STRENGTHENING SOCIAL DIALOGUE in the

Hospital Sector in the Baltic Countries

GHK

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FINAL REPORT

A report submitted by GHK

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CONTENTS

01

INTRODUCTION

This document is the draft final report of a project on "Strengthening Social Dialogue in the Hospital Sector in the Baltic Countries". The project was run by HOSPEEM, supported by EPSU and co-funded by the European Commission.

1.1 Aims and objectives of the project

The goal of the project was to improve the dissemination of the priorities and outcomes of the European sectoral social dialogue in the hospital sector in the Baltic countries, to help share good practice on some of the core priority actions of the sectoral dialogue between EPSU and HOSPEEM, to help build the capacity of the hospital sector social partners in the Baltic countries and to assist in feeding national social dialogue interests from the "bottom up".

Dissemination specifically focused on the framework agreement reached at sectoral level in 2009 on sharps injuries (which subsequently became Directive 2010/32.EC). Good practice sharing related to the priorities of the work programme agreed by EPSU and HOSPEEM for 2010 and in particular recruitment and retention and skills development of health care sector workers. Capacity building was provided for social partner organisations in Latvia, Lithuania and Estonia to help them develop their national sectoral dialogue in order to allow them to feed their own priorities, concerns and good practices to the European level, as well as enabling them to implement European level agreements at home.

The project also aimed to build on the activities and findings of a previous project completed in 2008 by GHK in which focussed on strengthening social dialogue in the hospital sector in all new Member States. This project involved the identification of relevant social partner organisations and social dialogue processes in all EU countries, as well as providing capacity building to social partner organisations in the Czech Republic and Slovakia[1].

1 For more information and the report from the previous project see http://www.epsu.org/a/3812

METHODOLOGY

This section sets out the main methodological approaches pursued in carrying out the project.

02

2.1 Capacity building

Employers organisations in the sector in Latvia and Lithuania have been members of HOSPEEM for a number of years and have actively participated in European social dialogue meetings, working groups and negotiations, whereas the sectoral employers organisation in Estonia has only recently decided to joint HOSPEEM. Trade unions in Lithuania, Latvia and Estonia have been members of EPSU for many years.

As a result, requirements for capacity building vary from organisation to organisation, depending on their level organisational development and current engagement with national and European social dialogue processes.

Capacity building took place during two seminars held in Vilnius on 15 February 2011 and in Tallinn on 30 March 2011. This primarily took the form of active information exchange on social dialogue structures in the Baltic countries as well as in the partner countries (Sweden, Finland, Denmark and Austria) attending the workshops. This was supplemented by good practice sharing regarding the key themes of recruitment and retention, skills development and the implementation of the sharps agreement at national level.

Emphasis was placed on identifying core strength and weaknesses in existing social dialogue processes and discussing ways in which social dialogue could contribute to meeting the current and important challenges facing the health care sector.

As part of the capacity building exercise, it was intended to work in national working groups to discuss priorities for social dialogue at this level and develop national work plans. However, because of the number and make-up of participants at the different seminar (insufficient numbers from various countries at different meetings), it did not prove possible to implement these small working group sessions.

Instead it was agreed to focus on drafting a common declaration to be signed at the closing conference on the key issues affecting the sector and addressed at stakeholders including the European Commission and Member State governments.

2.2 Survey research

Capacity building, as well as preparations for the closing conference, was further underpinned by a survey sent to all member organisations of EPSU and HOSPEEM. The survey covered questions on how social dialogue at national, regional and local level addresses issues of recruitment and retention, skills anticipation and skills development and the implementation of the sharps agreement. Regrettably only a total of 19 replies were received, which nonetheless yielded important information. The results of the survey are reflected in this report.

THE HEALTH CARE SECTOR AND SOCIAL DIALOGUE IN THE BALTIC COUNTRIES

03

3.1 Key characteristics of the health care sector in the European Union

The European health care sector plays a critical role in the achievement of the goals of the EU2020 strategy by contributing to the overall health and wellbeing of the workforce and society as a whole. In addition, the health and social care sector is also an important employer, whose significance is likely to grow in the context of demographic change. As a result, health care employers are not only affected by trends towards an ageing population in terms of the rising demands this places on service delivery, but also in the context of emerging labour market shortages resulting from declining birth rates.

Expenditure on health care is increasing overall in the EU as a result of ongoing advancements in medical science, making it possible to successfully treat and improve the prognoses for many conditions, which would previously have been unthinkable.

When looking at overall expenditure on health care services and the funding of health care it is important to remember that demand for health care is potentially open ended, particularly with advances in the development of medicines and medical technology. Therefore, a system of rationing has always been in place, be it through a "gatekeeper" system, financial restrictions, decision about the approval of drugs for widespread funding or indeed treatment decisions at the operational level.

These developments are taking place at a time, when health care funding systems are already coming under pressure from increasingly tight budgets, both for the

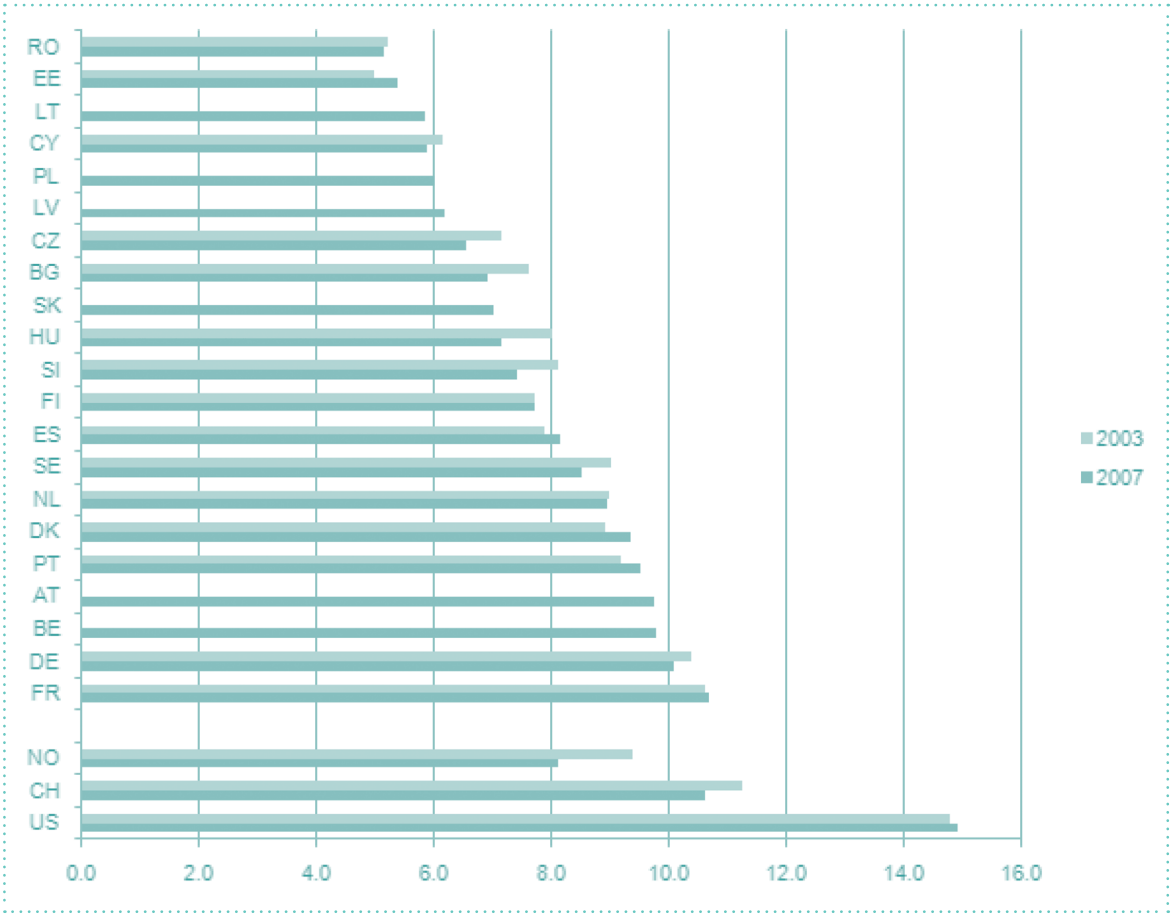
public purse and for household expenditure, particularly in the context of the economic crisis. This has affected the Baltic countries as well as many other Member States.

