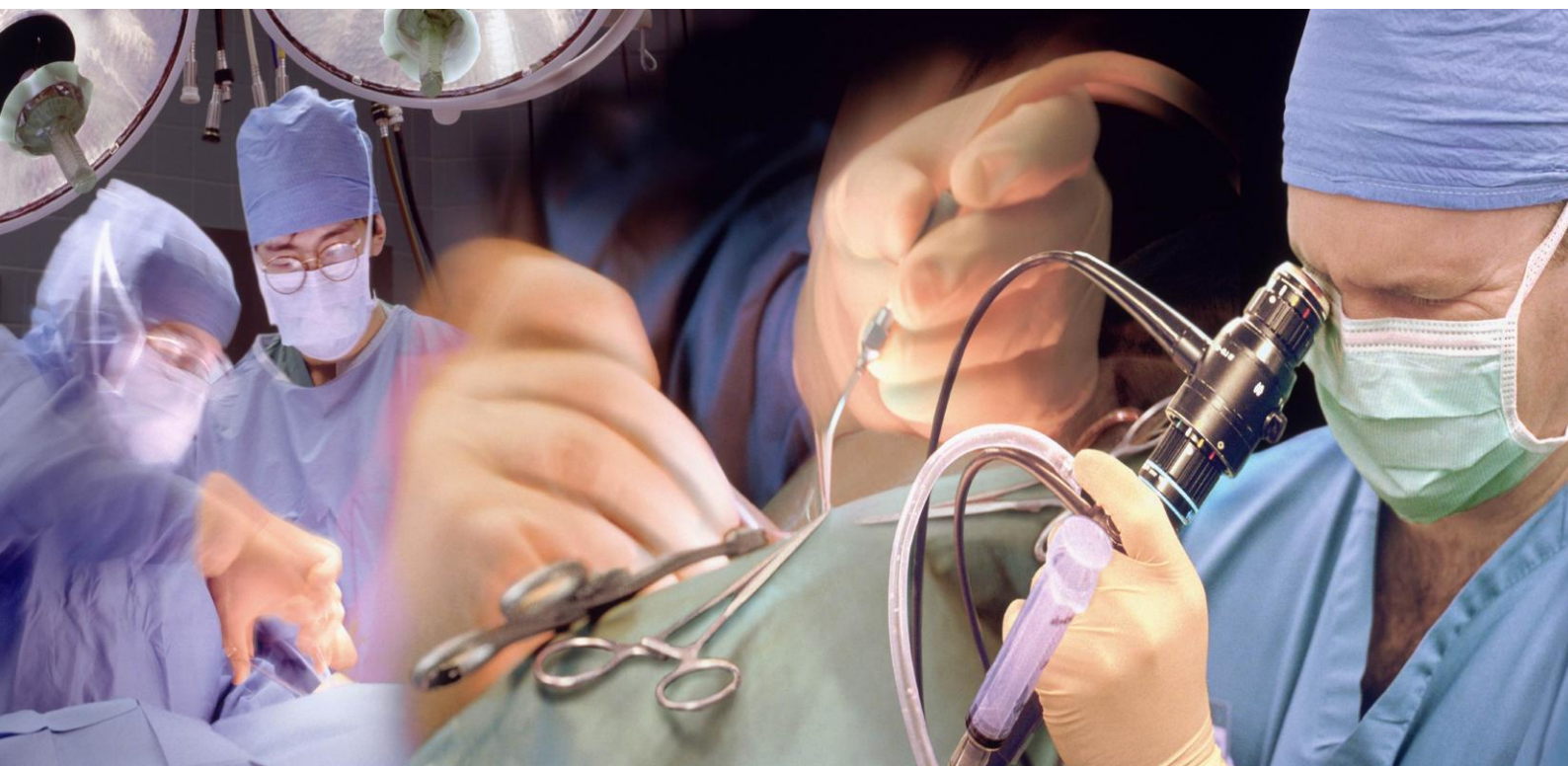


Activity

REPORT

2012



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I. INTRODUCTION

- > The European Hospital and Healthcare Employers' Association (**HOSPEEM**) was established in September 2005. Through European Sectoral Social Dialogue, HOSPEEM aims to ensure that the views of hospital and healthcare employers are properly taken into account by the EU institutions when they launch policies in the European Union (EU) that have a direct impact on management and labour relations in the hospital and health care sector. HOSPEEM is recognised as a Social Partner (since 2006) in the hospital sector by the European Commission and takes a part in the hospital sector Social Dialogue Committee alongside the European Federation of Public Service Unions (EPSU).
- > HOSPEEM was established following several years of work aimed at creating Social Dialogue in the European hospital sector that began after there was close contact between employers and trade unions in the late 1990's. The process began to gather pace in May 2000, when the Danish Social Partners, organised a conference under the auspices of the European Union's Leonardo Da Vinci programme.
- > In 2002, following a second conference of the European hospital sector Social Partners, a Joint Representative Taskforce was established with the aim of applying to the European Commission for a formal Social Dialogue Committee. Further momentum was added to the process in 2004, through a conference held by the Dutch Social Partners, which helped to identify the work areas that the hospital sector Social Dialogue could focus on.
- > Up to this point, CEEP (European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest) had been working alongside EPSU to establish a Hospital Sector Social Dialogue. However, CEEP's remit which covers the entire public sector, led to serious issues in relation to the representation criteria set by the Commission for Social Dialogue. As a result, CEEP's hospital members established HOSPEEM as a new organisation. Since its creation HOSPEEM has maintained its close links with CEEP by becoming a member.
- > The process of establishment was completed in July 2006, when HOSPEEM was officially recognised by the European Commission as a Social Partner in the Hospital Sector Social Dialogue. HOSPEEM then took its place alongside EPSU in the Hospital Sector Social Dialogue Committee.

II. ORGANISATIONAL DEVELOPMENTS

- > HOSPEEM has two bodies that govern the organisation and set its future direction. These are the **General Assembly** and the HOSPEEM **Steering Committee**.
