staff shortages in many European countries and because of workforce depletion, as healthcare workers represented a significant share of the total population infected by the virus. In addition, frontline health workers faced an increased risk of stress and burnout due to increased workloads and safety concerns (Winkelmann et al, 2021). Studies of countries' responses to these issues show that most EU countries adopted different strategies to enhance the surge capacity of hospitals and the flexibility of the health workforce (Eurofound, 2020b; Williams et al, 2020b, 2020c; Buchan et al, 2021b).

The majority of countries sought to maintain the capacity of the existing health workforce by adopting measures such as removing limits on overtime or modifying work schedules to increase availability and by redeploying health workers to different settings and health facilities, regions with greater needs or different disciplines. In addition, some countries redeployed private sector staff into the public sector, for instance by allowing governments to temporarily take over private hospitals and their staff. Implementing these measures often required adopting emergency legislation or suspending existing legislation. Countries also implemented emergency recruitment procedures to bring new workers into the health system. Recruitment strategies targeted foreign-trained health workers by easing the registration process and speeding up recognition procedures. In some countries, campaigns were launched to bring retired or inactive health professionals back to work (Eurofound, 2020b).

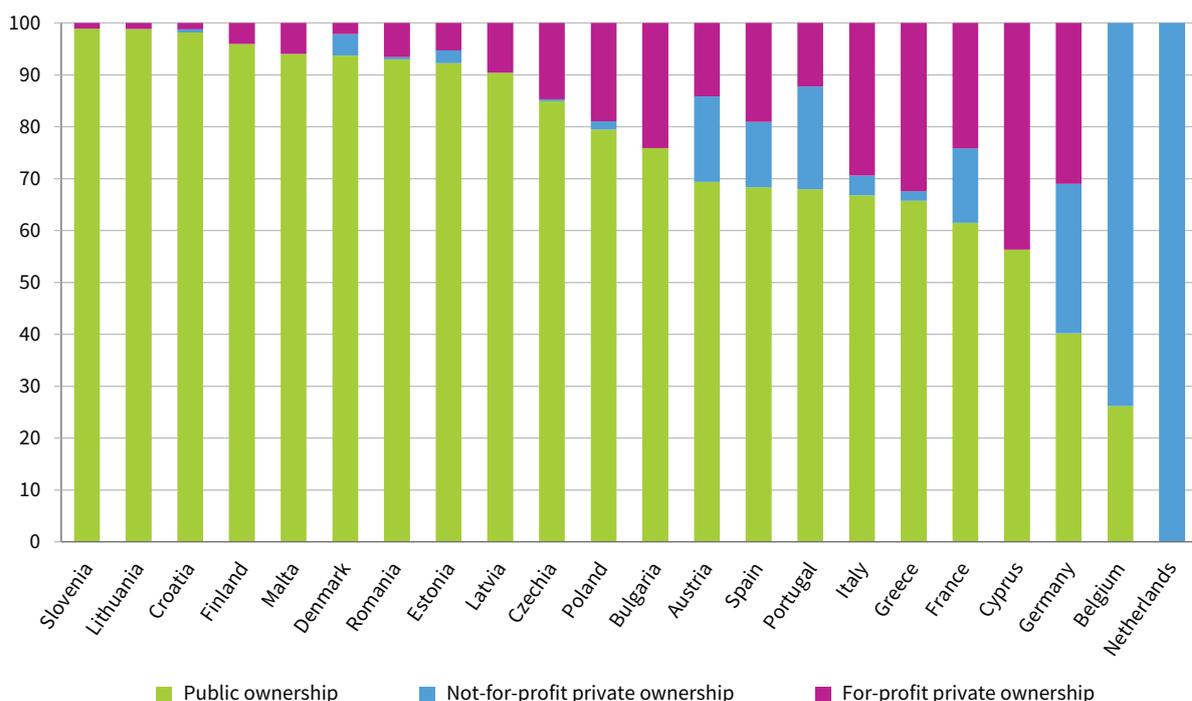
Hospital governance: Decentralisation and privatisation

This section sets out the potential consequences of privatisation of the hospital sector for employment and working conditions. This question has already been addressed by Eurofound (2017) and is particularly relevant to current debates on the performance and resilience of healthcare systems (Bureau et al, 2021).

Research points to the long-term implications of healthcare privatisation reforms for the capacity of health systems to cope with the pandemic. Assa and Calderon's study (2020) on the spread of the first wave of the pandemic across 147 countries found that the increase in the share of private health expenditure over the period 2013–2017 was associated with higher COVID-19 prevalence and mortality rates, while higher hospital capacity (in terms of beds per 1,000 inhabitants) significantly lowered mortality rates. Other studies suggest that differences in the extent of privatisation across regions translated into different approaches to tackling the pandemic, particularly in countries with highly decentralised healthcare systems. These were notably focused on the experience in Italy, one of the EU countries most affected by the pandemic (Buzelli and Boyce, 2021; Ciarini and Neri, 2021).

Hospital funding accounts for the largest share of health expenditure across the EU. Almost all inpatient health expenditure is publicly financed, and most hospital beds remain under public ownership (Figure 10). However, reforms to contain public spending – including on healthcare – implemented across Europe over the last two decades have reduced hospital facilities and the number of hospital beds. This was, in many cases, accompanied by a slight increase in the number of private inpatient beds (Garel and Gonzalez, 2021).

Figure 10: Distribution of hospital beds (%), by type of ownership, EU Member States, 2019



Note: Only countries for which data are available are shown.

Source: Eurostat, Healthcare facilities

Privatisation has also been pursued through reforms targeting public hospitals' governance and financing systems. On the one hand, in many EU countries, responsibility for financing, planning and providing hospital services has been transferred to local or regional authorities, aiming to improve efficiency through introducing a purchaser–provider split to promote greater fiscal accountability and responsiveness to local needs by public authorities (Rechel et al, 2018). On the other hand, these reforms have aimed to change the financing or reimbursement of hospitals' expenditures by granting them greater autonomy in the treatment of patients, which has made it possible to reduce the number of hospital admissions and the length of stay.

The introduction of prospective payment systems, such as those based on the diagnosis-related groups in place in many EU countries,² aimed to reduce the cost of inpatient care and provide strong incentives for adopting cost containment strategies. Adopting market mechanisms in the financing of public hospitals has extended different forms of private involvement in the provision of hospital services. These include outsourcing, changing the legal status of public hospitals, management by private institutions through 'corporatisation', and the establishment of public–private partnership projects for the construction and management of public hospital facilities under a concession contract (Atun, 2006; Eurofound, 2017).

The extent of privatisation differs not only between countries but also within countries (Rechel et al, 2018). In some countries, the joint effect of underfunding and privatisation, along with increased decentralisation of healthcare systems, widened regional differences in the provision and quality of hospital services and in preparedness for the COVID-19 pandemic. In this regard, Buzelli and Boyce (2021) highlight that the underfunding of Italy's health system between 2010 and 2017 led to the adoption of cost-saving strategies that resulted in an overall reduction in the numbers of medical and non-medical staff and beds in public hospitals. In regions weighted more towards the private sector, this shift reduced the availability of emergency services and weakened primary care services, placing further pressure on hospitals at the start of the pandemic (Ciarini and Neri, 2021).

Research carried out prior to the pandemic on the impact of outsourcing and contracting out public services shows predominantly negative effects on employment and working conditions (Vrangbæk et al, 2015). Studies of the implementation of public–private

partnerships in Spain show substantially lower employment levels of clinical staff than in directly managed public hospitals, with potential negative effects on service quality and patient safety (Alonso et al, 2016). These results align with other studies on the impact of hospital privatisation in Germany, which found significant employment reductions after hospitals were acquired by private for-profit organisations. The largest employment reduction was in the number of non-clinical staff, which is partly explained by outsourcing activities, while the reduction in clinical staff was concentrated among nurses (Heimeshoff et al, 2014).

Working conditions before and during the COVID-19 pandemic

Staff shortages and the increasing challenges of attracting and retaining employees have given rise to concerns over working conditions in hospitals. Recent research on working conditions in the hospital sector has focused on the impact of the pandemic, with an emphasis on the potential consequences for psychosocial well-being. Most of the research has looked at medical staff. Much less attention has been given to non-medical occupations, such as cleaners and janitors, who were exposed to similar risks to those that doctors and nurses faced during the pandemic and whose working conditions have also been deeply affected by spending cuts and the social undervaluing of their jobs (McBride and Martínez Lucio, 2021).

Evidence on the effects of pandemics shows that frontline workers are exposed to various psychosocial and somatic risks, ranging from sleep disorders to anxiety, stress, depression and burnout (Cabarkapa et al, 2020; Busch et al, 2021). The research points to widespread job dissatisfaction and intentions to leave, particularly among nurses (Rafferty et al, 2019). Critical aspects of working conditions such as low wages, increased workloads, long working hours and irregular working patterns (shift work) are the main causes of job dissatisfaction and burnout among health professionals (Manyisa and van Aswegen, 2017; Domagała et al, 2019; Kansoun et al, 2019), and they also have implications for well-being and job-related health outcomes (Karhula et al, 2017; Rosa et al, 2019).

Three aspects of working conditions and their implications for workers are examined in the discussion that follows: psychosocial risks at work, hospital workers' wages and working time in the sector.

² Diagnosis-related groups are a method for reimbursing hospital expenses based on a pre-established patient classification system that sets costs according to variables related to the patient and the treatment characteristics. If a hospital treats a patient for a cost below the diagnosis-related group established for the treatment, the difference becomes part of the hospital's profit; if not, it generates a loss (Geissler et al, 2011).

Psychosocial risks

Research on psychosocial risks among healthcare workers has identified differences in the prevalence of burnout and job dissatisfaction between countries and occupational profiles. One systematic review found that doctors working in hospitals in EU Member States since 2000 had lower levels of job satisfaction than their US counterparts (Domagała et al, 2019). Lower job satisfaction is reported in EU countries with higher levels of income inequality and with lower public spending, such as Croatia, Hungary and Lithuania. Common issues reported in these countries relate to changes resulting from the transition of health systems, increased workloads, reduced wages, and inadequate staffing and technical resources, with an impact on the quality of services and career prospects.

Evidence from Greece, Ireland and Spain during the period of austerity following the 2008 financial crash also points to higher rates of depressive disorders and burnout among healthcare workers than the general population (Russo et al, 2021). A review of the evidence in France shows a higher prevalence of burnout among emergency doctors than other specialists. Working conditions associated with high workloads and regular night shifts are the main risk factors reported for burnout (Kansoun et al, 2019). Excessive workload is also one of the main causes of burnout among primary care nurses, which has adverse effects not only on nurses' health but also on the quality of patient care, as there is a higher risk of nurses making mistakes owing to overload and burnout (Pérez-Francisco et al, 2020). A systematic review of the prevalence of burnout among midwives reported similar findings; the high prevalence is explained by low salaries, lack of professional recognition, a poor work environment and a shortage of appropriate resources (Suleiman-Martos et al, 2020).

Most of the empirical evidence on the psychological impact of the pandemic on healthcare workers is from Asian studies, but similar issues have been identified in various European countries. One of the main stressors for frontline workers was the fear of being infected and spreading the disease to friends and family. Long working hours and concerns about the efficacy and adequacy of protective measures were also sources of stress and anxiety (Cabarkapa et al, 2020; Busch et al, 2021).

Results from a study of a mental health support unit in a Spanish hospital during the peak of the first wave of the pandemic highlighted the stress experienced by health professionals resulting from the pressure to quickly adapt and reorganise teams and the emotional implications of treating patients in isolation. The protective equipment that professionals were required to wear was also a stress factor, as it made performing regular medical tasks more difficult. In addition, increased workload, working time extensions and reduced recovery time resulted in physical and emotional exhaustion (Jiménez-Giménez et al, 2021).

In Germany, survey-based research covering a large sample of healthcare workers ($N = 3,678$) with different occupational profiles found an increase in the prevalence of symptoms of depression and anxiety during the pandemic, but a smaller increase than that in the general population. Occupations such as nurses and medical technical assistants reported more adverse outcomes. Lack of recovery time between shifts was identified as one of the main risk factors, although participants did not report major workload increases or a lack of staff. Increased alcohol consumption and lack of trust in one's team were also risk factors related to increased depression and anxiety levels.

In Italy, findings from a survey study ($N = 627$) of the psychological adjustment of healthcare professionals during the peak of the pandemic showed that those working with COVID-19 patients were at higher risk of stress, anxiety and burnout than those working with patients without the infection (Trumello et al, 2020). Similarly, findings from another study in Italy ($N = 376$) showed that health professionals directly involved in the care of COVID-19 patients reported significant increases in work-related psychological pressure, burnout and somatic symptoms such as increased irritability and changes in food habits and sleep patterns (Barello et al, 2020).