3.1.1 Expenditure on health care

According to the most recent Eurostat data, health care expenditure in Europe ranged between 5.1% of GDP in Romania and 10.7% in France. It is important to note that these figures pre-date the onset of the economic crisis. Since these figures were published in 2007, the situation has changed in a number of countries, and Latvia now has the lowest expenditure on health care in the EU as a share of GDP with around 3.9%. In 2008, health care expenditure as share of GDP was 4.6% in Estonia and 4.5% in Lithuania. At the same time, it was 4.7% in the EU12 and 6.9% in the EU overall, demonstrating the gap in expenditure between the Baltic countries and the EU average.

The most common method of funding health care in the EU is through a system of compulsory health insurance, usually funded through a system of employer and employee payroll contributions, which is often complemented by some funding from general taxation. This is also true from the Baltic countries. Only Denmark, Finland, Ireland, Malta, Portugal, Spain, Sweden and the UK have systems that are funded largely from general taxation (with some out of pocket payment for particular items and services). In almost all cases, the share of private involvement in the health care sector is increasing, for example through a reduction of services covered by health insurance funds, more out of pocket payments, and an increase in private insurance and hospital care provision. In Austria (28%), Bulgaria (45.5%), Hungary, Poland, Romania (all over 30%) and Spain (23%), as well as in the Baltic countries, private, out of pocket payments are playing an increasingly important role in health care expenditure (GHK, 2008).

FIGURE 3.1 Health care expenditure as a percentage of GDP, 2007 and 2003



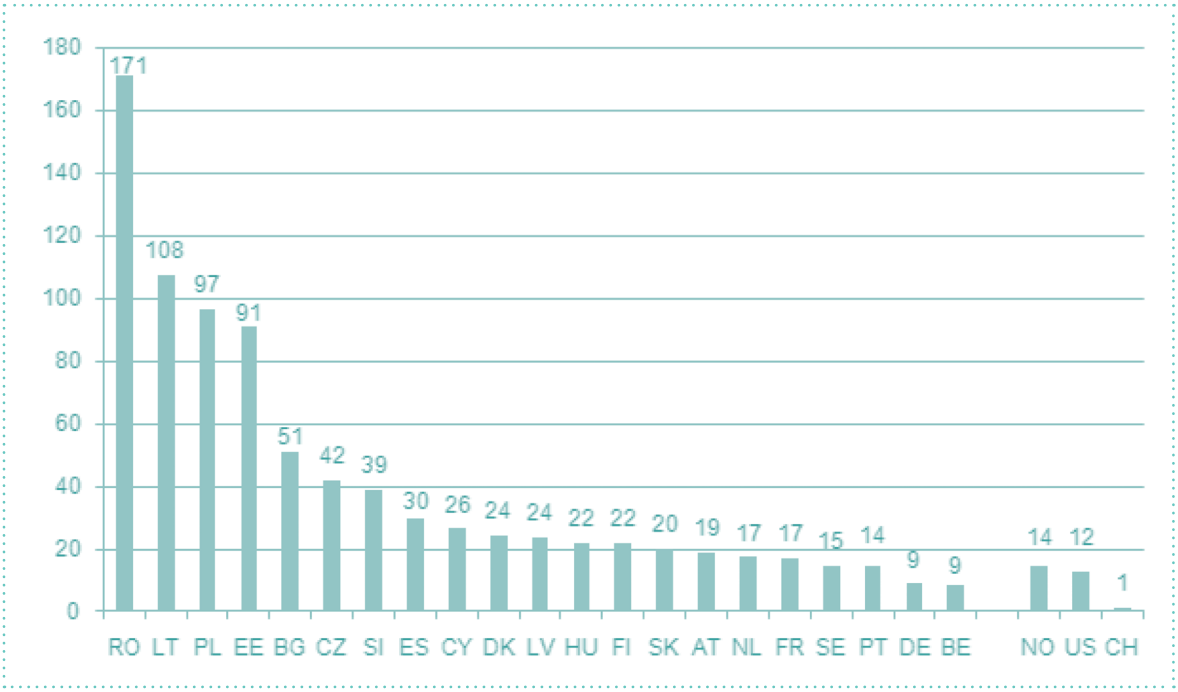
Source: Eurostat, 2010

Note: Health care data on expenditure are largely based on surveys and administrative (register) data sources in the countries. Therefore, they reflect the country-specific way of organising health care and may not always be completely comparable. The database is based on a co-operation between EUROSTAT, the OECD (Organisation for Economic Co-Operation and Development) and the WHO (World Health Organisation), executing a Joint Questionnaire on Health expenditure since 2005. The area covered consists of EU-27 (excluding EL, IE, IT, MT, and UK), Norway, Iceland, Switzerland, Japan and USA.

Note: The latest available data provided by Eurostat is for 2008. The 2007 figures are used as 2008 data is available only for a handful of countries.2006 figures used for Latvia, Portugal, Slovakia, Norway and the US in absence of statistics for 2007.

For the reasons outlined above, per capita health care expenditure has been rising in all European countries between 2003 and 2007/2008 (most recent figures available). Largely starting from a lower base and often requiring significant investment to improve health care infrastructure, the most significant increases can be found in the Eastern European Member States (e.g. 171% in Romania).

FIGURE 3.2 Percentage change in total healthcare expenditure in Euro per capita, 2003 – 2007/2008



Source: Eurostat, 2010

Note: The following figures have been used for this table:
- 2008 figures for AT, CY, LT, PL, RO, SI and SE; 2007 figures for BE, BG, CZ, CH, DK, DE, EE, ES, FI, FR, HU and NL; and 2006 figures used for LV, NO, PT, SK, US.

2003 figures used for all other countries apart from: BE, LV, SK (2005); AT, LT, PL (2004).

When looking at the reasons for increases in expenditure, Table 3.1 below, which compares changes in hospital expenditure with resources for nursing and residential care facilities, demonstrates that in the majority of countries, expenditure on nursing and residential care facilities has increased more significantly. This appears to be in line with trends towards an ageing population, but is by no means true for all countries.