- > The HOSPEEM General Assembly has the power to modify the organisation's statutes and accept applications by potential members and observers. It also has the power to appoint and dismiss the HOSPEEM Secretary General, the two vice Secretary Generals and the HOSPEEM Steering Committee.
- > The HOSPEEM Steering Committee sets the strategic direction of the organisation. It also manages and administers the association and drafts the mandates on behalf of HOSPEEM, subject to final approval by the General Assembly, for negotiations on European Social Partners' agreements. The HOSPEEM Steering Committee consists of the Secretary General, the two vice Secretary Generals plus four other members elected from the HOSPEEM membership.
- > HOSPEEM also has a **Board** that consists of the Secretary General and the two vice Secretary Generals. The Board is involved in the day-to-day management of HOSPEEM.
- > Since December 2011 HOSPEEM has had a separate body responsible for advice on its financial matters, i.e. the **Financial Advisory Committee**.
- > HOSPEEM Steering Committee's composition in 2012 was as follows:
 - Godfrey Perera – Secretary General
 - Miroslav Jiranek – Vice Secretary General
 - Tjitte Alkema - Vice Secretary General
 - Jevgenijs Kalejs
 - Ulrike Neuhauser
 - Eva Weinreich-Jensen
 - Elvira Gentile
- > As a result of elections in the end of 2012 the positions of Secretary General and Vice Secretary Generals as of the beginning of 2103 will be given to:
 - Tjitte Alkema - Secretary General
 - Ulrike Neuhauser - Vice Secretary General
 - Elvira Gentile - Vice Secretary General
- > HOSPEEM Financial Advisory Committee in 2012 is composed of:
 - John Delamere
 - Bjørn Henriksen

- Nadège Houdeau

> The Secretary General, Vice Secretary Generals, the Steering Committee will continue to oversee and foster the growth of the organisation and will continue to set its future direction and goals.

III. MEMBERSHIP

> One of HOSPEEM's key objectives over the coming years will be to increase its membership in order that the organisation can become even more representative in the European hospital sector Social Dialogue.

> Becoming a Member of HOSPEEM allows organisations to have their voice heard at European level, as well as the opportunity to learn from and make connections with employer's organisations from other European Member States. The Hospital Sector Social Dialogue also gives national employers the opportunity to take part in European level discussions and increase their influence at European level.