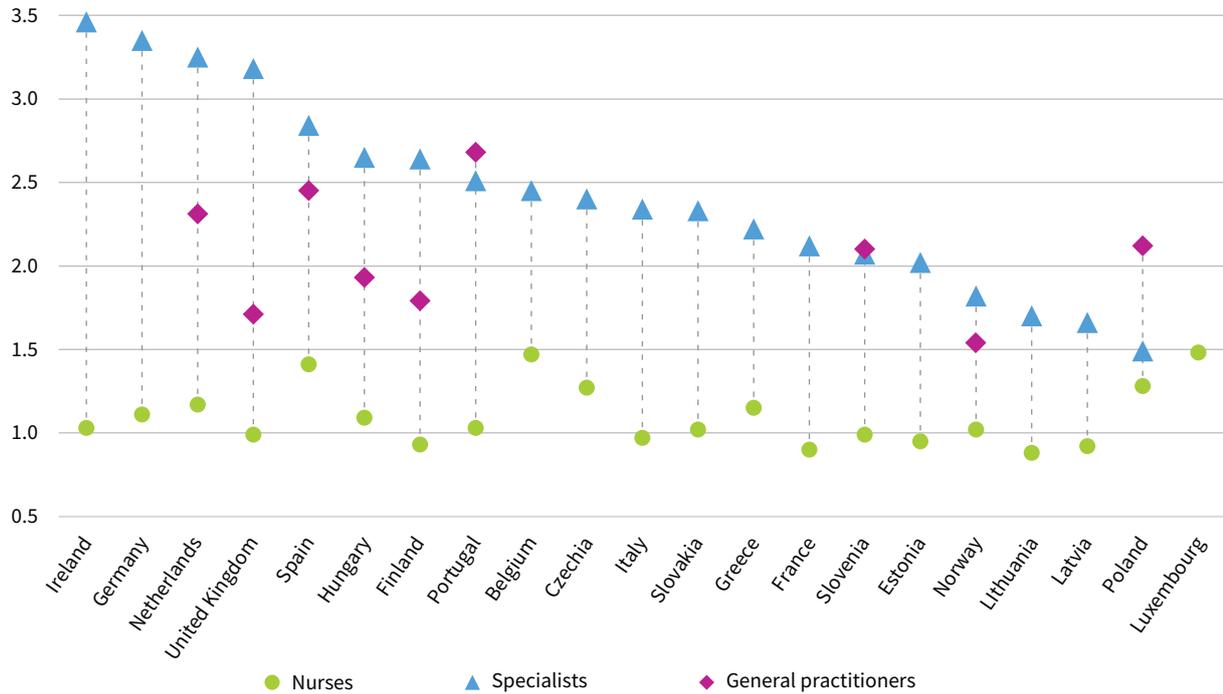
Wage differentials within and between countries

As already mentioned, dissatisfaction with wages is one of the main factors reducing the attractiveness of the health professions, and it is related to workers' intentions to leave their job in search of better opportunities in other regions or countries. Data available on wage levels in the health sector show wide differences between nurses and physicians (Figure 11). Remuneration of hospital nurses is around the national average in most countries, but differences in wage levels are more significant among doctors. Nurses' remuneration in 2019 ranged from about 10% lower to 20% higher than the national average wage, while in a few cases (Belgium, Luxembourg, Poland and Spain) they earned much more than an average worker.

Among doctors, specialists earn more than general practitioners in most of the countries with data available (with the exceptions of Poland, Portugal and Slovenia), and specialists earn double or nearly triple the national average wage in most cases. In Ireland, Germany and the Netherlands, the ratio of specialists' wages to average wages is even higher. By contrast, the earnings of doctors in Poland, Latvia and Lithuania are low compared with other countries (although not lower than the national average), and the wage differentials with hospital nurses are narrower.

The remuneration of hospital nurses has increased over the last decade, although the pace varies between countries. Nurses in central and eastern European

Figure 11: Remuneration of nurses and doctors (salary ratio to national average wage), EU Member States, Norway and the United Kingdom, 2019

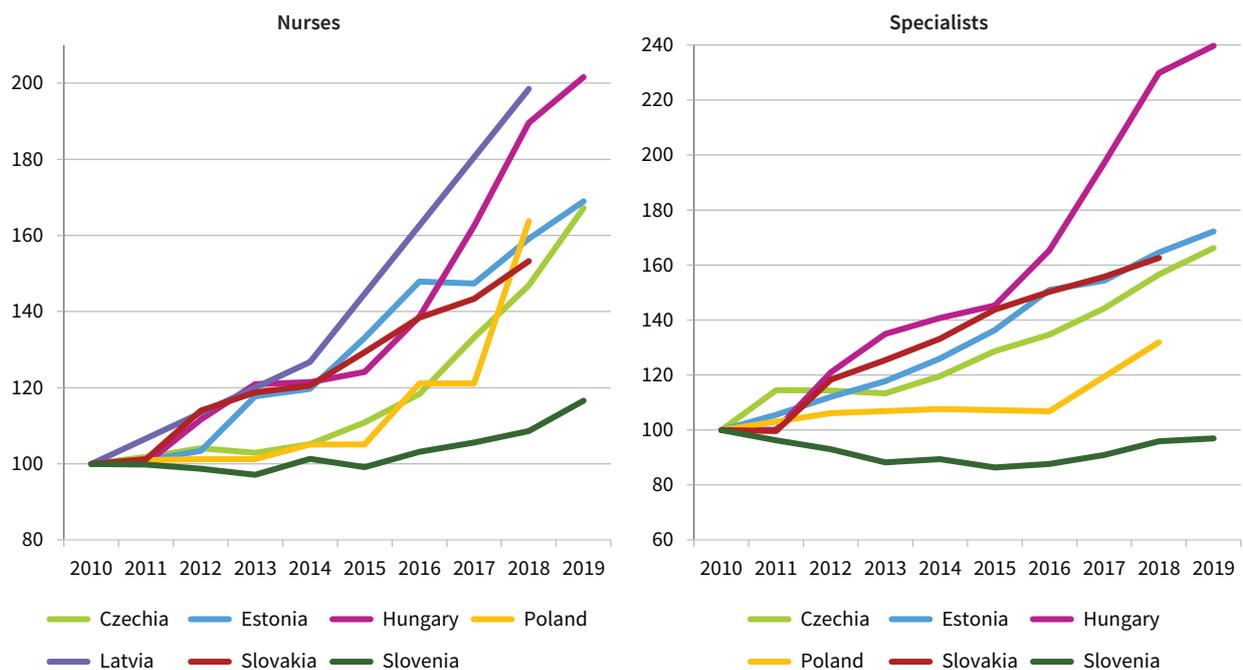


Note: Only countries for which data are available are shown; only the available points of data are shown.
Source: OECD, Health workforce statistics

Member States have received significant pay increases, ranging from 40% to 100% between 2010 and 2019. The remuneration of doctors in these countries follows a similar trend: wages were increased in order to reduce

emigration by health professionals and in response to demands for better working conditions. Figure 12 illustrates the growth in nurses’ and doctors’ wages in these countries.

Figure 12: Wages of hospital nurses and specialists in selected central and eastern European countries, 2010–2019



Notes: Index 2010 = 100. Wages are in national currency units. Data on hospital nurses in Latvia only for 2010, 2014 and 2018; data on specialists in Poland only for 2010, 2012, 2016 and 2018.
Source: OECD

In Estonia and Hungary, the governments have substantially increased the wages of both nurses and doctors to discourage emigration (OECD, 2019b). In Romania, unions used the migration argument to demand better wages, although the unions representing nurses and doctors' associations had different approaches (Stan and Erne, 2016). In Poland, low wages and poor working conditions were the main reasons for resident doctors going on strike in 2017. Medical graduates are required to complete an internship in which they must take on the most demanding shifts for low wages. In 2018, Polish nurses led similar protests against understaffing, increased workload and low wages, which force most of them to take on additional jobs (Žuk et al, 2019).

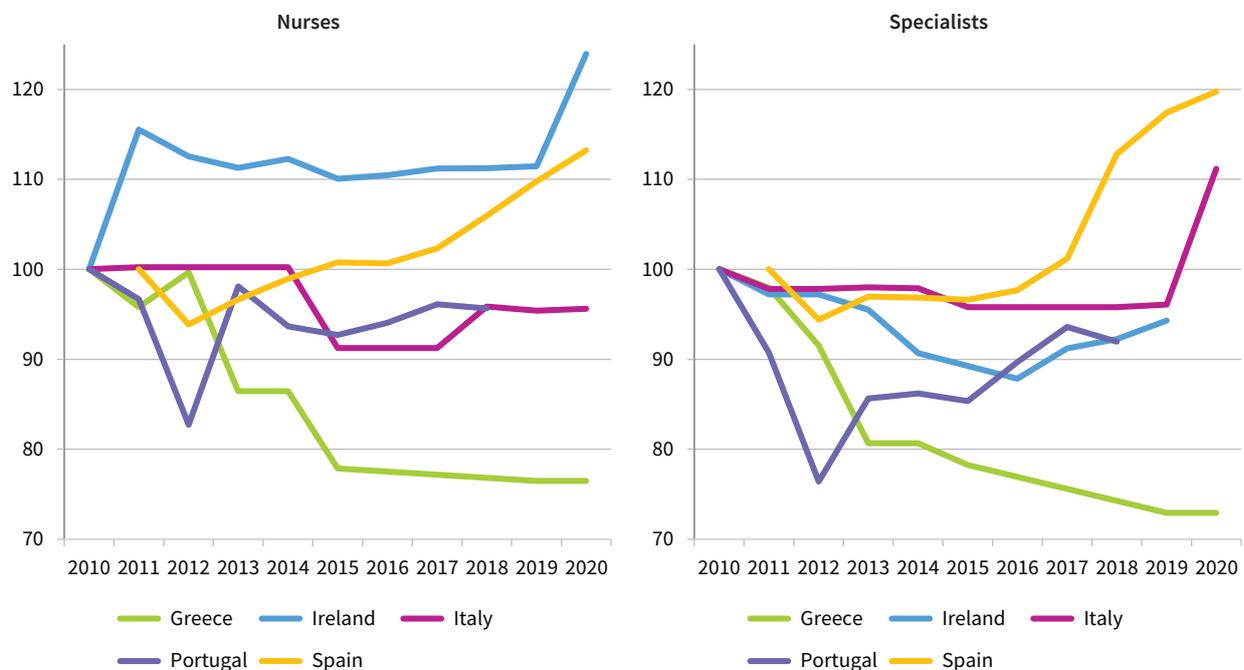
Wage differentials are also significant between the public and private parts of the sector. In Czechia, the public sector has been sheltered from austerity measures, and the government sets public hospital employees' wage levels. These levels are considerably higher than those in the private sector, which are regulated by statutory minimum wage laws or agreements at hospital level (Martišková, 2020).

In Slovakia, public employees lost their public servant status in 1991, but legislation still helps them secure wage increases and reduce wage differentials based on

specialisation or hospital ownership. Wages of medical staff have increased at a faster pace than the average wages, fuelled by union protests and staff shortages (Kahancová and Sedláková, 2020).

In those countries most concerned with adopting public spending reduction measures after the 2007–2008 financial crisis – such as Greece, Italy, Portugal and Spain – wages in the hospital sector have only partially recovered in recent years (Figure 13). This is not the case for nurses and doctors in Greece, whose wages decreased by 20% over the same period. In Italy, the development of collective bargaining on wages in the public and private parts of the health sector was severely limited by government initiatives aiming to curb public spending. National collective bargaining in the public sector was suspended from 2010 to 2015, and pay levels have stagnated for nearly a decade. In the private sector, lower prices for contracted services from the National Health Service and local institutions reduced the margin for negotiating wage increases at decentralised levels (Ciarini and Neri, 2021). Similarly, in Spain, collective bargaining at national and regional levels came to a standstill in 2009, and public employees' wages decreased significantly through wage cuts and the elimination of additional monthly payments, which have only recently been reinstated (Molina and Godino, 2020).