TABLE 3.1 Health expenditure in Euro per capita, 2003 – 2008; Total health expenditure and expenditure for two areas of the health sector

	TOTAL EXPENDITURE			HOSPITALS			NURSING & RESIDENTIAL CARE FACILITIES		
	2003	2008	Change	2003	2008	Change	2003	2008	Change
AT	2,819	3,354	19%	1081	1235	14%	216	242	12%
BE	2,838	3,084	9%	893	922	3%	300	342	14%
BG	173	261	51%	63	102	61%	1	2	54%
CY	1,003	1,269	26%	418	532	27%	25	32	28%
CZ	567	805	42%	260	365	41%	7	11	54%
DE	2,724	2,966	9%	810	880	9%	205	236	15%
DK	3,115	3,876	24%	1383	1792	30%	621	481	-22%
EE	319	610	91%	140	281	101%	4	15	296%
ES	1,471	1,911	30%	544	745	37%	68	100	48%
FI	2,153	2,620	22%	786	941	20%	195	223	14%
FR	2,725	3,183	17%	969	1129	17%	158	215	36%
HU	590	719	22%	218	240	10%	16	22	42%
LT	292	607	108%	105	225	114%	5	9	86%
LV	350	432	24%	141	178	26%	10	12	25%
NL	2,641	3,097	17%	955	1141	19%	325	371	14%
PL	317	623	97%	97	215	122%	4	8	128%
PT	1,220	1395	14%	458	519	13%	21	24	18%
RO	126	343	171%	59	134	128%	1	7	570%
SE	2,772	3,174	15%	1281	1488	16%			
SI	1,045	1,451	39%	397	603	52%	50	77	56%
SK	482	579	20%	135	157	16%			
NO	4,087	4,676	14%	1553	1784	15%	714	812	14%

Source: Eurostat, 2010

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

For total expenditure, the following figures have been used for this table: 2008 figures for AT, CY, LT, PL, RO, SI and SE; 2007 figures for BE, BG, CZ, CH, DK, DE, EE, ES, FI, FR, HU and NL; and 2006 figures used for LV, NO, PT, SK, US. 2003 figures used for all other countries apart from: BE, LV, SK (2005); AT, LT, PL (2004).

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

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

3.1.2 Employment in the health care sector

As demonstrated in Table 2 below, in 2009 over 21.5 million people worked in the health and social work sectors.

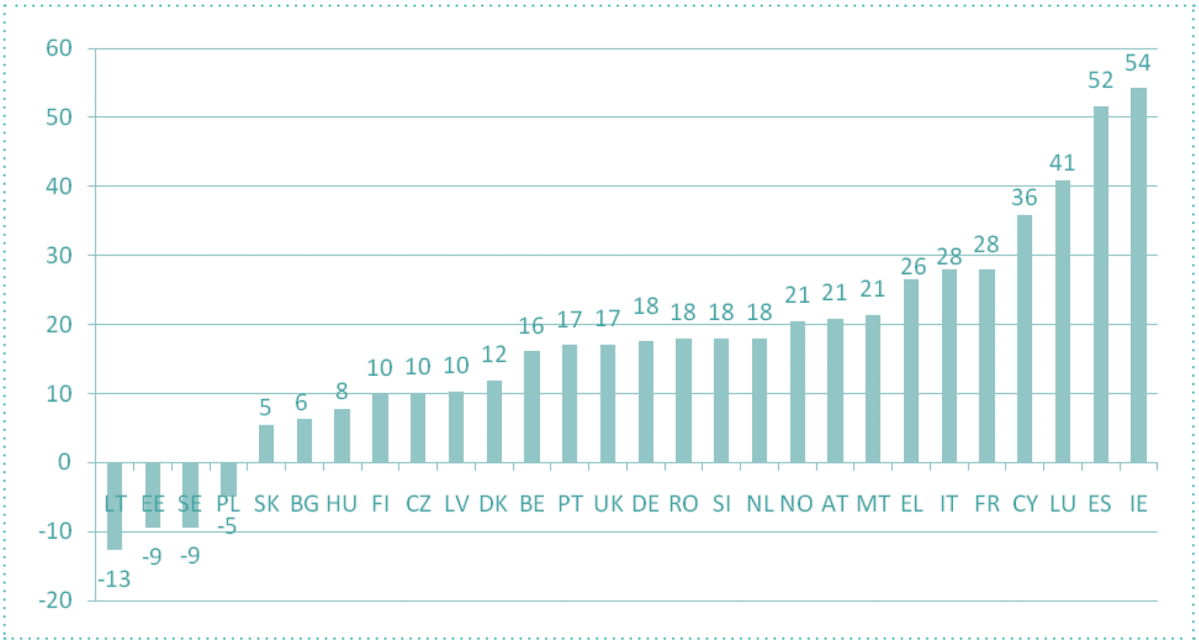
TABLE 3.2 Employment in the 'Human health and social work activities' sector (NACE Q), 2009 quarter 1 (1000s)

COUNTRY	EMPLOYMENT	COUNTRY	EMPLOYMENT
Austria	379.4	Latvia	48.3
Belgium	581.7	Lithuania	89.8
Bulgaria	159.4	Luxembourg	21.4
Cyprus	14.8	Malta	11.1
Czech Republic	318.0	Netherlands	1,354.8
Denmark	496.1	Poland	894.7
Estonia	33.0	Portugal	300.0
Finland	387.3	Romania	382.3
France	3,257.7	Slovenia	52.8
Germany	4,537.4	Slovakia	148.7
Greece	229.4	Spain	1,287.2
Hungary	242.8	Sweden	695.5
Ireland	222.0	United Kingdom	3,740.5
Italy	1,680.4		
European Union (27): 21,566.6			

Source: Eurostat, Labour Force Survey, [DS-073433-Employment by sex, age groups and economic activity (from 2008, NACE rev.2), (1000), Data downloaded 18.03.2010]

Over the last decade employment in the sector largely increased, although some countries have witnessed a decline (Estonia, Lithuania, Poland and Sweden) as demonstrated in Figure 3.3 below. On the whole, employment in the sector in the EU15 has grown more substantially than in the EU12.

FIGURE 3.3 Change (%) in employment in the 'Health and social work' sector (NACE N) between 2001 and 2008 (percentage change), Quarters 2, EU27 + NO



Source: Eurostat, Labour Force Survey, [Employment by sex, age groups and economic activity (1998-2008, NACE rev.1.1) (1000) (lfsq_egana) Data downloaded 08.08.2010], age group 15-64.

Notes: In the absence of employment figure for 2008 Quarter 2, 2007 Q4 figure is used for BG, SE and SI, and 2008 Q1 for PL..

The workforce in the health care sector is dominated by women with no less than 78% of workers being female. This share has risen marginally in the EU15 from 79% in 2000 to 80% in 2006. In the EU12, there has been a small decline in the share of women in employment in the sector from 81% to 80% (European Commission, 2009).

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

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

3.2 Structure of health care sector in the Baltic countries – recent developments and key challenges

This section briefly summarises the key findings and issues discussed during the two seminars which took place in Vilnius and Riga during this project. Further information on the presentations given during the seminar can be found online at http://www.epsu.org/r/577.