>The HOSPEEM members are divided into two categories: full members and observers.

HOSPEEM full members have the possibility to propose subjects for discussions on the HOSPEEM meetings and possess voting rights. They can be also elected to the HOSPEEM statutory bodies.

The full members of HOPSEEM in 2012 are:

The Austrian Hospital and Health Services Platform – Austria

HIC Nadejda S.A. – Bulgaria

Association of Czech & Moravian Hospitals – Czech Republic

Danish Regions – Denmark

Estonian Hospitals Association – Estonia

CLAE – Commission of Local Authority Employers – Finland

FEHAP – France

VKA – Germany

HSE – Ireland

ARAN – Italy

Latvian Hospitals Association – Latvia

Lithuanian National Association of Healthcare organizations – Lithuania

SPEKTER – Norway

SALAR – Sweden

NVZ – The Netherlands

NHS European Office – UK

> Becoming a HOSPEEM observer allows to participate in the work of HOSPEEM as an associate member without the possibility to propose subjects for discussions on the HOSPEEM meetings and without voting rights. Observers cannot also be elected to the HOSPEEM statutory bodies.

> The HOSPEEM observer in 2012 is:
AGE.NA.S - Italy

IV. REPRESENTING MEMBERS VIEWS

> As an association of hospital and healthcare employers, one of HOSPEEM's key objectives is to represent the views of its members to the European institutions, including the European Commission. As a Social Partner, HOSPEEM has represented its member's views by responding formally in writing to European Commission consultations and through its networking activities with key individuals from the European Institutions. Both these methods have been successful in ensuring that the views of employers have been heard at the highest levels.

> As HOSPEEM is a recognised Social Partner in the hospital sector. The European Commission (in particular the Directorate General on Employment, Social Affairs and Equal Opportunities – DG EMPL) has an obligation, following Article 154 of the TFEU (Treaty on the Functioning of the European Union) to consult HOSPEEM on any draft proposals concerning social policies in the hospital sector. Moreover, HOSPEEM has the opportunity to give its views on open consultations relevant to the healthcare sector, such as those launched by the Directorate General on Health and Consumers – DG SANCO. HOSPEEM has responded to several European Commission consultations on behalf of its members. The responses submitted have been formed from a consensus view of all the members. HOSPEEM has responded to the Commission on a number of issues that are relevant to the hospital and healthcare sector. The issues were:

- **DG SANCO** consultation regarding Community action on health services
- **DG EMPL** consultation of the Social Partners on protecting European healthcare workers from blood-borne infections due to needlestick injuries
- **DG EMPL** questionnaire on the practical implementation of Directive 2003/88/EC concerning certain aspects of the organisation of working time.
- **EUROPEAN COMMISSION'S** green paper consultation on the European workforce for health.
- **DG EMPL** first and second stage consultation of the European social partners on the protection of workers from the risks related to exposure to electromagnetic fields at work.
- **DG EMPL** first and second stage consultation of the European social partners on the reviewing of the Working Time Directive

- **DG EMPL** HOSPEEM-EPSU Joint response on the proposal for a directive on the modernisation of the Directive 2005/36/EC on the recognition of professional qualifications

Networking activities

> As a Social Partner, HOSPEEM has access to senior figures within the European Institutions, other relevant European organisations and stakeholders for the European hospital and healthcare sector. This means that HOSPEEM has the opportunity to put forward the views of employers on employment and industrial relation issues directly to key individuals at the EU Commission, the European parliament and the Council. The most relevant involvement of HOSPEEM in the activities of EU Institutions has been:

DG Employment

HOSPEEM closely cooperated with DG Employment on numerous issues, e.g.:

- HOSPEEM-EPSU joint Project “Promotion and support of the implementation of Directive 2010/32/EU on the prevention from sharps injuries in the hospital and health care sector” which has been supported by the DG.
- HOSPEEM involvement in the cross-sectoral negotiations on the Working Time Directive, including HOSPEEM-EPSU meeting with László Andor, the European Commissioner for Employment, Social Affairs and Inclusion aimed to discuss the issue.
- HOSPEEM involvement in the "Feasibility Study on the Establishment of a European Sector Council on Employment and Skills for Nursing and the Care Workforce" which was supported by DG Employment.