Figure 13: Wages of hospital nurses and specialists in Greece, Ireland, Italy, Portugal and Spain, 2010–2019



Notes: Index 2010 = 100. Reference period for Spain starts in 2011. Wages are in national currency units.
Source: OECD

Working time developments: Increased flexibility versus work intensification

Working time is a critical dimension of working conditions in the hospital sector because of its implications for workers' health and safety and for recruitment and retention strategies. Working irregular hours, nights and shifts is an intrinsic feature of nursing and medical professions that ensures continuity of care but also presents an occupational health risk. Nurses are among those most exposed to irregular working patterns and related physiological and psychosocial issues, such as sleep problems. Night work is also linked to a higher prevalence of cardiovascular and metabolic diseases than day work (Rosa et al, 2019). Shift workers, with and without night shifts, often have more difficulties balancing their work and private lives than day workers (Karhula et al, 2017). Long shifts are associated with reduced recovery time, fatigue and increased risk of medical errors, and they are a major source of job dissatisfaction in public hospitals (Manyisa and van Aswegen, 2017).

Part-time roles offer working time flexibility that can attract workers to the health sector. The social partners at European level (the European Public Service Union (EPSU) and European Hospital and Healthcare Employers' Association (HOSPEEM)) agreed a framework of actions on recruitment and retention in May 2022. They committed to actions supporting the recruitment and retention of workers in the hospital sector, improving work organisation, developing and implementing workforce planning mechanisms, encouraging diversity and gender equality, achieving continuous professional development for all workers and achieving the safest possible working environment (see EPSU and HOSPEEM (2022) for further details).

Some countries have implemented working time reduction policies in an attempt to retain workers at the end of their careers. For instance, in Belgium, the social partners agreed that nurses aged between 45 and 55 years working full time can reduce their weekly hours (by between two and six hours) without a wage reduction, while those continuing to work full hours receive a bonus (Rafferty et al, 2019).

In the Netherlands, collective bargaining allowed older employees to work irregular shifts, and innovative solutions for scheduling working shifts ('self-scheduling') were also agreed; these respected employees' preferences and improved efficiency by adapting staffing levels to changes in demand for patient care (Stiller and Boonstra, 2020).

The extension of flexible working time arrangements in the health sector has improved the quality of services while also enabling many workers to balance family and work responsibilities. The most common arrangements agreed in collective bargaining were those increasing the flexibility of working time allocations in a given period and those reducing working hours through the compression of work periods and introduction of part-time roles. However, staff shortages and cost reduction policies challenged these developments, limiting access to flexible arrangements. In addition, some countries opted out of the Working Time Directive to cope with staff shortages and budget restrictions that affected new hiring processes (ETUC, 2012; Eurofound, 2015).

Many reports suggest that work intensification due to higher workloads, increased overtime and stagnating wages are among the main factors affecting job dissatisfaction. In Czechia, overtime is the main sign of growing precariousness in the health professions. Both nurses and doctors are exposed to a widespread practice of signing a second contract that allows an increase in overtime hours beyond otherwise legal limits, paid at lower rates than regular working hours (Martišková, 2020).

Work intensification is often reported in connection with understaffing. Surveys conducted in German hospitals showed that the working conditions of most health workers have deteriorated because of the increased workload due to understaffing. Many workers feel that they do not have enough time to do their job or to take their breaks, and many night shifts are covered by lone workers (Schulten and Seikel, 2020).

France faces similar issues. In parallel to improvements regarding flexible working time, there is a trend towards work intensification through increased workloads and overtime due to hospital reforms conducted during the austerity years. Nurses are most affected by work intensification, having to shift tasks frequently to deal with the growing number of patients. Union reports also point to negative impacts on workers' health because of increased overtime hours (Ramos Martín, 2020).

In Italy, nurses and doctors are excluded from regulations on weekly working hours and rest periods. Restrictions on staff replacement mean they cannot hire new workers to replace retired staff, resulting in an increased reliance on overtime and larger workloads (Pedaci et al, 2020).

Cuts to healthcare budgets affected nurses' working conditions in Spain. Studies show that cost containment measures adopted in 2010–2012 led to wage losses, longer total working hours, and increased work intensity and complexity. This resulted in a deterioration in working conditions and the quality of health services, reflected in longer waiting lists and treatment delays (Granero-Lázaro et al, 2017; Gea-Sánchez et al, 2021).

Industrial relations: Actors and institutions

The representativeness of the social partners and the collective bargaining structure in the hospital sector have been addressed in Eurofound's studies on the representativeness of the European social partner organisations in the human health sector and on the industrial relations landscape in Europe (Eurofound, 2020b, 2021b). Other sources have analysed recent developments regarding actors and collective bargaining institutions in the context of the restructuring of public services (Keune et al, 2020). Overall, these studies describe a highly fragmented industrial relations landscape, which is reflected in the large number of sector-related organisations, particularly trade union organisations. Greece is the only country in which union representativeness is concentrated in a single organisation. The largest numbers of union organisations are found in the Nordic countries (Denmark, Finland and Sweden) and in France, Italy, Portugal and Spain.

Employers' representation is generally more concentrated, with a few exceptions, such as Belgium, France and the Netherlands. Where present, the fragmentation of employers' representation reflects the segmentation of healthcare providers. Apart from public sector bodies operating at different administrative levels (central, regional or local), a range of non-profit institutions and private actors also operate in most countries. This has implications for the representation of employers' interests, which depends on the precise nature of healthcare provision and health funding. In Belgium, the high number of employer organisations partly reflects the regional structure of the country. In the Netherlands, the high degree of fragmentation is explained by the fact that health provision is mostly private, and several organisations cover different hospital subsectors.

For worker representative organisations, the fragmentation is because different union organisations represent different occupational groups and activities within the health sector. In some countries (Hungary, Poland and Slovakia), professional associations, such as nurses' chambers, play a significant role in representing workers' interests. However, they have a consultative role and are not directly involved in collective bargaining. In other countries, the structure of unions' representation has become more fragmented because particular occupational groups were dissatisfied with existing organisations. In Slovakia, nurses and midwives who felt misrepresented by the main trade union organisation in the sector (the Slovak Trade Union Association of Healthcare and Social Services (SOZZASS)) created their own organisation in 2012 (the Trade Union Association of Nurses and Midwives (OZsaPA)). They take different strategic approaches

from the union organising doctors (the Labour Union of Physicians (LOZ)) (Kahancová and Sedláková, 2020). Bearing this in mind, union membership figures in the health sector tend to be quite small, although most have the recognised representative status needed to take part in collective bargaining and social dialogue institutions (Eurofound, 2020c).

According to recent and comprehensive research on the participation of national social partners in sectoral social dialogue at EU level, most of these organisations are directly involved in the meetings and activities of the EU Sectoral Social Dialogue Committee for Hospitals and Healthcare Sector via either EPSU or HOSPEEM, the only EU-level organisations with recognised representativeness. The fragmentation of national representation and the lack of resources are the main factors explaining the lack of involvement by a number of union organisations. Likewise, employers' participation in EU social dialogue institutions is rather limited, and some national trade unions have urged employer organisations to become HOSPEEM members in order to establish a more effective EU social dialogue process (CELSI, 2021). The recent activity of the sectoral social dialogue committee has been mostly concerned with occupational health and safety issues (musculoskeletal disorders and stress at work); developing a recruitment and retention action plan; sharing guidelines and good practices to address the challenges of an ageing workforce; implementing a code of conduct on ethical cross-border recruitment and retention; and other activities promoting professional development and lifelong learning in digitalisation.

Overall, more than half of the workforce in the EU human health sector is covered by collective bargaining; Greece is the only country where there is no collective bargaining. Some Member States' coverage rates are below the EU average, namely Czechia (45%), Bulgaria and Romania (30% each), Portugal (16%) and Poland (2%). By contrast, the coverage rate is close to 100% in many EU Member States, such as Austria, Belgium, Denmark, Finland, France, Italy, Luxembourg, Malta, the Netherlands, Slovenia, Spain and Sweden. In most Member States, collective bargaining coverage is unevenly distributed between the public and private parts of the sector.

The main differences in the structure and coverage of collective bargaining in the hospital sector are between public and private providers and between occupational groups. Sectoral bargaining is more centralised in the public sector, a feature associated with higher coverage rates than in the private sector, which has low to medium levels of coverage. These differences are significant in Croatia, Finland, Germany, Italy, Lithuania, Malta, Portugal, Romania and Spain. In certain cases, some professional groups are excluded from collective bargaining and other regulations apply, for example

self-employed medical specialists in the Netherlands (Stiller and Boonstra, 2020). Available estimates show that employees in hospitals, and especially those in public hospitals, benefit from higher levels of collective bargaining coverage than other groups in the health sector (Eurofound, 2021b).

Coordinating collective bargaining strategies and goals in hospitals is particularly challenging given the differences in collective bargaining structures between the public and private parts of the sector, and the fragmentation of interests in relation to representation between different groups. Research on the recent evolution of industrial relations in the sector points to the growing fragmentation of the industrial relations landscape as one of the main results of implementing healthcare reforms (Keune et al, 2020). The implementation of these reforms often entailed shifting towards more unilateralism on the part of governments, and the suspension or reduction of collective bargaining practices in the sector.

In Italy and Spain, unions' coordination strategies have been marked by the double impact of austerity measures and the decentralisation of responsibilities for healthcare management, which moved to regional governments. In Italy, national sectoral bargaining in the public sector was suspended from 2010 to 2015; in the private sector, the sectoral agreement expired in 2004, and the new agreement was concluded only recently (the summer of 2020) (Ciarini and Neri, 2021).

In Spain, the last collective agreement in the public sector was concluded in 2009, and negotiations were resumed in 2015. The negotiations focused on restoring working conditions and benefits lost during the years of budget cuts and improving employment security through reducing temporary employment (Molina and Godino, 2020). Collective bargaining at regional level has become more relevant because of national pay freezes, but differences in unions' bargaining power across regions and regions' financial performance have resulted in increasing wage disparities in the sector.

In other cases, austerity programmes created further divisions between unions. In Romania, for instance, the Healthcare Workers Solidarity Federation (FSSR) supported the government's privatisation plans that would allow doctors in public hospitals to increase their

incomes by working privately, while the Sanitas Federation (Sanitas) pursued a strategy aiming to reduce wage differentials through sectoral bargaining (Stan and Erne, 2016).

The situation is somewhat different in countries that were not as directly concerned with adopting policies to slash public spending. Research in some of these countries shows the relevance of existing actors and collective bargaining institutions in shaping the outcomes of healthcare reforms. In Germany, union campaigns have ensured that the growing number of private sector employees is covered by collectively agreed working conditions similar to those in public sector agreements (Schulten and Seikel, 2020). In Slovakia, the impact of decentralisation and the 'corporatisation' of public hospitals has been balanced by the social partners' attachment to well-established, coordinated bargaining procedures in both public and private parts of the sector. In addition, the social partners succeeded in introducing changes in the legislation for reducing wage differentials across hospital types and occupational groups (Kahancová and Sedláková, 2020).

Another noticeable development is the intensification of protest and industrial conflict in the sector over the last decade (Keune and Pedaci, 2020; Vandaele, 2021). Strike activity is more prevalent in countries with traditionally high levels of industrial conflict, such as Spain, but strikes in the health and social care sector also account for a considerable share of total strike activity in countries characterised by labour quiescence (Vandaele, 2021). The main causes of conflict relate to the deterioration of wages and working conditions due to increased workloads and understaffing. However, these issues are often framed as more general questions about the impact of healthcare reforms and austerity policies on the quality of public services, particularly in southern and eastern European countries. The connection between workers' demands and the quality of public services is reflected in the diversification of forms of collective action. These include moves towards more 'expressive' (non-strike) types of mobilisation and the involvement of new actors from civil society movements that defend the public sector as a guarantee of equal access to health and social rights.

2 Social dialogue and collective bargaining during COVID-19

To understand the role of social dialogue and collective bargaining in tackling the main challenges for the hospital sector during the COVID-19 pandemic, this chapter presents the results of an analysis of policy initiatives reported by Eurofound's national correspondents from the EU27 and Norway. Overall, 72 policy measures were collected, and a cross-case analysis was conducted using qualitative data analysis software.

Conceptual and methodological approach

Given the wide variety of policy measures reported in the national contributions and of the social dialogue practices involved, the measures were classified according to two criteria:

- types of social dialogue practice and degree of social partner involvement
- main issues addressed or tackled

Regarding the first criterion, the measures were first classified based on the form of social dialogue practice, whether it was negotiation, consultation, joint action, discussion or information sharing involving employers and workers. In addition, four main categories of social partner involvement were considered:

- measures adopted in the context of **regular social dialogue** and collective bargaining rounds
- measures stemming from **extraordinary formal or informal social dialogue** initiatives involving some kind of negotiation or agreement on specific issues
- measures in which the social partners were involved only through **information or consultation procedures** but not through negotiation and agreement, including situations in which the social partners successfully influenced a policy despite not being directly involved
- measures in which there was **no involvement of the social partners**, an exceptional situation that mainly applies to a few countries and some examples of union mobilisation that do not involve other stakeholders

The second main classification criterion covers the issues addressed through these social dialogue practices. Generally, sectoral social dialogue tends to

address some of the key problems identified in the literature review in Chapter 1: working conditions, such as pay and working time, and other aspects related to staffing of hospitals and health and safety issues that have become particularly relevant in the management of COVID-19. To classify the policies and initiatives reported in national contributions in terms of the themes addressed by the social partners, the following categories were identified.