3.3 Social dialogue in the health care sector in the Baltic countries

Social dialogue is essential to understanding the needs of the health care sector and its workforce and to develop negotiated and joint solutions to the challenges it faces. Social partner organisations in the health care sector in the Baltic countries have in the last 10 years or more developed an as a rule active tripartite dialogue with national governments to exchange information and contribute to the development of legislation and policy, as well as (in some cases) setting appropriate financial frameworks for the funding of health care services. While this co-operation generally takes place in a spirit of positive co-operation, there are of course instances when the views and recommendations of social partner organisations are insufficiently reflected in decisions taken and the signatories therefore call on national governments to recognise and value the importance of social dialogue at the national level. In addition, further steps could be taken to improve bi-partite dialogue between the relevant partners.

Below we provide a brief introduction on the participants and structure of social dialogue in the health care sector in the Baltic countries as well as the key issues being discussed.

3.3.1 Estonia

3.3.1.1 Social partner organisations in the hospital sector

In the following sections we give information on active trade unions and employers' organisations in the Estonian health care sector.

Trade unions

The Estonian Medical Association (Eesti Arstide Liit, EAL)
The Estonian Medical Association aims to protect the professional and economic interests of some 2,878 doctors.

Union of Estonian Healthcare Professionals (Eesti Tervishoiuöötajate Kutseliit, ETK) The Union of Estonian Healthcare Professionals organises around 4,700 workers in the sector.

The Federation of Estonian Healthcare Professionals Unions (Eesti Tervishoiutöötajate Ametiühingute Liit, ETTAL) The Federation of Estonian Healthcare Professionals Unions represents doctors, nurses, care assistants, professionals with university degrees and mid-ranking professional staff, kitchen personnel, drivers, cleaners, departmental secretaries, and customer service staff in the healthcare sector in Estonia. The union has 2,113 members and the union is a member of EPSU.

The Estonian Nurses Union (Eesti Õdede Liit, EÕL) The Estonian Nurses Union, which is the largest trade union organisation in the healthcare sector, represents 3,800 nurses.

Employers

There is one employers' organisation in the sector - **the Estonian Hospitals Association (Eesti Haiglate Liit, EHL)**, which represents 19 major hospitals..

3.3.1.2 Structure of collective bargaining and social dialogue in the hospital sector

The health sector is one of the few sectors in which sectoral bargaining takes place in Estonia; with company level bargaining predominating the Estonian industrial relations system. At national sectoral level, agreements

essentially cover minimum wages and basic working conditions and are negotiated between relevant social partner organisations and the Ministry of Social Affairs. Another important partner in tripartite discussions is the Estonian Health Insurance Fund which sets rates regarding the reimbursement levels for different procedures/services.

More detailed agreements on wages and working conditions are negotiated at the local level and outcomes largely depend on the strength of local unions.

The first agreement on wages and conditions was negotiated at sectoral level in 1995 between EHA, EMA and the nurses' union. Between 1996 and 2001 negotiations were held on a new agreement but without reaching a conclusion. The next agreement was formally signed in 2002/3003. The first tripartite agreement between the Ministry of Social Affairs EHA, EMA. EÕL, EKTK and ETAL was signed in 2005. The next round of negotiations in 2007 failed to reach agreement that all partners could sign, but its recommendations were essential agreed by hospitals and the health insurance fund.

When signed, sectoral agreements are usually valid for two years and all the local agreements must respect the conditions set out in the sectoral agreement. Other terms and conditions, apart from the minimum wages, are rarely discussed during the centralised bargaining rounds. Local agreements are usually signed by managers of individual hospitals and the trade unions. Local negotiations are carried out normally once a year.

Tripartite dialogue in other than wage related matters is weak. The three parties only come together to negotiate wages. Bi-partite collaboration is marginal too. Both sides, however, co-operate closely with universities and other training providers. Furthermore, the Ministry of Social Affairs has recently established an expert group to advice the development of the new Estonian Hospital Master Plan 2015.

3.3.1.3 Key issues for the health care sector

The main issues discussed by social partners in the hospital sector at tripartite level include the development of health care policy, the setting of reimbursement scales for the health insurance fund and the setting of ba-

sic wages and terms and conditions for health care sector staff. Initial and ongoing vocational training are also being discussed in dedicated bodies.

3.3.2 Latvia

Social partner organisations in the hospital sector

The **Latvian Hospitals' Association**[2] **(LHA)** was established in order to promote organizational and managerial improvements in hospitals. LHA is a member of HOSPEEM.

The LHA comprises members from both hospital and health sector in general mostly in national level social partner negotiations, but also on the sectoral and local level.

Trade Union of Health and Social Care Employees of Latvia[3] **(LVSADA**) was established in 1990. It represents and defends the social and economic interests and rights of 12.650 members in the health care sector and 5 146 members in other sectors - in total 17.796 invoiced members.

LVSADA is a member of EPSU.

LVSADA has its own youth centre and newspaper "Arodbiedrības vīrds" (Word of Trade Union) that come out four times a year on the current issues in health and social agenda.

Another trade union that represents the interest of the workers of health and hospital sectors in Latvia is the **Nursing and Healthcare Personnel Trade Union (Latvijas ĀrstniecĀbas un aprĀpes darbinieku arodsavienĀba, LĀADA)**. It was created and registered in 1992. LAADA was admitted to LBAS in November 2002 and is also a member the European Confederation of Independent Trade Unions (CESI).

2 Latvian: Latvijas Slimnīcu biedrība (LSB)
3 Latvian: Latvijas Veselības un sociālās aprūpes darbinieku arodbiedrība, LVSADA

3.3.3 Structure of collective bargaining and social dialogue in the hospital sector

Minimum salaries and working conditions in the health care sector as well as the tariffs for state covered services are negotiated on the national tripartite level and included in the national labour laws. Specific issues related to the hospital sector are discussed in the relevant Health Care Sector Sub-council. Specific working groups are focusing on improvement of labour conditions, salaries, tariff policies, compulsory social insurance and social guaranties, healthcare as well as employment, vocational education and lifelong learning. Local level negotiations take place on more detailed terms and conditions.

3.3.3.1 Key issues for the health care sector

The key issue facing the health care sector in Latvia relates to the year-on-year reductions in the level of the health care budget as a share of GDP and the attendant reductions in the level of service provision (and increasing out of pocket payments). These budget cuts have led to restricted access to health care not falling under the category of "emergency treatment". The limitations placed on non-emergency treatments in this country have led to a 33% increase in emergency hospital admissions in 2009 and 2010. At the same time, the relative risk of in-patient fatality has increased by 20%. WHO reports that in Latvia 30% of the population indicated that they are not using health services when they feel ill because they expect high out-of-pocket payments which they cannot afford. Figures presented during the national seminars show that in addition to increasing hospital fatalities and maternal death rates, disability numbers are also increasing as conditions go untreated. This is likely to have an impact on the labour force with regard to absences from work and reduced productivity.

Latvia already has to lowest number of doctors and nurses per head of population in the Baltic countries (311 doctors per 100,000 population and 534 nurses compared to 324 doctors in the EU (335 in Estonia, 370 in Lithuania) and 775 nurses in the EU (640 in Estonia, 711 in Lithuania). The sector is also experiencing significant ageing with 32% of physicians nearing retirement age. Salaries of doctors and nurses have declined in

real terms in recent years which is making the job of ensuring recruitment and retention more difficult for individual hospitals. Increasing efforts are being made by hospitals to implement training and work-life balance policies designed to make the sector more attractive in order to retain staff.

In the context of the social dialogue, the national tripartite council has repeatedly recommended that health care expenditure be increased to safeguard the health of the nation. However, these agreements have so far failed to influence government policy.