DG SANCO

HOSPEEM further strengthened its relations with DG SANCO through its engagement in shaping and implementation of the Action Plan on EU healthcare Workforce, including participation in stakeholders working group meetings, regular contacts with DG SANCO officials, and involvement of DG SANCO in HOSPEEM-EPSU Social Dialogue meetings.

Continuing to represent member's views

> During the coming years, HOSPEEM will continue to network and lobby on behalf of members in order that the views of employers are taken in to account when policy is being formed. HOSPEEM will keep members informed and involved in the latest developments and will continue to represent their views to the European Institutions. HOSPEEM will also seek to recruit new members in to the organisation so that it can more accurately represent the views of healthcare employers across Europe.

V. INFLUENCING LEGISLATION AND POLICY

> HOSPEEM members feel it is very important that the organisation is a Social Partner and take a part in European sectoral Social Dialogue. Being a Social Partner has many benefits for HOSPEEM and this stems from the key role accorded to European Social Partner organisations as co-legislators and influencers of European policy by the TFEU (Articles 153-155).

Article 154 of the TFEU envisages the obligatory consultation of social partners on all matters of social policy laid down in **Article 153**. The consultation process has two stages:

- If the Commission considers EU action advisable, it must then consult workers and employers on the **content** of its planned proposal.
- Before submitting proposals for new social policy legislation, the Commission has to consult workers and employers on the possible **direction** of EU action.

After the second stage, the European social partners can inform the Commission that they wish to open negotiations and start the process laid down in Article 155.

Article 155 addresses the negotiations through which the European social partners can conclude agreements on social policy. In this way, employers and workers have the opportunity to conclude agreements at EU level. Any agreements concluded by the European social partners will be legally binding once implemented.

The **implementation** can take one of the following forms:

Either the European social partners ask the Council to adopt a decision (in practice, this is a directive, proposed by the Commission). In this way, the agreement becomes part of EU law; or the social partners make their national member organisations responsible for implementing the agreement in line with the relevant national procedures and practices. These are known as "autonomous agreements".

> As well as being consulted by the European Commission on potential legislation, the other benefits to HOSPEEM of being a Social Partner include:

- **The Hospital Sector Social Dialogue committee** provides a structured and regular platform for the exchange of information, the opportunity to learn from European solutions and experiences and to agree joint positions, not solely under the form of framework agreements.
- **Full members of HOSPEEM** have the right to take an active role in negotiations and discussions on issues that are important to the hospital sector.

- **Full members of HOSPEEM** are seen as major players (and as a source of expertise and information) in the hospital and health sector by the main European institutions.
 - **The ability to exercise political pressure** and to have the right to participate in negotiations at European level increases the lobbying pressure and the influence of HOSPEEM members at national level.
- > HOSPEEM's high profile has enabled it to represent its member's views effectively. Being a Social Partner has meant that the European Commission has sought the views of HOSPEEM members and has listened to their opinions. The status of Social Partner is giving HOSPEEM and its members excellent access to the European Commission and its officials.

VI. HOSPEEM SUCCESSES

- > As a Social Partner, HOSPEEM has jointly taken forward several strands of work with EPSU (The European Federation of Public Service Unions), its partner in the Sector Social Dialogue Committee for the Hospital Sector. As part of the first work programme of the Social Dialogue committee, HOSPEEM and EPSU established three working groups to examine issues that were of key concern to the hospital sector in Europe and worked on a project to strengthen Social Dialogue in the new Member States and candidate countries. HOSPEEM and EPSU have also issued a joint statement on health services in Europe and supported a conference in Poland that examined the role of Social Dialogue in the privatisation of healthcare and the migration of healthcare staff.
- > The working groups, project, joint statement and conference have demonstrated to the European Commission, the willingness and ability of employers and trade unions to work together effectively in the hospital sector. As a new Social Dialogue committee, it has been vital for HOSPEEM and EPSU to demonstrate viable joint working.