- **Pay:** Measures related to either the financial compensation of health workers in the context of the pandemic or to collective bargaining on wages in the hospital sector.
- **Health and safety:** Measures adopted in support of health workers' safety and well-being. It covers the provision of adequate protective equipment and vaccination programmes and support for the psychosocial well-being of health workers.
- **Working time:** Measures dealing with the organisation and distribution of working time to meet the increase in service demand, and compensation for overtime and increased availability of staff during the pandemic.
- **General working conditions:** Measures dealing with different aspects of employment and working conditions. Some of the initiatives reported in national contributions address a range of issues and cannot be covered by a single dimension. This is mostly the case for collective agreements that include provisions on working time and wages, but also for other initiatives concerning the regulation of employment in the sector (for instance, changes in the terms of the contractual arrangements for some occupations).
- **Staffing:** Measures involving the recruitment of additional health professionals or the transfer of employees across health units to ensure workforce capacity in response to the pandemic. More broadly, it covers initiatives addressing staff shortages and uneven distribution of health workers, such as the implementation of e-health systems.
- **Surge capacity:** A residual category that applies to measures described in general terms as addressing issues such as the provision of additional resources (financial and material but not staff) or restructuring to improve hospital infrastructure.

The review of the issues addressed through social dialogue initiatives is complemented by an analysis of the social partners' positions regarding the measures adopted or the solutions agreed through social dialogue or collective bargaining. The main purpose of this analysis is to identify the critical aspects raised in the negotiation of these measures. In addition, the analysis identifies and describes the main conflicts triggered by the implementation of these measures in the absence of agreement or social partner involvement.

The chapter ends by examining the expected outcomes from two perspectives. First, from a 'procedural' perspective, the analysis aims to identify the role of social dialogue and collective bargaining institutions in the context of the pandemic and the extent to which this role makes a difference in comparison with previous experience in the sector and each country's overall situation. This part of the analysis mostly builds on the national correspondents' assessments of the recent evolution of the social partners' relationships and whether the relationships have improved or deteriorated as a consequence of the social partners' involvement in managing the health crisis.

Second, from a 'substantive' perspective, the analysis focuses on the extent to which the pandemic has changed the social partners' views on the issues in the hospital sector. The analysis of the initiatives distinguishes between, on the one hand, those addressing the challenges arising from the pandemic, which have a more limited scope, and, on the other hand, initiatives that are more likely to result in far-reaching, long-term solutions to the issues addressed. The analysis of the initiatives' outcomes is restricted by the fact that most of the measures adopted are temporary or only recently implemented. In addition, the sustainability of their effects depends on the fiscal strategies adopted in the aftermath of the pandemic.

Forms of social partner involvement and main issues addressed

Overview

Table 1 shows the distribution of the initiatives identified in the national contributions according to the social partners' type of involvement. When interpreting the results in the table, it must be borne in mind that the national contributions do not detail the same number of initiatives for each country and that if a country is not mentioned, this does not necessarily mean that no such initiatives were taken.³

The initiatives are evenly distributed across countries in terms of the three types of social partner involvement. In 15 countries, initiatives arose from regular social dialogue and collective bargaining procedures (Belgium, Bulgaria, Croatia, Czechia, Estonia, Finland, France, Germany, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal and Sweden). Also in 15 countries, initiatives arose from extraordinary negotiations with the involvement of social partners, owing to the unprecedented nature of the impact of the pandemic (Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, France, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Slovakia and Spain). In 13 countries, the social partners were informed of and consulted on actions largely implemented by governments (Austria, Estonia, Germany, Hungary, Ireland, Latvia, Lithuania, Malta, the Netherlands, Poland, Romania, Slovakia and Spain).

The category indicating social partners' non-involvement is overrepresented, as most of these measures were reported in Greece and Hungary. In Greece, this category applies to six of a package of legislative measures that were enacted without any form of social partner involvement. In Hungary, it applies to government initiatives aiming to restrict the scope of collective bargaining in the sector. In other countries, the category applies to industrial action taken by unions in order to press the government to adopt specific measures supporting the sector in the absence of formal negotiations (Italy) or to adopt these measures during existing negotiations (Poland).

Before presenting the findings, it should be noted that, given the diversity of issues covered in the category of general working conditions, they are analysed within the discussion of the other themes (pay, staffing and so on) in order to make full use of the information provided in the national contributions.

³ Eurofound national correspondents were asked to provide up to three initiatives for each country, but the final number of initiatives included varies between countries. A single encompassing initiative was reported by three countries (Luxembourg, Norway and Sweden). Two initiatives are included in the national contributions for 10 countries (Austria, Belgium, Czechia, Denmark, Finland, Germany, Lithuania, Romania, Slovakia and Slovenia), and three initiatives per country are reported for 14 countries (Bulgaria, Croatia, Cyprus, Estonia, France, Hungary, Ireland, Italy, Latvia, Malta, the Netherlands, Poland, Portugal and Spain). In Greece, seven initiatives have been reported in connection with different government legislative measures.

Table 1: Distribution of social dialogue and collective bargaining practices, by type of social partner involvement and issues covered

	General working conditions	Pay	Staffing	Health and safety	Working time	Surge capacity	Total
Extraordinary negotiation	3	8	5	5	1		22
Regular negotiation	9	6		1	4		20
Information/consultation	5	4	5	1		4	19
No involvement	3	2	3	2		1	11
Total	20	20	13	9	5	5	72

Source: Network of Eurofound Correspondents, authors' analysis

Pay

Social partners' involvement in COVID-19-related compensation

Pay-related initiatives and developments are reported in nearly all national contributions, indicating that pay issues are high on the social partners' bargaining agenda. The most common initiatives in this area relate to compensating health workers in recognition of the increased efforts they made and risks they were exposed to during the pandemic. Examples of health workers' COVID-19-related financial compensation are reported in most countries, with different degrees of social partner involvement.

In **Germany**, bonuses for hospital workers have been the subject of regular collective bargaining rounds. The collective bargaining agreement covering public hospitals for 2020–2022 established a one-off payment ranging from €225 to €600 as part of a wider package of wage increases for all employees covered by the agreement (additional extraordinary monthly bonuses were agreed for employees with care responsibilities). In most countries, however, bonuses were the result of extraordinary negotiations at national level, through the initiative of either the social partners or the government (Belgium, Croatia, France, Ireland, the Netherlands and Slovakia).

In **Belgium**, the federal government asked the social partners to submit a proposal for the financial compensation of health workers in the care and hospital sectors. A one-off payment of €985 was agreed in 2021 for all employees in public and private hospitals. In **France**, the government's early decision to award extra compensation to health workers in May 2020 was adopted without formally consulting trade unions. Trade unions contested the initiative, questioning the award criteria, which led the government to enter into an ambitious negotiation process at national level. The *Ségur de la Santé* agreement was the result of a comprehensive social dialogue process involving social

partner representatives from the health and social care sectors, which covered a wide range of issues that the standard social dialogue process does not usually deal with, notably decisions on investment in the public sector. The agreement provided for general pay increases and other wage improvements (compensation for overtime and night work) for healthcare professionals in the public sector (paramedics and non-medical staff, hospital doctors, interns and medical students).

In other countries, the social partners' involvement has been significant, although limited to information and consultation, with no specific agreements concluded. In **Austria**, the government awarded a special bonus in June 2021, aiming to compensate all health and care workers. Unions were able to amend the initial government proposal and widen the scope of beneficiaries. This measure followed the 'corona hazard' bonus agreed in the collective bargaining rounds in the health and social economy sector in 2020, which served as a model for the draft bill the government presented in the spring of 2021. In **Bulgaria**, the government approved a monthly bonus of BGN 1,000 (€510 as at 23 September 2022) for frontline workers in healthcare services, as proposed by the main trade unions (the Confederation of Independent Trade Unions of Bulgaria (CITUB) and the Confederation of Labour Podkrepa). The bonus programme was subsequently extended and the coverage criteria amended following union protests. These bonuses nearly doubled the monthly wages of medical workers in the country.

In **Czechia**, trade unions (the Open Association of Health Insurers (OSZP) and the Trade Union of Doctors in the Czech Republic (LOK-SCL)) negotiated with the government to secure a range of one-off bonus payments for both medical and non-medical staff in the first and second waves of the pandemic. In **Croatia**, trade unions pushed the national government into negotiating a COVID-19 bonus, equivalent to 28% of

basic pay for all employees in public hospitals. However, the government finally decided on a bonus equivalent to 10% of basic wages for medical staff directly involved in the treatment of COVID-19 patients only. In **Slovakia**, formal consultation between tripartite sectoral bodies resulted in the agreement of temporary wage increases (€7 per hour) for frontline workers (medical and non-medical staff) until the number of COVID-19 inpatients in hospitals dropped to under 1,000.

In **Lithuania**, trade unions were consulted and supported a legal amendment that improved social protections in the event of sick leave and increased wage supplements for those workers exposed to higher risk of infection. These temporary wage increases ranged from 60% to 100% of monthly wages, depending on the functions and responsibilities of the workers concerned. In **Slovenia**, the government agreed a new ‘crisis bonus’, equivalent to 30% of the fixed salary, for all workers in the public health sector treating COVID-19 patients. The measure applied from November 2020 to December 2021. In **Romania**, the trade union Sanitas lobbied for the implementation of an extraordinary bonus equivalent to 75–85% of the salaries of medical and auxiliary staff involved in transporting, treating and assisting COVID-19 patients. The bonus was granted during the states of alert and emergency in the country.

In **Ireland**, the union representing nurses (the Irish Nurses and Midwives Organisation (INMO)) campaigned for payments for student nurses working in public hospitals during the pandemic. It had argued for years that student nurses were actually being used as replacements for nurses on leave or to make up staffing shortfalls and that they were usually underpaid. As a result of the union intervention, which was supported by the Psychiatric Nurses Association (PNA) and the Services, Industrial, Professional and Technical Union (SIPTU), student nurses were allocated a ‘pandemic payment’ of €100 a week for hospital placements. A government decision adopted in January 2022 finally met the union’s calls for the recognition of frontline workers during the pandemic. The decision provided a ‘pandemic special recognition payment’ of up to €1,000 for health workers employed in healthcare services dealing with COVID-19 patients between March and June 2020.

In Greece – and, to some extent, Hungary – there was no social partner involvement in measures related to the financial compensation of health workers regarding the pandemic. This resulted in the unilateral intervention of the government in both countries. In **Greece**, the government decided on an extraordinary one-off payment in 2020 as part of emergency legislation. In **Hungary**, health workers received a one-off bonus of HUF 500,000 (€1,229) in the summer of 2020 as compensation for their extra efforts during the first wave of the pandemic. While welcoming the measure,

sectoral unions the Independent Trade Union of Healthcare (FESZ) and the Chamber of Hungarian Health Professionals (MESZK) campaigned for the introduction of a new ‘COVID-19 supplement’ for health workers in March 2021. Unions had criticised the way that the government bonuses were distributed: distribution was at hospital management’s discretion, resulting in the exclusion of large groups of workers. The unions proposed a new monthly wage supplement to ensure equitable distribution across groups of health workers. However, their demands were unmet, and the new public medical service contract relationship still allows the employer to decide supplementary pay (see the section ‘Outcomes’ for further discussion).

Pay issues in regular collective bargaining and social dialogue

In addition to measures to compensate health workers in recognition of their contribution during the COVID-19 pandemic, there were wage developments in the course of regular social dialogue and collective bargaining rounds. A distinction can be made between initiatives related to pay increases for specific groups of health workers, mostly implemented through changes in legislation (with different degrees of social partner involvement), and recent developments arising from regular collective bargaining and social dialogue rounds at different levels (national, regional or company) or covering different parts of the hospital sector (public versus private).