3.3.4 Lithuania

3.3.4.1 Social partner organisations in the hospital sector

In the following sections we give information on active trade unions and employers' organisations in the Lithuanian health care sector.

Trade unions

Lithuanian healthcare workers trade union (LSADPS),[4] was established in 1991, and has around 4,500 members, covering all types of workers in a healthcare institution LSADPS is a member of EPSU.

Lithuanian doctors union[5] was established in 1989. It covers around 80% of doctors in Lithuania. It is a member of CPME (Standing Committee of European Doctors).

Other relevant organisation include the Lithuanian young doctors' association, the Lithuanian nursing specialists organisation, the Lithuanian nursing managers' organisation, the Lithuanian health care administrators' trade union and a few other organisations.

Employers

There is one employers' organisation in the sector - the **Estonian Hospitals Association (Eesti Haiglate Liit, EHL)**, which represents 19 major hospitals.

4 http://www.abc.lt/LSADPS/
5 http://www.lgs.lt/

In addition there are the association of private healthcare providers, the Lithuanian hospitals' association, the Lithuanian emergency care organisations' association and few other organisations, none of whom are officially recognised as employers' organisations for collective bargaining.

3.3.4.2 Structure of collective bargaining and social dialogue in the hospital sector

Wages of healthcare workers are determined in the state budget, which assigns healthcare funds. A healthcare provider operates with an annual budget, and together with the body responsible for establishing and overseeing the provider (which can be the Ministry of Health, country administration or local municipality) determines the budget proportion allocated to wages.

Additional collective agreements at the workplace level are not signed in all healthcare workplaces. It is estimated that around 50-60% of workplaces in the healthcare sector have collective agreements in place.

In 2005, an agreement was reached on wages which provided to increase wages over a four year period, and in the Lithuanian context the increases were significant. For example, in the first year wages were increased across the board by around 30%. This year, 2007, the wages are again expected to increase by around 20-30%.

The wage increases were tied with increased payments from the state budget for healthcare services provided by healthcare providers. However, if providers were not providing a certain level of services, such wage increases did not necessarily take place. Hence, the trade unions report that wage increases took place in a very differentiated way between different providers, resulting sometimes in wage differences of 2-3 times between different providers.

During the seminars held for this project, key challenges facing social dialogue in the health care sector in Lithuania were defined as follows:

- Lack of bipartite social dialogue
- Lack of continuity in social dialogue
- Power of NGOs in the health care system

3.3.4.3 Key issues for the health care sector

Recruitment and retention are important issues, particularly as the sector is seen by many to be unattractive with high demands, relatively low pay (despite recent increases), unsocial hours and high, unregulated work-loads. Migration of health care workers to other countries in Western and Northern Europe is an important concern.

As one of the key reforms in the health care sector in the years to come will be to shift the focus from hospital based towards primary case, changes will also be required in training and skills requirements. Social dialogue should play an important role in shaping such developments, but resources for ongoing training are currently seen to be insufficient. Some new initiatives aimed at improving the funding situation for training are described in section 5 of this report.

04

RECRUITMENT AND RETENTION

As outlined above, demand for health care services is set to grow in the years to come at a time when labour supply in the European Union is set to shrink as a result of demographic trends. In addition, skill requirements are set to change and call for more highly skilled staff, thus increasing the potential for both labour and skill shortages.

Making the health care sector more attractive to current employees as well as future recruits to enhance recruitment and retention is therefore among the critical concerns being dealt with by social partners at the local, national and European level.

4.1 Scale of skill and labour shortages

It is not surprising that all responses submitted to the survey carried out as part of this project indicated that recruitment and retention are important issues to be addressed for their organisation. Having said that, data provided on the precise level of labour and skill shortage anticipated in the coming years is scarce:

- **The Dutch trade unions argue that the Netherlands are likely to see a dramatic turnaround from no staff shortages to requiring an additional 450,000 care workers by 2025 as a result of demographic changes;**
- **The Latvian social partners predict a shortage of between 500-2000 doctors and 1000 nurses in future;**
- **In France there is likely to primarily be a shortage of doctors while in**
- **Slovakia shortage is predicted among all health care personnel;**
- **Sweden is likely to lack around 2000 doctors, 10,000 nurses, 7000 dentists, 750 physiotherapists and 50,000 support staff by 2010.**

The European Commission estimates a possible shortage of 2 million health care workers in the EU by 2020.

4.2 Measures to tackle recruitment and retention and European and national level

4.2.1 Increasing initial and ongoing training provision

Measures to enhance initial and ongoing training provision in the sector are the subject of section 5 of this report and will not be elaborated here.

4.2.2 Improving working conditions

Matters of wage negotiation and wage setting are clearly outside the scope of European social dialogue. Nonetheless, it is undeniable that wage levels in the health care sector have a significant impact on recruitment and retention as well as migration trends.

A recent report commissioned by EPSU and carried out by Dr Jane Pillinger[6] examines pay levels in health care, child, elderly and other dependent care in 8 EU countries[7] compared to average wages in the public and private sector, the extent of the pay gap and the relationship with the national gender pay gap. The report finds that in the countries surveyed, workers in these sectors generally earn wages below the national average. Wages of unqualified or low qualified staff are often at minimum wage or basic collectively agreed level, whereas well qualified workers earn below the average for their country for an equivalent qualification level.

According the a recent Eurofound report on employment and industrial relations in the health care sector (http://www.eurofound.europa.eu/eiro/studies/tn1008022s/index.htm), in just under half of EU countries multi-employer collective bargaining has contributed to improving the wages of health and/or social care workers over the last five years. In a further four countries, local agreements have been concluded which aimed at increasing pay.

In a number of agreements particular emphasis was placed on improving the remuneration of low skilled, particularly low paid workers in the sector where there was often a particularly high rate of staff turnover (e.g Austria, Ireland, Sweden)...

6 Pillinger, Jane (2010); Pay in Health and Social Care; http://www.epsu.org/IMG/pdf/FINAL_REPORT_ON_PAY_IN_HEALTH_AND_SOCIAL_CARE.pdf

7 The report covered Belgium ,Estonia, Finland, Germany, Ireland, Latvia, Sweden and the UK.

Agenda for Change in the UK

The "Agenda for Change" agreement reached by the sectoral social partners in the UK in 2004 is the most wide ranging reform of National Health Service pay in recent years. It largely aims at greater transparency in pay scales and is based on detailed job evaluations and classifications which also seek to make it easier for workers to progress between grades. Efforts are also under way to achieve greater parity between the salaries of health and social care staff in the private and public sector.

While pay is clearly an important factor in individuals' decision making whether or not to enter and remain in the sector, other terms and conditions also have an important role to play. The Eurofound report highlights a number of collective agreements have gone further than addressing wages and have also sought to improve wider terms and conditions, the box below provides an example of such a more wide-ranging agreement.

Tripartite agreement in Belgian health care sector

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

01 Easing workload and stress for the nursing staff

Implementing the 2005-2010 Social Agreement: one extra full time nurse or auxiliary per 30 hospital beds can be used by hospitals to create a moving team of nurses to help counter lack of personnel in the nursing teams.