Code of conduct on ethical recruitment

- > One of HOSPEEM's main achievements has been the launch of a code of conduct and follow-up on ethical cross-border recruitment and retention in the European hospital sector with EPSU. HOSPEEM and EPSU signed the Code in April 2008. These voluntary guidelines focus on healthcare professionals moving to work in another European Union State and highlight the responsibilities of both employers and healthcare professionals in this process. The guidelines examine issues such as induction, the information healthcare professionals need to give employers, registration and permits.
- > The guidelines were signed and shared across the European Union and implemented by HOSPEEM and EPSU members. A joint report on the

implementation of the Code of conduct was published by HOSPEEM and EPSU in 2012. A full version of the Code of Conduct can be found in annex.

> HOSPEEM started also cooperation on recruitment and retention issues with the World Health Organization who had issued a Code of practice on the international recruitment of health personnel.

Project to Strengthen Social Dialogue in the new Member States and candidate countries

> In 2007/2008 HOSPEEM and EPSU worked together on a project to strengthen Social Dialogue in the new Member States and candidate countries. The aim of the project was to help the Social Partners in these countries to build up their domestic Social Dialogue systems. The underlying belief is that strengthening national Social Dialogue in these countries will lead to an improved representation from these countries in European level Social Dialogue.

> The project had two main deliverables. The first was background research on the organisation and financing of the hospital sector in Europe, the key labour market issues facing the sector and the Social Partners, and the processes of collective bargaining and Social Dialogue at the national level in the EU-27. The second deliverable focused on capacity building, which would help Social Partners to better influence the Social Dialogue process at both national and European level.

> The capacity building part of the project was centred on the Czech Republic and Slovakia. Social Partners from other Member States shared with the Czech and Slovak Social Partners their experiences of Social Dialogue and demonstrated the value of working in partnership. Two seminars were held in the Czech Republic and Slovakia with the closing conference being hosted in Prague. The seminars and conference gave the opportunity to the Czech and Slovak Social Partners to get together, build relationships and learn from the experience of Social Dialogue in other countries.

> All parties agreed that the project had been very useful in establishing links and strengthening Social Dialogue in both the Czech Republic and Slovakia. It also provided invaluable information on Social Dialogue across the whole of Europe, which has proved to be indispensable for HOSPEEM to improve its representation at European level.

Joint declaration on health services

> In response to the European Commission's plans to publish a directive on cross-border healthcare, HOSPEEM and EPSU published a joint declaration on health services in December 2007. The declaration set out the joint view of the Social Partners on the principles upon which the management, financing

and delivery of healthcare in the European Union should be based. The importance of the joint declaration was that it highlighted the many areas in which HOSPEEM and EPSU agree and sent a powerful message to the European Commission.

> A full version of the declaration can be found in annex. The health declaration was an excellent example of partnership working between HOSPEEM and EPSU and demonstrated the value of being a Social Partner and the influence that the Social Partners can have when they work together. The declaration also helped to establish the lobbying position for HOSPEEM when the Directive was eventually published in July 2008.

> HOSPEEM responded to this draft Directive in a position statement that emphasised:

- The importance of the principle of subsidiarity in healthcare;
- The need for effective prior authorisation procedures to be in place;
- The desire of healthcare employers to avoid unnecessary administrative burdens in relation to national contact points on cross border healthcare and data collection.

> HOSPEEM will continue to try and influence the European Commission on future proposals relating to cross border healthcare.

Conference on the role of European and national Social dialogue in a changing hospital and healthcare structure

> In 2008 the Hospital Sector Social Dialogue committee, HOSPEEM and EPSU helped to support and secure funding for a conference on the role of European and national Social dialogue in a changing hospital and healthcare structure. The conference, hosted in Warsaw, was organised by the Polish Health Confederation and examined two key issues. It looked at the role of Social Dialogue in the privatisation of healthcare and at the migration of healthcare professionals in Europe.

> The migration of healthcare professionals across borders is an issue that affects many HOSPEEM members. This is particularly an issue in some of the new Member States that are losing qualified health professionals who decide to migrate to other countries offering better working conditions. The conference was valuable as it gave a chance for the issue to be discussed and for solutions to be debated. It also emphasised the value of Social Dialogue in helping to achieve partnership solutions to some of these key issues.