Pay increases for specific groups of workers: Four countries report initiatives targeting specific groups of workers. In **Ireland**, public health doctors were offered a new contract that allowed them to work exclusively in public hospitals and receive higher wages. Their trade union (the Irish Medical Organisation (IMO)) had been calling for public health doctors to be recognised as consultants since the early 1990s with no success, despite various government commitments. Public health doctors had lower wages on the grounds that they were allowed to take work in the private sector. The pandemic brought the issue into focus, as these doctors were suddenly at the frontline of identifying and investigating outbreaks of COVID-19 in institutions such as nursing homes and schools. After the postponement of industrial action due to surging COVID-19 cases in early 2021, a new Public Service Pay Bill was passed, which provided for an increase in public health doctors’ salaries. This decision was adopted in the framework of the current government’s policy aiming to strengthen the public health medicine sector.

In **France**, the *Ségur de la Santé* package included a similar agreement for intern doctors, providing additional funding that raises their allowances to the level of the statutory minimum wage. In **Hungary**, doctors were offered a new public medical service contract, with substantial pay increases determined by their years of experience. In **Poland**, negotiations within

the tripartite Social Dialogue Council resulted in a legal amendment to the basic pay system that mostly benefited those health occupations with lower wages (nurses and paramedics), although it did not fulfil all unions' expectations. In Hungary and Poland, the trade unions opposed these measures (see the section 'Outcomes' for more details).

Pay increases arising from regular social dialogue:

Reports on recent developments in regular social dialogue and collective bargaining rounds show an overall improvement in wages and working conditions for hospital workers. In some cases, these wage rises, even if moderate, were agreed after a long period of stagnation, specifically in the countries most affected by the implementation of austerity measures following the last economic crisis (Italy, Portugal and Spain). However, the examples reported in national contributions cannot be taken to represent the overall situation in the sector, as most relate to specific agreements or some parts of the sector only. Table 2 summarises the level at which these initiatives were agreed.

Table 2: Bargaining level of pay initiatives addressed in social dialogue and collective bargaining rounds

Bargaining level	Countries
National	Finland, France, Germany, the Netherlands, Norway, Sweden
Regional	Belgium, Bulgaria, Portugal, Spain
Local	Portugal

Source: Network of Eurofound Correspondents, authors' analysis

In **Bulgaria**, the latest sectoral bargaining rounds at regional level resulted in a 10–22% increase in the monthly salaries of those working in the health sector from 1 January 2021. In **Belgium**, the renewal of the social agreement in Flanders in the health and social care sectors (2021–2025) brought general improvements to wages and working conditions. Union campaigns and mobilisations also secured additional funding from the federal government to increase wages, the implementation of a new pay system and harmonisation of pay in the private and public sectors, and the hiring of new staff to improve staff-to-patient ratios. In **Germany**, bargaining rounds for the renewal of the sectoral collective agreement for public hospitals concluded in October 2020, resulting in significant improvements to the wages of care personnel and employees working in intensive care units (increases of 8.7% and 10%, respectively). These wage increases comprise improvements in basic pay rates, shift allowances, and specific 'corona bonuses' or one-off payments for certain groups of workers.

In **Finland**, where the impact of the pandemic has been relatively limited compared with other EU Member States, wage increases agreed in the local and regional government collective agreement covering hospitals were in line with other sector-level agreements. Trade unions asked for a COVID-19 bonus to be included in the negotiations, but this proposal was not considered because municipalities could not afford such payments, and there were concerns about other groups of public employees demanding similar compensation. However, individual hospitals' agreements included various formulas for compensating employees who worked additional shifts or cancelled holidays.

In **the Netherlands**, negotiations on the renewal of the collective agreement for university hospitals resulted in structural pay increases of around 3.5% and a commitment to reduce workloads, as well as better compensation for irregular shifts and more rest time after an on-call or a night shift. The agreement was concluded after unions called three days of collective action during which these hospitals ran a 'Sunday service' and only emergency care was provided.

In **France**, trade unions had been campaigning against pay freezes or below-inflation increases in the public part of the hospital sector for some time before the pandemic. The conclusion of the Ségur de la Santé national agreement provided an additional €7.5 billion to increase the wages of different groups of workers, mostly in the public sector, with the agreement of representative unions. The package included a €183 net increase per month for nurses, paramedics and non-medical staff in public hospitals from March to September 2020. In addition, the agreement provided for the setting up of a working group to re-evaluate the pay scales for certain occupations with lower salaries. An agreement was also concluded with unions representing doctors, which increased the public service allowance for those practitioners who work exclusively in the public sector.

In **Spain**, hospital workers are covered by pay arrangements negotiated at sectoral bargaining tables between union representatives and national or regional governments. Unions have complained about these bargaining tables' lack of activity during the pandemic. The most recent pay rise (2%) was implemented in January 2020 and was negotiated as part of a three-year deal in 2018. Reports of an extraordinary agreement covering nurses in the Castile and León autonomous community reflected the need to upgrade wages in line with the national average for this group of workers. The agreement followed a call for strike action from the main union representing nurses in the region (the Spanish Trade Union of Nursing Professionals (SATSE)). Trade unions had repeatedly asked the regional government to increase nurses' wages, which remained at lower levels than those paid in other regions and had not recovered from 2010 cuts imposed during the last economic recession.

In **Portugal**, collective bargaining agreements concluded at regional and local levels also improved wages and working time, securing, for instance, better payments for overtime work and a reduction in annual overtime limits. However, these examples are exceptional. Public sector unions were already facing difficult negotiations with the government before the COVID-19 outbreak, and the unions were forced to suspend protests owing to restrictions on the right to strike under a state of emergency.

Staffing

Initiatives addressing the need to scale up the workforce capacity of health systems in the wake of the pandemic were reported in 11 countries. These initiatives comprise measures aimed at increasing staffing levels through extraordinary hiring procedures or increasing flexibility in the allocation of tasks, staff transfers and the use of technologies such as remote consultations. In general, these issues are not the subject of regular social dialogue or collective bargaining rounds, but the measures adopted in some countries (such as Cyprus, Denmark, France and Malta) resulted from specific agreements. In other countries, the social partners' involvement was limited to information and consultation on an initiative of the government (Estonia, Portugal, Romania and Spain), or they were not involved owing to unilateral government intervention (Greece), even when under pressure from union organisations (Germany and Italy).

In **Denmark**, the social partners participated in formal meetings dealing with the main challenges posed by the pandemic and agreed on the need to increase flexibility in allocating tasks and in working time during the pandemic, within the framework of existing collective agreements. In April 2020, the social partners reached an agreement that allowed staff to transfer between regional and municipal health facilities to ensure there were enough staff in COVID-19 service departments. In **Cyprus**, trade unions pushed for the hiring of additional medical staff (nurses) and other non-medical and ancillary staff in formal negotiations with the state entity in charge of the management of public hospitals.

In **Malta**, formal negotiations were conducted between unions and the government regarding the recruitment and retention of foreign healthcare workers. The rising demand for health workers has resulted in increased competition between countries and further aggravated existing staff shortages in Malta. In March 2021, the Maltese government agreed on a set of measures aiming to facilitate the establishment of foreign health professionals and their families by extending their residence permits and reducing the cost of related administrative procedures. Malta has experienced an increasing loss of nursing staff, mostly to the United Kingdom, since the beginning of the pandemic, due to

better wages in other countries and other advantages and benefits in terms of work permits. In **Estonia**, a new system of 'remote appointments' (e-consultations and telephone consultations) was implemented to cope with the increased demand for care services during the pandemic; this measure had already been under discussion as a strategy to tackle long-term staff shortages and the uneven distribution of medical staff between rural and urban areas.

As mentioned above, the understaffing of hospitals was considered in the Ségur de la Santé agreement in **France**, which allowed public hospitals to hire 15,000 workers and provided significant career and wage improvements for health workers in the health and social care sectors. In **Germany**, union mobilisations in Berlin's largest hospital groups (Vivantes and Charité) during collective bargaining negotiations resulted in the agreement of new minimum standards for carer-to-patient ratios and new rules for workers' compensation if this ratio is not met. That agreement followed a four-week strike during which these hospitals had to operate on emergency staffing levels in departments that could not be closed completely.

Despite these examples, measures related to the staffing of hospitals are usually not addressed in formal negotiations with the social partners; instead their role is limited to information and consultation. In **Spain**, the national government adopted a law on urgent measures in the health system to tackle the pandemic in September 2020 without any negotiation with unions representing nurses and doctors. The law enabled regional governments and the national health authorities to hire health professionals who lack the qualifications required to practise in Spain, under certain circumstances. The law also allows the reallocation of staff between hospital departments or units. Although the government's priority was to increase the system's response capacity, trade unions claimed there was a need to improve health professionals' working conditions and wages, as many have not fully recovered from previous wage freezes implemented during the economic crisis of 2008–2012.

In **Portugal**, the government passed a package of legal measures in the context of the state of emergency in March 2020, aiming to secure staffing capacity in hospital facilities by temporarily suspending termination of employment contracts in the Portuguese National Health Service and removing legal limits on overtime. These measures were adopted without consulting trade unions and professional associations. These organisations brought proposals on compensation for overtime and sick leave to the few informal meetings on the implementation of the measures, some of which were agreed with the government (such as 100% compensation for COVID-19 sick leave).

In **Italy**, the government announced a plan for recruiting permanent staff following a national mobilisation on November 2020. The main trade union organisations in the public sector (the Italian General Confederation of Labour (CGIL), Italian Confederation of Trade Unions (CISL) and Italian Labour Union (UIL)) had called a national strike to raise the public's awareness of the need to increase staffing levels in the public health sector through derogation from existing laws limiting new hires and the promotion of employment stability for temporary workers.

In **Romania**, the government introduced a set of legal amendments in May 2020 aiming to retain medical staff by extending temporary contracts for specialists and allowing doctors to provide care outside their specialties to COVID-19 patients, on the basis of medical protocol. Trade unions (such as Sanitas) had called for the negotiation of a mid-term recruitment strategy to ensure optimal staff capacity beyond the pandemic, but the government agreed only to extend temporary contracts for 30 days after the end of the emergency period (October 2021).

In **Greece**, emergency legislation adopted in March 2020 included a special dispensation for public hospitals to hire additional medical staff, which resulted in the hiring of more than 7,500 new medical and non-medical staff on a short-term basis. Another legal provision allowed public hospitals to employ doctors from the private sector on a temporary basis. The law also regulated other measures, such as staff transfers or reallocations to ensure the proper functioning of healthcare services. The social partners' involvement was not sought in either the design or the implementation of these initiatives. Healthcare workers in the public sector held demonstrations protesting against the absence of social dialogue, the poor working conditions and the lack of appropriate means to treat patients.

Health and safety

Initiatives related to health and safety were reported in eight countries (Austria, Croatia, Czechia, Estonia, Greece, Italy, Malta and Lithuania). The types of issues addressed through either social partner agreements or unilateral government intervention (mainly in the case of Greece) relate mostly to the following areas:

- the provision of psychosocial support to health professionals
- protective measures in the workplace, including compulsory vaccination programmes
- general health policies that may have a positive impact on hospital workers' health and safety

Estonia and Greece have addressed the provision of psychosocial support for frontline workers, although through different levels of social partner involvement. In **Estonia**, these issues had long been a topic of

discussion during formal collective bargaining rounds before the pandemic. However, specific measures were adopted in the latest collective agreement for public hospitals concluded in April 2021. The agreement provides for access to psychological counselling for employees exposed to work-related traumatic events. According to the Estonian Nurses Union (ENU), the measure targeted the increase in reported burnout among health professionals, which resulted from increasing workloads and reduced wage levels in the sector, both issues aggravated by the pandemic.

In **Greece**, the Ministry of Health introduced a similar measure supporting frontline hospital staff in February 2021, with no social partner involvement. In **Czechia**, the government agreed to introduce spa vouchers for all medical staff working in hospitals with COVID-19 patients in an effort to minimise the psychological burden on health professionals during the pandemic.

Various protective measures in the workplace were reported in Austria, Croatia, Greece and Lithuania. In Austria and Greece, these measures included controversial mandatory vaccination programmes for health professionals. In **Austria**, trade unions were informed of and consulted on the decision of the Vienna Health Group (a public company) to require mandatory vaccination for all new staff in care and hospital facilities under the responsibility of local authorities, including not only health personnel but all occupations (administrative staff, technicians and cleaning staff). In **Greece**, the measure was enacted by the Ministry of Interior Affairs without any trade union involvement. The measure covered all workers in public and private health facilities (medical, paramedical, administrative and ancillary staff).