Relaunching 'Training project 600': auxiliary nurses – non-graduate care workers – have the opportunity to upgrade their nursing skills and to obtain a graduate nurses degree. It is considered that these people know the job, are motivated to do it, but only need help to study. This form of horizontal promotion is organised by giving the employer an additional auxiliary nurse salary, so that the employer can engage someone else to carry out the job while the auxiliary studies. The target group is supporting 350 auxillaries a year.

02 Qualifications and lifelong learning

Hospitals will get a gradual increase in funding for nurses' training (EUR 1 million in 2009, which is a 7.5 % increase). A new accreditation scheme will be implemented for nurses working in residential homes for older people and nurses in home care services. The scheme provides for a higher reimbursement rate for some services by the public authorities to the care provider on the condition that a continuous training programme is run.

Further specialisation and differentiation of nursing needs will be organised and recognised in the way hospitals are financed (re-funded by the specific care

they provide to patients). Furthermore hospitals will receive a budget to hire (or promote) more specialised nurses (geriatrics; oncology; paediatrics).

03 Specific increases in remuneration

Better payment for working at unsocial hours: Extra-bonus per hour for services in the early morning (between 6 - 7am) or evening (7 - 10 pm);

Increasing the pay rewarding for basic specialties and special competences: introduction of between 5-10% pay increase for officially recognized expertise and specialization, combined with a current practicing of this expertise in the sector;

Nursing executives: Further improving the rewarding of executive tasks, first by extending the so-called complément fonctionnel (extra bonus for managerial activities) and afterwards by granting a pay level compatible with relevant legal training requirements

04 Promotion campaign

Campaigns to promote becoming a nurse (seeSource: Eurofound (2011), Employment and Industrial Relations in the Health Care sector

In addition, the Irish agreement raising wages for home helps also includes provision for an increase in holiday entitlements (to 23 days). It also covers improvements in pension provisions, grievance and disciplinary procedures for workers in this sector. Another sectoral agreement covering nurses in Ireland reduced weekly working hours to 37.5 (nurses' demands had been for a 35 hour week). A sectoral agreement for nurses working in residential care centres for the mentally ill in Poland provides for enhanced pension rights facilitating early retirement for those who wish to take it. In Germany, an agreement in the public health care sector (TVöd-Pflege) introduced a first partial-retirement scheme in the sector. The facility is restricted to 2.5% of the staff of an establishment. The agreement also calls on employers to offer employment to apprentices for at least 12 months following the completion of their apprenticeship.

A theme of collective bargaining in several Member States (Sweden, Spain, Italy, France and Norway) has been increasing the number of full-time and open-ended jobs in the health care sector. Collective bargaining at the sectoral level in Spain has also promoted stable recruitment. Article 15 of the 5th Agreement of Care Service for Dependent Persons and Development for the Promotion of Personal Autonomy determines that as of the 1st January 2008, 80 % of the staff working for companies affected by the agreement

must have open-ended contracts. In the case of recently set up companies, this percentage must reach 50% by the end of the first year and 80% by the end of the second year.

A number of measures have also been taken in different members states to specifically address stress and (third party) violence and harassment in the sector, which can also be significant factors in workers' decision to leave the sector.

The Eurofound report reflects that many of the examples mentioned above relate to agreements negotiated prior to the onset of the economic crisis and its knock-on effect on public budgets.

4.2.3 Improving work-life balance measures

Many workplaces in the healthcare sector are investing in measure enabling a primarily female dominated workforce to achieve a better balance between work and family life as a way of improving the recruitment and retention of workers. Such approaches include greater autonomy over working hours through self-rostering (co-operation at ward or unit level to allow staff to select the hours they wish to work in any given week/month); assistance with – or provision of childcare services; and other flexible working initiatives. It is clear that in the hospital sector greater autonomy over working time can be more difficult to achieve than in many others sectors as a result of requirements for 24 hours service provision and the prevalence of shift working. Nonetheless, work-life balance initiatives are become more widespread and particularly in the community care sector include efforts to reduce requirements to report into a central location through the use of modern technology (to file reports etc.).

4.2.4 Retaining older workers

In view of the ageing of the workforce and likely increasing demands for health care workers, the retention of older workers in particular is becoming a pressing concerns reflected by some respondents to the questionnaire. The UK and France have implemented measures for (older) workers to return to hospital sector after a period of absence (for family or other reasons). This is achieved by maintaining records of registered nurses and targeting them

with specific information, as well as maintaining their seniority status and (in some cases) entitlements to pension provisions.

In Denmark, specific annual review processes are carried out with workers over the age of 50 to establish their career aspirations and requirements to remain in employment (training, more flexible working, change of work task etc.). These reviews are used to develop approaches and specific individualised assistance to encourage and help older employees in the sector to continue working.

4.2.5 Improving the integration of migrant workers

As recruitment of health care professionals from other countries within and from outside the European Union is becoming more widespread, more significant challenges are arising relating to the integration of these workers in the workplace as well as in wider society. On 7 April 2008, EPSU and HOSPEEM jointly adopted a Code of Conduct on Ethical Cross-border Recruitment which not only highlights the importance of considering existing skill shortages in sending countries when targeting foreign recruitment efforts but also focuses on effective measures to integrate migrant workers.

Specific procedures are in place for to certain health care professions with regard to the recognition of their qualifications obtained abroad. These are critical not only to ensure patient safety in the receiving country, but also to ensure that highly skilled human resources are utilised to their full potential.

In a number of countries specific language training is also offered to facilitate working and assist in the wider integration process.

Other aspects of full workplace integration include familiarisation with working procedures and administrative structures and getting to know colleagues and their respective responsibilities.

In order to achieve greater societal integration, training is also offered in some countries on cultural awareness and assistance can be provided with housing and the integration of family members (schools etc).

In addition, anti-discrimination training is offered in a number of countries to the wider workforce to prevent prejudice and misunderstanding from souring working relationships.

05

SKILLS ANTICIPATION AND SKILLS DEVELOPMENT

This section sets out the main methodological approaches pursued in carrying out the project.

5.1 Importance of skills anticipation and skills development

Skills anticipation is an important task in ensuring to adequate provision of a well trained workforce, capable of meeting the challenges of the future and remaining adaptable to changing needs. A number of important drivers are effecting developments in the health care sector. A study carried out as part of the Commissions Sector Skills Profiling[8], summarises these drivers as follows:

> *Ageing population:* **Demographic trends are likely to increase demand for health care provision at a time when workforce ageing is shrinking the potential supply of labour. While the trends are towards increasing healthy life expectancy, living into older ageing is bringing with it increasingly complex and chronic illnesses.**

> *Technological developments:* **medical and pharmaceutical technology and treatments are advancing at a rapid pace, making it critical for health care workers to stay abreast of new clinical and pharmaceutical developments as well as innovations in care regimes. This can change not only the types of conditions which can be treated, but also how conditions are treated and the nature of follow-up care provided. While for minor conditions (and even some conditions previously considered very serious and debilitating) outpatient treatment or only short stays in hospital are increasingly becoming the norm, intensive inpatient treatment is increasingly become focussed on the most serious conditions, thus changing skills**

8 For more information see http://ec.europa.eu/social/main.jsp?langId=en&catId=782&newsId=583&furtherNews=yes

profiles and requirements. To some extent ICT and medical and assistive devices are replacing staff, but in a labour intensive, care giving sector, this is less the case than in other service sectors and industries.

> *Changes in life-style:* **As mentioned above, there is in general an increasing trends towards reduced inpatient care and more home based outpatient treatment and care. While overall improved economic status is leading to the reduction of certain lifestyle related conditions, other conditions are on the increase and are likely to require a significant proportion of health care budgets in future (heart disease etc).**

These and other factors are requiring ongoing changes in initial training curricula as well as ongoing training and skills development.

The recent *Council Conclusions on Investing in Europe's health workforce of tomorrow* – Scope for innovation and collaboration, adopted on 7 December 2010, call on the Member States to raise awareness of the importance of attractive working environments, working conditions and professional development opportunities in motivating the health workforce. The Council Conclusions also call on Member States to stimulate training and education of the health workforce with the aim of guaranteeing and further promoting quality and safety of care.

As indicated above, the ability to develop one's career is an important factor supporting recruitment and retention in a sector which may in principle attract somewhat lower financial rewards than others, or provide a more challenging and in some ways less attractive working environment (shift work, unsocial hours etc).

The involvement of social partners in the planning of initial and ongoing skills development is imperative to meet the requirements of modern hospitals and other health care settings. Skills development has therefore been at the heart of the sectoral social partners work programme for some time and also formed part of the survey and capacity building undertaken as part of this project. In the following sections we summarise the most common approaches taken by social partners in the sector to support ongoing skills development as well as obstacles faced in implementing effective strategies.

5.2 Actions being taken to improve skills development

According to a report on Employment and Industrial Relations in the Healthcare Sector in the European Union (GHK for Eurofound, 2011), collective bargaining and social dialogue has contributed to improved access to training in at least half of the countries under review (Austria, Belgium, Bulgaria, Cyprus, France, Ireland, Malta, Slovakia, Slovenia, Spain and Sweden). It has particularly helped individual to become qualified to take a step up the occupational ladder (for example to allow care assistants train as qualified nurses in Austria, Belgium, Ireland and Malta). Most of the measures are taken at sectoral level and often relate to a specific number of training days, the introduction of a training subsidy or the availability of interest free loans for further study.

In Slovenia collective bargaining has regulated work organisation in such a way to allow for additional training time for staff. For example, there is now a special right for nurses to 30 minutes daily preparation time (meant to be used for the purposes of additional professional training). The collective agreement also guarantees between 7 and 20 paid days of professional training per year. The Spanish 5th agreement of care service for dependent persons and development for the promotion of personal autonomy that applies to care workers in the private sector in Spain includes the right to carry out courses that will improve their professional skills.

In the recent rounds of collective bargaining in Sweden, measures implemented in previous agreements that supported training have been retained. This includes, for an example, an entitlement to attend a certain number of courses, conference or educational measures during working hours on full pay.

On the recommendation of the arbitrator assisting in the settling of a dispute between the Slovak Association of Healthcare and Social Services and the Association of Hospitals of Slovakia, a contribution of EUR 30 per month to lifelong learning for all healthcare personnel was included in the collective agreement.

The Irish social dialogue agreement "Towards 2016" includes a commitment towards training and upskilling health care assistants (though many aspects of this agreement have now been put on hold as a result of the crisis). A new qualification developed as a result enables health care assistants to support nurses in

the delivery of patient care. In addition, a dedicated SKILL (Securing Knowledge Intra-Life-Long Learning) project to enhance the role of support staff in delivering quality patient care started in 2006. The project addresses the training needs and aspirations of home helps and other support workers.

The 'Conversion Course' in Malta is another initiative derived from social dialogue in the public sector intended to assist nursing assistance in enhancing their knowledge base.

As part of the survey carried out for this project, member organisations of HOSPEEM and EPSU were asked to what extent current provisions for skills anticipation and skills development in the health care sector were adequate to meet the needs of a modern health care system. While a significant number of respondents felt that current structures and provisions are adequate, with initial and ongoing training being offered as and when required, others argued that current systems are inadequate and insufficient, in particular with regard to providing ongoing training for lower skilled health care workers (and thus failing to provide them with career pathways and opportunities). The lack of systematic planning for future skills requirements was particularly highlighted by some respondents. Therefore on the whole, ongoing skills development is considered to be more developed that systems for systematic skills anticipation, which can have an impact on the quality of training curricula and the level of preparedness and adaptability of health care staff to new requirements.

It was also considered that more training is required for senior staff in relation to management skills and for working in multi-disciplinary teams.

Activities taken by the social partners in relation to skills development largely revolve around:

- **Support for skills planning and delivery (as part of tri- or multi-partite structures)**
- **Delivery and financial support for the acquisition of professional qualifications and ongoing training**
- **Negotiation of collective agreements ensuring paid time off (time off during working hours) to receive training**

In the Baltic countries, while the social partners in Latvia and Estonia consider competence development, particularly for highly skilled personnel to be rather well developed, the Lithuanian trade unions considered strategic skills and competence development to be virtually absent in their country. Training provision is considered to be largely reactive, based on annual applications for training courses from health care professionals, which are collected from the different health care institutions. A requirement exists for doctors to pursue 150 hours of training every year. Nurses are licensed for a period of five years and most receive updated training in order to re-qualify for their licence. However, only 60% of training costs are covered by the state with the rest having to be funded by the individual (although some of the learning can be acquired on the job).

A recent initiative in Lithuania (Government of the Republic of Lithuania Resolution on Human Resource Development Programme (23 July 2008 Nr.789) sought to provide assistance to develop management and human resource potential in the public sector. This funding was also avaialble to the health care sector. A total of 20,355,229 EUR of funding were avaialble for projects from the health care sector, with 22 projects (out of 52 applications) receiving funding. Some projects aimed to improve nursing and medical qualifications nation wide whereas others were more locally focussed.

The following boxes provide some examples of social partner engagement in ongoing skills development in the sector provided during the two seminars and as part of survey responses.

Setting up of a "Care College" in Sweden

In Sweden, social partners and training providers in the sector have set up a so-called "Care College" (Vård- och omsorgs-college, VO-College) primarily to address the shortage of training provision for lower skilled health care staff.

In the VO-College, training organisers and the social partners co-operate in order to renew and improve education within the care sector. The co-operation strengthens the link between theory and practice in basic training. The VO-College also improves the skills' development for assistant nurses already employed as well as the vocational training for adults.

All VO-Colleges are certified as a guarantee for high quality standards. The aim is to improve the occupational status particularly of lower skilled workers and increase the number of students from among assistant nurses.

Planning for skills development in the health care sector in Denmark

The social partners in the health care sector have agreed on a general framework regarding the development of competences with the purpose to oblige both employers and employees (at local level) to prioritise the ongoing development of competences. This includes both on the job learning as well as college based courses and lifelong learning. The agreement obliges the so-called "Co-operation and coordination committee" (works council) of each region to have yearly strategic discussions regarding the necessary development of competences. In addition to these discussions the different workplace level units also have to have a competences development plan. Furthermore the agreement states that each employee has the right (and the obligation) to take part in a yearly performance review. During this review the employer and the employee draw up an individual development plan for the year to come.

As a quite recent initiative each region has established a Competence Foundation (financed by the tripartite agreement mentioned above) with the purpose of supporting and promoting the development of skills and competences. The Foundation allocates funds to different initiatives and courses supporting skills, competences and employee development in general. The local units apply for financing on concrete actions and the Foundation takes a decision on whether or not to finance the concrete initiative (the Foundation includes both employer and employee representatives).