In **Lithuania**, the social partners agreed to temporarily prevent health workers from working in multiple hospital institutions during the lockdown period (from March to June 2020) for health and safety reasons. This aimed to reduce the risk of spreading the disease and to protect workers' and patients' safety. Despite trade unions' support of the measure, its implementation proved difficult. Workers and employers were reluctant to implement the measure, as most of the health workers in the country combine jobs because of the low wages and staff shortages. In **Croatia**, trade unions in the hospital sector influenced government decisions on the acquisition of protective equipment and the application of organisational measures aiming to reduce infection rates among health professionals (such as the postponement of non-urgent medical treatments; the application of telemedicine solutions, when feasible; and the distribution of work shifts).

Malta and Italy provide examples of social partner interventions in the adoption of health and safety measures with a wider scope. In **Malta**, the sectoral union organisations the Medical Association of Malta (MAM) and the Malta Union for Midwives and Nurses

(MUMN), acting through social dialogue institutions and threatening industrial action, were pivotal for the government's adoption of more restrictive measures, such as a ban on mass events and quarantine measures, which aimed to avoid the collapse of the public health system and the depletion of the health workforce. In **Italy**, as mentioned in the discussion of staffing, the main sectoral union organisations in the health sector (CGIL, CISL and UIL) called on 13 November 2020 for a national strike, amid continuing COVID-19-related restrictions, to raise awareness of several interrelated issues, one of which was the need to guarantee adequate protective equipment for healthcare workers.

Working time developments

Measures to address working time issues in the hospital sector were reported in five countries (Croatia, Cyprus, Finland, Norway and Sweden). These measures entailed negotiation and agreement on various topics, including the following:

- compensation for overtime or on-call work
- increased working time flexibility
- increasing workers' availability through derogation from existing regulations during the pandemic

These issues have been the subject of agreements between the social partners, particularly in the Nordic countries (Finland, Norway and Sweden), but also in Croatia and Cyprus.

In **Cyprus**, the General Nursing Staff of the Pancyprian Public Servants' Trade Union (GNP/PASYDY) and the Ministry of Health reached an ad hoc agreement on a leave period for nurses during the summer of 2021, after nearly three years during which they were not allowed to take statutory annual leave (to ensure the continuity of health service provision). The agreement provided increased overtime pay to compensate the nurses taking additional shifts to cover those on leave. This decision was adopted in the midst of the pandemic due to fears that nurses would start taking sick leave to make up for the absence of rest days. A similar agreement on compensation for overtime work was concluded in **Croatia**. There, however, negotiations on the issue were already in progress before the pandemic. Since 2017, trade unions had been demanding that overtime rates should consider other factors related to job responsibilities and specific working conditions. The agreed solution formed a draft bill that the government submitted to the parliament in June 2021.

In **Finland**, working time issues have been present in regular collective bargaining rounds at sector and company levels, which had met union demands prior to the pandemic. For example, the sectoral collective agreement agreed to remove the *kiky* hours (unpaid overtime) that the tripartite Competitiveness Pact had

introduced in 2016. Meanwhile, different forms of compensation for additional working time availability and flexibility were agreed at hospital level.

In **Norway**, the social partners quickly reacted to the lockdown decree and agreed on the need for increased working time flexibility in hospitals. The Working Environment Act allows trade unions to enter into negotiations on derogations from working time regulations. The agreement derogates from the statutory notice period of 14 days to introduce a new working plan and lays down a minimum notice period of three days, if deemed necessary to respond to service demand. As regards the calculation of working time, employers have the right to make changes within the statutory regulations without prior agreement from local trade union representatives, although consultation is required prior to the decision. The social partners also agreed to a general increase in overtime pay of 50%.

In **Sweden**, the social partners agreed on similar changes to those agreed in Norway concerning compensation for overtime and increased working time flexibility requirements in the framework of a crisis agreement in force since 2019. The agreement was adopted in the aftermath of the 2018 forest fires and responded to the need to provide more flexible rules on working time regulation for managing emergency situations. The agreement was renewed in June 2021, and nearly all trade unions representing employees in the local public sector signed it. Ten Swedish regions applied this agreement's provisions to alleviate staff shortages in hospitals. The agreement provides for crisis compensation of 130% of the regular monthly salary and compensation of 180% in the case of overtime. The agreement also sets a new limit for the maximum duration for which extraordinary measures extending and distributing working time can be applied to an individual worker.

Surge capacity

Social partner involvement in measures to provide additional funding and investments in equipment and hospital infrastructure was reported in a few countries (Estonia, Germany and Latvia), and mostly in connection with legislative developments on the mobilisation of additional financial and human resources. In **Estonia**, the government decided to allocate additional resources from state budgets to hospitals in April 2020 in response to demands from the social partners, who were satisfied with the government's quick response. These funds were to be used to increase intensive care capacity (through extra equipment and protective measures) and also covered additional compensation for doctors and nurses during the pandemic, mostly benefiting public sector institutions.

In **Latvia**, social dialogue on financing issues was a regular practice before the pandemic, although it was mostly concerned with pay issues. Shortly before the pandemic, the government agreed to increase wages in response to long-running trade union protests. The COVID-19 outbreak drew attention to urgent issues such as the need for rapid restructuring of hospital services and for additional resources for increased investment and overtime compensation. The government decided on a supplementary pay package for frontline hospital workers, but the largest financial input was expected to come from the country's resilience and recovery plan, which did not fully incorporate the social partners' proposals for increased investment in hiring new staff.

In **Germany**, the social partners played an advisory role in a new Hospital Future Act, passed in June 2020. The act provides additional financial support for hospitals, including reimbursement for decreases in revenue and pandemic-related costs, and new investment for the development of better digital infrastructure (patient portals and digitalisation of documentation). The United Services Trade Union (ver.di) greeted this initiative with enthusiasm, as it has long fought against the lack of adequate financing and the understaffing of hospital facilities and argued in favour of digital innovations that can help to reduce workloads and increase efficiency.

Social partners' views

The developments described above suggest that the bargaining power of hospital workers and sector-related union organisations has considerably increased as a consequence of the pandemic. Overall, the hospital sector and its workers have been essential in dealing with the COVID-19 outbreak. The increase in demand for health services put national health systems under stress and brought to light many critical issues in workforce management and working conditions in the health sector that were present prior to the pandemic, such as low wages and staff shortages. The pandemic has raised the visibility and legitimacy of trade union agendas, which has been reflected in the conclusion of various agreements meeting unions' demands to some extent. These include general pay increases agreed in regular bargaining rounds or granted through legislation, which may have an influence on future wage developments in the sector.

Nevertheless, these achievements do not erase aspects on which the social partners have dissented. In some countries, the main points of disagreement are pay issues and the adoption of mandatory vaccination programmes for health workers (for example, in Austria and Greece). Other issues related to staffing, additional resources, management and compensation of working time flexibility do not raise similar concerns, although the agreed solutions have often fallen short of trade unions' initial demands.

Regarding pay, the social partners (mainly the trade unions) criticised the implementation of COVID-19-related bonuses and the potential discrimination resulting from differences in coverage across the public and private parts of the sector and for different types of workers. This was particularly the case when the bonuses were not specifically agreed with the social partners.

In **Austria**, the Association of Private Health Institutions complained that there was no objective reason to exclude employees in private for-profit hospitals from bonuses, as several of these facilities were directly involved in the treatment of COVID-19 patients and relieved public hospitals from additional pressure. For their part, trade unions representing employees in both the public and private parts of the sector rejected the exclusion of certain occupational groups, such as cleaners, ambulance staff and psychosocial care staff. In **Croatia**, trade unions claimed, in negotiations with the government, that all employees in public hospitals should be eligible for the COVID-19 supplement, but the final decision restricted it to frontline workers exposed to contagion risks.

In **France**, the government's initial decision to award a bonus was intended as an alternative to a general re-evaluation of salaries in the sector, but protests from trade unions urged the government to arrange negotiations on basic pay increases in public and private hospitals and to revise pay for certain occupations. The Ségur de la Santé agreement provided monthly pay increases of around €183 for a wide range of medical and non-medical staff in the health sector. However, unions point out that there are many non-health occupations in the homecare and social care sectors that are still excluded from the general revaluation of salaries. These occupations include psychologists, social workers, specialised educators, home assistants, cleaners and night security guards in specialised institutions.

Overall, trade unions show a clear preference for statutory pay increases as the main strategy for compensating workers, as one that ensures equal treatment. In several countries where the unilateral decision of the government has awarded bonuses, trade unions have pointed to problems due to the final responsibility for payment being left in the hands of hospital management. In **Czechia**, unions indicated that many workers have seen payments delayed or unpaid because some health providers have used the funds for other purposes, such as overtime compensation or to cover other costs. In **Slovenia**, unions criticised the distribution of crisis bonuses in public hospitals, claiming it increased inequalities among employees in similar jobs and facing similarly hazardous working conditions. In **Hungary**, unions complained that leaving the payment of COVID-19 bonuses to the discretion of the management of individual hospitals resulted in the exclusion of large groups of workers, mostly nurses.

In **Ireland**, trade union proposals for rewarding frontline work during the pandemic considered larger groups of potential recipients than the government was willing to accept, such as clerical staff in hospitals, who are represented by the same unions.

Trade unions representing specific groups of the health workforce, particularly those at the lower end of the wage scale, express different views. This can be interpreted as a reflection of the fragmentation of the industrial relations landscape in the sector in many EU Member States. In light of these developments, the current stress on the health system has provided a new impetus for those health workers with comparatively poor working conditions to demand better wages.

In **Finland**, pay negotiations have caused tensions with trade unions representing nurses (the Union of Health and Social Care Professionals (Tehy) and the Finnish Union of Practical Nurses (SuPer)). These unions argued for higher pay increases than those agreed in the export sector (which traditionally sets the pace for the rest of the economy) during bargaining rounds for the renewal of sectoral collective agreements and the establishment of a COVID-19 bonus on a national scale. Instead, the decision regarding financial compensation for health workers' extra efforts during the pandemic was left to local bargaining, where there are wider differences in the bonuses for doctors and nurses, which tends to be perceived as unfair. These developments indicate that conflict may be likely during the next rounds of collective bargaining.

In **Poland**, negotiations defining basic pay schemes for health professions in tripartite social dialogue also resulted in tensions between unions representing nurses and midwives (the National Union of Nurses and Midwives (OZZPiP)) and paramedics (the National Trade Union of Paramedics (OZZRM)), which argued for higher basic pay rates (equivalent to 1.5 times the average wage) in opposition to the main national union confederation (the All-Poland Alliance of Trade Unions (OPZZ)). The OPZZ agreed with the government's proposal, arguing that the scheme would enable the reduction of the differentials between all professional groups. Both the nurses and the paramedics led protests and demonstrations from the end of 2020, resulting in a nationwide protest on 1 September 2021 involving all health workers, calling for better wages and working conditions in the sector. In Estonia, the Estonian Nurses Union (ENA), representing nurses, has refused to sign a sectoral collective agreement, despite years of being a signatory, and has made direct proposals to the government with the aim of reaching a separate agreement covering wages and workloads for nurses.

In **the Netherlands**, bargaining rounds for the renewal of the collective bargaining agreement in academic hospitals have also shown the different approaches to pay issues of trade unions representing different groups. Employers' initial proposals envisaged higher

pay increases for nurses, as they are the lowest-paid group of workers. The union representing nurses in the sector (NU'91) approved of the offer, but the other union organisations representing a wide range of hospital workers (the Federation of Dutch Trade Unions (FNV) and the Christian National Trade Union Federation (CNV)), from medical assistants to managers and receptionists, opposed it, arguing for an overall increase in wages and reduction in wage differentials.

Outcomes

This section examines the initiatives in terms of their outcomes from two perspectives. The first concerns the social dialogue and collective bargaining processes (that is, the procedural perspective). The second concerns the efficacy of the solutions adopted (that is, the substantive perspective).

Procedural perspective

The procedural perspective assesses whether the management of the COVID-19 crisis through social dialogue and collective bargaining institutions was significantly different from the way processes were previously conducted in the hospital sector. More generally, it investigates the national industrial relations landscape. It considers how social dialogue and collective bargaining in the sector have improved or deteriorated compared to the period prior to the COVID-19 pandemic and considers the overall situation in each country.

A tentative conclusion is that the need to tackle the emergency enhanced the role of sector-related social dialogue and collective bargaining institutions in many countries. The need to quickly mobilise the health workforce and adapt working conditions to new requirements was initially undertaken through emergency legislation. However, sustaining these efforts has required the involvement of the social partners.

In some cases, national governments sought the involvement of the social partners in making decisions on staffing and providing additional resources to hospitals. Although the continued involvement of the social partners remains an open question, these developments could make a substantial difference, given past experiences of health reforms in the context of austerity measures. Overall, examples of initiatives involving the social partners can be found in most Member States, with patterns varying according to the different industrial relations systems and traditions (see Table 3).

Cross-country differences in industrial relations patterns have been analysed through typologies based on theories of national production and employment regimes (Visser, 2009) and typologies exploring cross-country diversity in terms of industrial democracy. These have been elaborated through a

combination of ‘normative’ indicators (such as degree of information provided to employee representatives) and ‘contextual’ indicators (such as state intervention in collective bargaining) (Eurofound, 2018; Sanz de Miguel et al, 2020). These typologies have explored differences and similarities across selected sectors and countries in terms of the characteristics of industrial relations actors (such as organisational density, membership density and fragmentation) and processes (such as collective bargaining coverage) (Eurofound, 2011; Bechter et al, 2012).

These approaches have shown that in sectors that are characterised by transnational transferability of production or by EU regulations, or by both, industrial relations can vary more by sector than by country. The hospital sector is less exposed to international competition than other sectors, and the relevance of public institutions in the funding, regulation and provision of healthcare services places it among the sectors that are most dissimilar across countries. This means that national industrial relations configurations are more relevant than sectoral specificities.

Table 3 summarises the main developments in social dialogue and collective bargaining in the hospital sector during the COVID-19 pandemic across countries categorised into industrial democracy clusters (Eurofound, 2018; Sanz de Miguel et al, 2020). In the clusters where ‘associational governance’ is strongest (organised corporatism and social partnership), social dialogue and collective bargaining played an important role in addressing sectoral challenges in this period. In these cases, the pandemic has not led to any profound transformations of sectoral collective bargaining institutions.

In the remaining clusters, different developments are observed that reflect higher internal diversity. In some cases, new patterns are evident in the role of sectoral social dialogue and collective bargaining compared with their role before the pandemic and in the general evolution of tripartite social dialogue during the pandemic. In several countries classified in the last three clusters – company-centred governance, voluntarist associational governance and market-oriented governance – the evolution of social dialogue seems more contingent on the direction of government interventions.

Table 3: Summary of major developments in social dialogue and collective bargaining in the hospital sector during the COVID-19 pandemic in different industrial democracy clusters

Industrial democracy cluster	Countries	Main developments
Organised corporatism	Denmark, Finland, Germany, Norway,* Sweden	Social dialogue and collective bargaining institutions provided an adequate framework for workforce governance in a crisis.
Social partnership	Austria, Belgium, Luxembourg, Netherlands	No major changes took place in an already highly institutionalised setting, and positive outcomes were reported in terms of additional investments and improved wages.
State-centred associational governance	France, Italy, Portugal, Slovenia, Spain	Developments differed across the countries most affected by the impact of austerity policies pursued during the 2008–2012 economic crisis, with significant outcomes in France and Italy.
Company-centred governance	Croatia, Hungary, Slovakia	Developments differed across countries. In Slovakia, social dialogue in the health sector considerably improved during the pandemic. In Hungary, trade unions faced unilateral government intervention. In Croatia, collective bargaining and social dialogue did not change significantly during the pandemic.
Voluntarist associational governance	Bulgaria, Cyprus, Czechia, Greece, Ireland, Latvia, Lithuania, Malta, Romania	Developments differed across the countries, with the most extensive government interventions in a context of generally weak institutionalisation. In some countries (Cyprus, Ireland and Malta), there was a general intensification of social dialogue in parallel with increased tensions between the social partners.
Market-oriented governance	Estonia, Poland	Developments differed and contrasting trends were apparent. In Estonia, sector-level agreements and social dialogue played an important role in tackling the pandemic. In Poland, there were conflicts and a lack of social dialogue.

* Norway was not included in the typology of Eurofound (2018).

Source: Network of Eurofound Correspondents, authors’ analysis

Organised corporatism cluster: Social dialogue and collective bargaining institutions in the hospital sector played a prominent role in this cluster, which encompasses the Nordic countries and Germany. In all cases, these were well-established institutions that showed they had the capacity to adapt to the management of the health crisis. In Denmark, the agreements on extraordinary measures that enabled the reallocation of responsibilities and staff transfers across hospital facilities were crucial in solving staffing needs during the pandemic. In Germany, the government involved the social partners in designing the investment plan for modernising and digitalising hospitals. Finland and Sweden resorted to emergency legislation and existing ‘crisis agreements’, allowing increased flexibility in hospital work through exemptions from overtime and rest time regulations. Notably, the agreements on these extraordinary measures did not prevent conflicts in connection with the development of collective bargaining on wages, workload and understaffing – issues that were present before the pandemic.

Social partnership cluster: In the countries of this cluster – Austria, Belgium, Luxembourg and the Netherlands – no major changes were reported regarding the formal development of collective bargaining and social dialogue during the pandemic compared with before the pandemic. In most of these countries, social dialogue practices are highly institutionalised. Governments sought the social partners’ involvement on issues such as the implementation of COVID-19 bonuses (Austria, Belgium and the Netherlands) and the decision on compulsory vaccination of health workers (Austria). The pandemic has raised public awareness of long-standing issues in the sector and has placed additional pressure on public authorities to meet trade union demands for better wages in regular collective bargaining rounds. For instance, in Belgium, union campaigns secured an additional €1 billion in funding from the federal government to improve the pay and working conditions of health workers and to recruit additional staff to ensure better staff-to-patient ratios (see EPSU (2020a) for more information).

State-centred associational governance cluster: The pandemic has had different impacts in the countries of this cluster (France, Italy, Portugal, Slovenia and Spain). In Portugal and Spain, the COVID-19 outbreak took place in the context of stagnating social dialogue and collective bargaining, which was partly a consequence of previous austerity measures.

In Portugal, social dialogue was also restricted in the context of the state of emergency, and the government has shown reluctance to accept unions’ proposals for improving wages and working conditions in regular collective bargaining rounds. Union demands included not only adequate compensation of employees for

mandatory extensions of overtime during the emergency period but also the strengthening of the Portuguese National Health Service’s workforce capacity in light of the increasing numbers of professionals opting to work in the private sector or leave the country.

In Spain, social dialogue in the health sector has been rather limited compared with the role played by social partners in the response to labour market and economic challenges posed by the pandemic. Trade unions have criticised their exclusion from any of the decision-making taken at national and regional levels. This has been reflected in strikes and protests in Madrid, Andalusia and Catalonia, which focused on the worsening of working conditions in the sector since the 2008 financial crisis, with high levels of employment insecurity, high work intensity and inadequate pay.

Reports from Italy and France, countries where austerity measures did not as directly affect the health systems, were significantly different. In Italy, social dialogue institutions provided a good institutional setting for the reorganisation of the healthcare system beyond the emergency measures the government adopted following the COVID-19 outbreak. This is reflected in the renewal of the national collective agreement in the private health sector in October 2020 after 14 years of stalemate. The private health employer organisations finally ratified an agreement after three years of negotiations and a national strike, along with pressure from the health minister and regional authorities. In France, social dialogue in the health sector has substantially improved from before the pandemic, mostly due to the agreement of the *Ségur de la Santé* package for the public hospital sector. It is argued that the escalation of collective mobilisations and strike activity since 2019, along with the need to tackle the unprecedented challenges posed by the pandemic, were the main reasons the government sought a broad agreement for increased funding for health and social care.

Company-centred governance cluster: Trends in the countries included in this cluster – Croatia, Hungary and Slovakia – differ. In Croatia, collective bargaining and industrial relations did not change significantly during the pandemic. In Slovakia, social dialogue in the health sector has performed better than tripartite social dialogue at national level: wage improvements agreed in the initial stages of the pandemic were extended until the end of 2021.

By contrast, trade unions in Hungary have been confronted by government plans that substantially alter the regulation of employment relations in the sector. Emergency legislation allowed the Hungarian government to bypass parliamentary debates and further weaken social dialogue institutions in the sector. The government passed a bill on new public medical service contracts in October 2020 that fundamentally

changed employment relationships in state-owned hospitals. The new law includes substantial increases in the statutory wages of doctors, but requires them to sign a new public service medical contract that binds them to more restrictive conditions: doctors cannot take second jobs in the private sector, and they can be relocated anywhere in the country at short notice and for longer periods.

More importantly, last-minute amendments to the new regulation by the government included a ban on collective bargaining and limited the right to strike. Subsequently, in November 2020, the government declared the existing sectoral collective agreement in the hospital sector null and void. This move was part of a more general strategy initiated in 2018 aiming to gradually exclude public service employees from coverage by laws that provide better working conditions than the Labour Code. Although most health professionals have signed these new contracts, trade unions have joined ranks in a new Action Alliance for Health (including the National Federation of Workers' Councils (MOSZ), FESZ and the Free Trade Union of Healthcare Workers (EDSZSZ)) and have turned to the Constitutional Court and international institutions, alleging a breach of collective bargaining rights and the right to strike, as established in the International Labour Organization principles and the European Social Charter.

Voluntarist associational governance cluster: Trends are similarly mixed in the countries of this cluster: Bulgaria, Cyprus, Czechia, Greece, Ireland, Latvia, Lithuania, Malta and Romania. In some, social dialogue in the health sector improved considerably during the pandemic in terms of its intensity or outcomes for working conditions (Bulgaria, Czechia, Ireland and Latvia). In Bulgaria and Ireland, social dialogue in the sector performed better than tripartite social dialogue at national level, which has been affected by ongoing political crises and changes in government. In Ireland, the pandemic led to unprecedented collaboration between the state and different stakeholders, such as 'voluntary' public hospitals run by private bodies, enabling a faster, adaptive and more cooperative approach to work organisation and redeploying staff. Social dialogue with health service unions also played a key role in managing COVID-19-related disputes, with an agreement on moderate pay increases totalling 3% in a new public sector pay agreement for the period 2021–2023 and the deferral of any industrial action until the health emergency ends.

By contrast, in Romania and Lithuania, the social partners feel that they have not been properly consulted or have been excluded from decision-making processes owing to emergency legislation allowing the unilateral intervention of governments. In Lithuania, changes in government representatives and in their attitudes towards collective bargaining in the sector

have challenged industrial relations. In bargaining rounds for the renewal of the sectoral collective agreement for 2022–2024, the government's representatives proposed removing the minimum wage provisions and replacing them with a new basic pay rate, which the government would set in accordance with budgetary possibilities. This means that there would be no obligation to index link the salaries of medical staff nor to allocate funds for this purpose concurrent with increases in the minimum wage. In addition, the government's intention to limit collective agreement coverage to trade union members only and place new restrictions on information rights compromise unions' abilities to represent workers. Similarly, sectoral social dialogue in Romania has been of a merely informative nature, and the government has made decisions without any consultation with the social partners.

In Greece, the government's executive response to the pandemic was to issue emergency legislation, bypassing all forms of social partner involvement through social dialogue and collective bargaining institutions. The Greek healthcare system was one of the areas of the public sector most severely affected by the budgetary cuts made by different governments under the terms of the 2010 memorandum of understanding with the European Commission, the European Central Bank and the International Monetary Fund. Collective bargaining institutions have traditionally had a very limited scope for regulating working conditions in the public sector, where they are mostly established by law.

In Cyprus and Malta, the increased social partner interactions have often resulted in new tensions and conflicts between the government and trade unions, and between different trade unions within the same sector. In Cyprus, this situation has led the State Health Services Organisation (OKYpY) to establish specific committees to solve different labour issues in the operation of hospitals, always under pressure from trade unions and in the absence of effective collective bargaining.

Market-oriented governance cluster: Estonia and Poland, the two countries in this cluster, show contrasting trends. In Estonia, sectoral industrial relations patterns differ from national traditions. The health sector is one of only two sectors in which sector-level agreements and social dialogue played an important role in tackling the pandemic (the other is the transport sector). In Poland, sectoral developments are more aligned with national industrial relations patterns. There, a set of legislative packages, known as the Anti-Crisis Shield, were enacted following the COVID-19 outbreak, without any consultation with the social partners. Although most of the measures aimed to secure hospitals' staff capacity, trade unions criticised the solutions imposed by the government and warned

that these might be counter-productive, leading workers to leave their jobs because of increased workload. Social dialogue was resumed in the autumn of 2020, resulting in increased tension with the government that led to nationwide protests and calls for strikes in 2021 – in particular from nurses and paramedics, who demanded better wages, adequate staffing levels and increased resources for the health system.