At national level, key decisions are taken on the future shape of training curricula (for example the strengthening of the curriculum on dealing with chronic conditions which are on the increase). This influences training curricula at national level for doctors and nurses in graduate and post-graduate education.

At regional level, further priority decisions are made by regional politicians (e.g. to improve resources for drug rehabilitation etc) which has implications on training provisions.

At local level, priorities for staff training are decided based on clinical requirements.

This way of elaborating competence development priorities and plans is considered to be highly democratic and largely evidence based, but also time consuming and requiring a highly evolved level of social partnership.

5.3 Obstacles to improving skills development

The lack of sufficient financial resources to fund ongoing training provision was considered to be the most important obstacle to strong skills development strategies in the sector. This was seen to be twinned with staff shortages, making it difficult to health care workers to take time off to pursue training courses. The need for a nationally supported and funded strategy for workforce development, developed in co-operated with social partner organisations, was highlighted to overcome such difficulties. Other obstacles mentioned in our survey include the increasing use of precarious contracts, with temporary agency workers – for example – in many countries not being entitled to take part in training, thus further enhancing labour market segmentation.

In the context of an ageing workforce, more efforts were seen to be required to assist the transfer of experience from other to younger workers (and potentially the transfer of more updated skills from younger to older workers).

IMPLEMENTATION OF SHARPS AGREEMENT

06

6.1 Negotiation of the sharps agreement

Injuries caused by needles and other sharp instruments are among the serious risks facing health care workers in the EU and represent a high cost for health systems and society in general. On 6 July 2006, the European Parliament adopted a resolution on protecting European health care workers from blood borne infections due to needle-stick injuries, requesting the Commission to submit a legislative proposal for a Directive.

Pursuant to Article 154 TFEU, before submitting a proposal for legislation, the European Commission launched a two stage consultation process of the European social partners in 2006 and 2007. A technical seminar was held by the social partner in the sector on 7 February 2008 to explore the most important issues and how they might be tackled. In a joint letter of 17 November 2008, EPSU and HOSPEEM informed the Commission of their intention to negotiate a framework agreement on the prevention of sharps injuries in the sector.

The European Commission consequently suspended the drafting of its legislative proposal, awaiting the result of the negotiation process. After only five months of negotiations, on 17 July 2009, the social partners in the health care sector signed an EU-wide agreement on the prevention of sharps injuries.

The agreement aims to achieve the safest possible working environment for employees in the sector and to protect workers at risk. Its goal is to prevent injuries to workers caused by all types of medical sharps (including needle sticks). For this purpose, an integrated approach to assessing and preventing risk, as well as training and informing workers, is foreseen.

The social partners requested the Commission to submit the agreement to Council for a decision, in accordance with Article 155(2) TFEU. In 26 October 2009, the European Commission issued a proposal for a Council Directive containing the full social partner agreement as an annex. On 11 February 2011 the European Parliament supported the proposed Directive in a resolution and on 8 March the Council reached political agreement on its adoption. The Directive was published in the Office Journal as Council Directive 2010/32/EU of 10th May 2010. Member States now have three years to implement the Directive.

In a survey carried out among EPSU and HOSPEEM members for this project, only 56% of respondents argued that reliable national data on the number of sharps injuries suffered by health care workers is available for their country. This is largely due to the fact while data and accident reports on such injuries are clearly gathered at local level, this information in not systematically passed on an accumulated at national level in most countries. Only two responding countries were able to provide data on the number of sharps injuries suffered in the sector per annum. These varied significantly from 68 such reported incidents in Sweden in 2010 to between 13,000–15,000 in the Netherlands. It therefore appears that in order to assess the impact of the Directive on the incidence of sharps injuries, it would be necessary to gather better baseline data at national level and assess any improvements (or otherwise) on a regular basis.

Despite the absence of national level data, our survey revealed that social partners in the sector considered the issue to be very (62%) or somewhat important (38%) for the health care sector in their country, thus underlining the importance of implementation measures involving consultations with national level social partners.

6.2 Implementation of the sharps agreement

The legal target date for the implementation of the agreement is not until the end of May 2013 and out survey revealed that most Member States appear to be working towards this target date in planning and negotiating steps towards implementation.

When looking at the process and nature of national level transposition of the EU Directive (essentially based on the social partner agreement), it is important to understand the level of awareness of the agreement among national level social

partners (as this can shape their involvement in steps towards transposition), the extent to which changes are required to national legislation in order to accommodate the requirements of the Directive and the shape which this implementation will take.

6.2.1 Awareness of the agreement

Our survey showed a high level of awareness of the agreement among social partner organisations in the sector, which is perhaps unsurprising because of their central role in the negotiation of the framework agreement (indeed 68% of respondents were directly involved in the negotiation of the agreement – although this may also contribute towards skewing the figures regarding national level awareness). Nearly 94% of respondents were aware of the sharps agreement and subsequent Directive. The 1 respondent who was not aware of the agreement represented an organisation not currently in membership of EPSU and HOSPEEM. This in itself could be seen as a factor highlighting the importance of membership of European social partner organisations and the resulting access to information and involvement in decision making at EU level.

6.2.2 Requirements for changes in national legislation

Around 75% of respondents to our survey argued that new legislation will be required in order to fully transpose the content of Directive 2010/32/EU at the national level. The remaining 25% felt that existing legislation is already sufficient to accommodate the requirements of the new Directive. Assessment of the likely impact of implementation on national legislation and practice ranges from low (in countries where similar provisions are already in force) to high. Most respondents argued that the transposition of the Directive would lead to increased awareness of risks relating to sharps injuries and improved training provision resulting in better prevention and a reduced incidence of injuries suffered.

6.2.3 Nature of implementation

The nature of implementation of EU legislation depends to a significant degree on the nature of national (and regional) governance structures and traditions, including the precedence given in some countries to universal col-

lective bargaining over legislation. Around 43% of respondents to our survey argued that the Directive would be implemented in their country purely by a legislative route (which can of course still involve social partner organisations in consultations and tripartite negotiations). Around 50% of respondents envisaged a "twin track" method of implementation using legislation as well as collective agreements. Collective agreement alone was considered to be the likely method of implementation in only one country.

Arguably, due to the first-hand knowledge of social partner organisation of the negotiation and therefore the content of the agreement, their involvement in national implementation process is likely to be stronger than may be the case for other pieces of legislation, particularly in countries which do not have a strong record of social partner involvement in tripartite decision making. This means that in countries where such engagement is usually weak, the implementation of the Directive can act as to raise their profile and involvement and could potentially act as a blueprint for future decision making.

6.2.4 Timing of implementation

Around 62% of respondents to our survey considered that steps have already been taken to start the process of implementation of the Directive (e.g. through consultations and negotiations between social partners and relevant ministries). In the remaining countries transposition efforts have not yet begun. As indicated above, the target date for implementation in most countries is 2013, with only two countries responding to the survey envisaging early implementation in 2011 (Netherlands) and 2012 (Germany).

07 NEXT STEPS

A closing conference for this project will be held on 26th May 2011. The goal of this conference is to disseminate the results of the project and to deepen the debate on the issues of recruitment and retention, skills development and the implementation of the sharps agreement. A separate conference report will be prepared to reflect on discussions at this event.

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