Substantive results

Regarding the substantive outcomes of the initiatives reported in the national contributions, a distinction is made between the outcomes of measures addressing short-term challenges of managing the COVID-19 pandemic and those resulting from initiatives with a more strategic approach, tackling long-term issues in the sector. Most solutions agreed in the hospital sector address long-standing issues that have become more visible in the context of the pandemic, such as the understaffing of hospital facilities and the worsening of working conditions, which has intensified the sector's difficulty in attracting and retaining employees and its

increased dependence on foreign-trained workers. The analysis of substantive outcomes is restricted by the fact that most of the measures that the national reports cover were being implemented at the time of data collection and in some cases are still under negotiation.

Measures agreed in collective bargaining rounds can be assumed to have more long-term effects than those tackling issues emerging from the pandemic. Agreements on pay increases, overtime remuneration and staffing levels in hospitals reflect a shared commitment from the social partners and therefore are more difficult to reverse in the future. However, whether these achievements will translate into sustainable developments is contingent on the fiscal strategies adopted in the aftermath of the health crisis. In this regard, EPSU has warned of recent attempts to return to 'coordinated austerity', as the recent European Commission statement on the budgets of some Member States potentially indicates. Countries such as Belgium and France have significantly increased pay for health workers, but the European Commission argues that these proposals will result in higher public debts (see EPSU (2020b) for more information).

3 | Conclusions

The COVID-19 pandemic challenged healthcare systems to an unprecedented degree and highlighted existing disparities in health workforces across Europe. Despite these disparities, studies on policy responses to the pandemic have not identified distinct patterns in relation to the funding, provision and workforce governance of national health systems (Bureau et al, 2021). This is mostly due to the exceptional nature of the pandemic, which required the implementation of similar emergency measures across countries. The impact on the hospital sector, on the frontline of the fight against COVID-19, was particularly intense. All countries had to quickly scale up hospital capacity to meet the growing demand for healthcare.

This report has analysed the extent to which the national-level social partners participated, through social dialogue or collective bargaining, in the development and implementation of measures to deal with the challenges created by the pandemic in the hospital sector. Because the hospital sector differs substantially across countries, the discussion of the findings was framed in terms of the typology of national industrial democracy configurations developed by Eurofound: organised corporatism, social partnership, state-centred associational governance, company-centred governance, voluntarist associational governance and market-oriented governance.

The research findings show relevant cross-country differences. Social dialogue and collective bargaining played a prominent role in addressing some of the challenges posed by the pandemic in countries with well-established social dialogue institutions and a long-standing tradition of cooperation between social partners. This is the case in the countries belonging to the organised corporatism (Denmark, Finland, Germany, Norway and Sweden) and social partnership (Austria, Belgium, Luxembourg and the Netherlands) industrial democracy clusters.

Within the organised corporatism cluster, existing institutions in the Nordic countries provided a framework for the social partners' involvement and for the negotiation of the changes to work organisation required to tackle the emergency situation. In Germany, in the same cluster, and Belgium, in the social partnership cluster, the positive role of social dialogue was reflected in the agreement on pay increases in regular collective bargaining rounds and the allocation of additional funding and resources to hospitals.

Some significant developments took place in countries where the governance of collective bargaining is more contingent on state intervention, such as those countries that are part of the state-centred associational governance cluster (France, Italy and Slovenia). For example, in Italy, the renewal of the private sector national collective agreement took place after a long period of stagnated collective bargaining. Meanwhile, in France, a major social dialogue process was launched by a government initiative after a period of intense strike activity and provided general pay increases in the healthcare and social care sectors.

Similar developments took place in countries where regulation resting on social dialogue and collective bargaining is, in general, comparatively less developed, such as Bulgaria, Cyprus, Czechia and Malta (in the voluntary company-based governance cluster) and Estonia (in the market-oriented governance cluster).

By contrast, reports from other countries pointed to the limited role of the social partners in managing the pandemic response. This is notably the case in the countries most affected by the implementation of austerity measures in the health sector in the aftermath of the 2007–2008 financial crisis – namely Greece, Portugal and Spain – where healthcare systems had not fully recovered from the staff cuts and pay freezes. The governments of these countries opted to enact legislation to deal with the COVID-19 pandemic without seeking the involvement of the social partners. Hungary and Lithuania were also highlighted, where government interventions dampened the role of social dialogue and collective bargaining in the sector.

This report has also explored the extent to which existing social dialogue and collective bargaining processes in the hospital sector had to adapt or change to address the challenges that arose from the pandemic. Results from the analysis of the national contributions align with previous research showing that the involvement of the social partners was more pronounced regarding issues traditionally dealt with through collective bargaining and social dialogue institutions, such as the regulation of employment, pay issues and working time. In fact, most of the examples of issues covered in formal negotiations and agreements between the social partners relate to pay developments, either ad hoc pandemic-related compensation (such as bonus payments) or wage increases in regular collective bargaining rounds.

However, there is also evidence of social partner involvement in topics beyond traditional employment issues. In this regard, the findings show that the need to secure workforce capacity in hospitals often required the involvement of social partners in agreements to adapt work organisation practices, reallocate staff and implement other measures related to the protection of staff's health and safety. In a few cases, the social partners were also involved in initiatives dealing with new investments in staffing or technologies. Although generally limited to information and consultation procedures, implementing these measures required cooperation between the social partners, resulting in increased interactions at different levels (local, regional and national).

Finally, there are problems raised or exacerbated by the pandemic for which social partners could not find joint solutions or that were only partially addressed. There is, for example, the problem of wage disparities between occupations and groups of workers within the hospitals' workforce. Wage disparities have long existed in the health sector, but the pandemic exacerbated them. In this regard, the research has shown that, in many cases, the distribution of COVID-19-related bonuses resulted in the exclusion of certain groups of workers. This reinforced existing wage inequalities between medical and non-medical staff in ancillary occupations but also among medical staff, depending on the eligibility criteria and their implementation by public authorities. In practice, there were significant differences in the coverage of these payments and in the amounts paid to workers across regions and across the public and private parts of the sector (see EPSU, 2022).

Reports from regular collective bargaining rounds in various countries (such as Estonia, Finland and Poland) show tensions arising from calls for increased wages and professional recognition from unions representing medical staff with lower wages. In Finland, nurses' trade unions requested pay increases above the national average and the inclusion of bonuses in the collective agreement, but these demands were not met.

In Estonia, tensions regarding wage increases led the nurses' unions to not sign the renewal of the sectoral agreement in 2021, despite being part of it for years. In Poland, nurses' and midwives' unions protested against the government's proposal to amend the method of determining basic wages for certain occupational groups employed in healthcare facilities, while the national union confederation supported this proposal.

The pandemic has exacerbated existing staff shortages and will probably lead to increased international competition for the recruitment of health workers, particularly nurses (Buchan et al, 2021a). It may also have an impact on staff retention, as there is growing evidence of burnout symptoms due to high stress levels and workloads, often associated with intentions to leave the sector. Evidence from previous economic recessions suggests that countries that fail to meet workers' and unions' demands for better wages or adequate staffing levels are more likely to be faced with a 'brain drain' of medical staff owing to increased exit options and the search for better opportunities in the private sector or abroad (Russo et al, 2021).

The extent to which these challenges can be successfully addressed through social dialogue and collective bargaining is not solely determined by the industrial relations context and actors. Future social dialogue and collective bargaining outcomes will also be contingent on the fiscal policies adopted after the crisis. These are expected to constrain chances of agreement, as shown by the difficulties in developing social dialogue initiatives in the southern European countries most affected by the consequences of austerity.

The evidence collected confirms that, where social dialogue and collective bargaining have played a prominent role in addressing the challenges experienced by the hospital sector during the COVID-19 pandemic, the responses have been stronger and quicker. This suggests that a strong hospital sector, which will increase the EU's preparedness for potential future health crises, relies on healthy, functioning social dialogue and collective bargaining.

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Annexes

Annex 1: Questionnaire for data collection

Topical update on social dialogue and collective bargaining in hospitals during the Covid-19 pandemic

1. What was the role of social dialogue and/or collective bargaining in the changes that have been introduced in your country to tackle the challenges faced by hospitals as a result of the pandemic?

1.1. Please provide up to three relevant examples of formal or informal social dialogue practices in the hospital sector in your country since the onset of the pandemic (March 2020). For each example, make sure to include the elements listed in the table below. Repeat the table for each example.

Indicative length: 1,000 words

Note: the examples provided can cover a) social partners involvement or consultation on relevant national legislation/measures impacting the sector or b) agreements/measures resulting from collective bargaining or social dialogue. In case the social partners did not participate directly in changes implemented in the sector through legislation or other public measures, please report, if possible, on their reactions and views about such changes.

Example designation	
Type of Social dialogue practice <i>Specify whether these were formal or informal negotiations/collective bargaining agreements/policies or measures stemming from social dialogue processes/any other relevant initiatives</i>	
Describe the involvement of social partners and specify the setting of the consultation and/or negotiation processes <i>Explain if these were regular rounds of negotiation/consultation/an extraordinary initiative; a bipartite/tripartite initiative</i>	
Indicate the main issues or challenges being addressed with this initiative. <i>Consider the following areas: employment, pay, workload, work intensity, health and safety (including protective equipment), working time duration and organisation, etc.)</i>	
Type of issues/challenges <i>Please indicate if the agreed solutions tackle ongoing (existing before the pandemic) or emerging issues (created or made visible during the pandemic)?</i>	
Social partners positions <i>If possible, please describe the points of views brought to the table by the social partners.</i>	

1.2. Please assess, from your own expert perspective, the overall role of social dialogue in tackling the challenges determined by the pandemic in the hospital sector

Indicative length: 500 words

2. What kind of changes have been implemented and what are the outcomes?

For each of the initiatives provided in the answer to question 1, please describe the changes introduced according to the elements indicated in the table below. Repeat the table for each initiative.

Indicative total length: 1,000 words

Example designation	
<i>Please describe the concrete change(s) introduced and areas affected: pay, health and safety, working time duration and organisation, volume of demand and/or operations, levels of employment, training, etc?</i>	
<i>Are the changes temporary (please indicate validity period) or permanent? Is the solution found a short-term or immediate fix, or does it have a long-term perspective (i.e. looking into the future of the sector)?</i>	
(Expected) Outcomes <i>What are the (expected) outcomes of these changes for the workers, the organisations they work for and the quality of services in hospitals in the post-pandemic future in your country? Please consider the implications for the private and public parts of the sector.</i>	
Groups of workers affected <i>Please explain how these changes are affecting the different groups of workers in the sector (for instance, health professionals – doctors, nurses, medical assistants -, clerical workers – managers, clerks, receptionists – or other workers – such as cleaners and helpers, janitors, maintenance workers, food service workers, etc.), as well as the different parts of the sector (public or private).</i>	

3. Have social dialogue and/or collective bargaining practices changed in the hospital sector in order to address the challenges caused by the Covid-19 pandemic in your country?

Please describe to what extent and how have the social dialogue and collective bargaining practices changed in the hospital sector, indicating, for example, if the relationship between social partners (and public authorities) has improved or deteriorated during the pandemic, if the intensity or frequency of interactions (formal or informal) between social partners increased-decreased, etc.

Indicative length: 500 words

References

Annex 2: Network of Eurofound Correspondents

Below is a list of the correspondents who contributed to the study.

Country	Contributor	Organisation
Austria	Georg Adam	Forschungs- und Beratungsstelle Arbeitswelt (FORBA)
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Croatia	Predrag Bejaković and Irena Klemenčić	Institute of Public Finance
Cyprus	Alexandros Perdikes	Cyprus Labour Institute
Czechia	Soňa Veverková	Research Institute for Labour and Social Affairs
Denmark	Mikkel Krogh	Employment Relations Research Centre, University of Copenhagen
Estonia	Ingel Kadarik	Praxis Center for Policy Studies
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France	Frédéric Turlan	IR Share
Germany	Axel Hauser-Ditz and Marc Breitenbroich	Institute of Economic and Social Research, Hans Böckler Foundation, German Economic Institute
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This report analyses the role of social dialogue and collective bargaining in addressing the challenges created or exacerbated by the COVID-19 pandemic in the hospital sector. It also explores whether existing social dialogue and collective bargaining processes at national level were adapted in order to address these new challenges. The research included a literature review to contextualise the structural features of the hospital sector and an analysis of policy initiatives to manage the crisis implemented across the EU27 and Norway.

The findings indicate that the level and nature of the social partners' involvement in pandemic responses varied across Europe. Social dialogue and collective bargaining played a prominent role in some countries, while in others the social partners were less involved. Although no substantial changes were identified in social dialogue institutions and processes, the breadth of issues they deal with expanded beyond the traditional areas of employment and working conditions.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