Framework agreement on prevention from sharp injuries in the hospital and health care sector

> The European Parliament has been very interested in this subject for a number of years and has been working with the European Commission to draft a directive on needlesticks. HOSPEEM was concerned at the financial implications of such a directive as it would have required the use of safer needles in all situations - even where their use was not the best solution. HOSPEEM therefore lobbied both the Commission and our partner EPSU to explore the possibility of negotiating an agreement on this. There was a seminar in February 2008 organised by the European Commission that clearly showed the complexity of this issue. EPSU agreed to negotiate with HOSPEEM, and the social partners jointly wrote to Commissioner Spidla proposing to enter in negotiations.

> HOSPEEM at that time was also invited to appear before the European Parliament, together with EPSU, to answer questions on why the social partners wished to negotiate on a subject that the Parliament had been working on for a number of years. The members of European Parliament were displeased by the fact that the social partners had intervened and that the Commission had given the approval to start negotiations for an agreement. Part of the Parliament's concern was the fact that once the social partners had made an agreement, which was going to be transposed into a directive, they would have no say in the matter and would have to rubber stamp the agreement. HOSPEEM and the EPSU agreed upon a framework agreement on the prevention from sharps injuries on 2 June 2009. The framework agreement was approved by the European Commission and was signed by representatives from HOSPEEM and EPSU on 17 July 2009 in the presence of Commissioner Spidla at the European Commission.

The agreement was then transposed into Directive 2010/32/EU on the prevention from sharp injuries in the hospital and healthcare sector adopted on 10 May 2010.

> The key purposes of the Directive are:

- to achieve a safe working environment;
- to prevent workers injuries with all medical sharps (including needlesticks);
- to protect workers at risk;
- to set up an integrated approach establishing policies in risk assessment, risk prevention, training, information, awareness raising and monitoring;
- to put in place responses and follow-up procedures.

> The benefits of this directive stemming from its nature of Social Partners agreement are:

- There are no provisions at European level on the use of the new safety needles for all treatments. According to the agreement the risk assessment should decide when and if the new safety needles need be used. As the new needles can cost far more than the cost of normal needles and if the directive

proposed by the Commission had gone through it would have had significant cost implications for our health budgets.

- The directive stresses the importance of risk assessment and requires employers to put in place a wide range of procedures to avoid injuries with medical sharps including needlesticks.

The deadline for the transposition of the Directive into national legislation is 11 May 2013.

The text of the agreement can be found in annex.

Multi-sectoral initiative and Guidelines on Third Party violence

> In April 2007, the cross sector Social Partners issued a framework agreement on harassment and violence at work. This agreement did leave the way open to cover third party violence in national implementation, which is an important issue for several sectors. A meeting between a number of sectoral employers (HOSPEEM, CEMR, CoESS, EuroCommerce) was organised and this was followed by a joint meeting with the trade unions (EPSU and UNIEuropa). At this meeting the employers elected Mr Perera to be the chair of the employers group. At the joint meeting with the trade unions it was agreed by all the parties involved that further research was necessary.

> HOSPEEM organised an event that took place on 22 October 2009 as part of the 'RESPECT' project involving relevant social partners' stakeholders to discuss the issue of third party violence and possible action in this area. The project had the following main objectives:

- to reduce the overall level of third part violence at work and to mitigate its negative effects;
- complement the 2007 cross-sectoral framework agreement adopted by ETUC, BusinessEurope, CEEP and UEAPME, in particular chapter 4 of this agreement;
- confirm the responsibility of employers, in co-operation with trade unions and workers, to ensure and promote a working environment free from third party violence;
- identify the different measures and processes introduced by social partners to prevent and manage problems of third party violence at work;
- provide a framework for monitoring, evaluation and review.

> At the conference, the multi-sectoral employers and the trade unions agreed that negotiations would follow. The negotiations started in January 2010. At the beginning of the negotiations, the employers group invited EFEE (European Federation of Educational Employers) to join them. A final agreement was made on 16 July 2010 and the European Commission/DG Employment, who followed this agreement very closely, expressed their pleasure at this achievement.

> On 30 September 2010, at the Liaison Forum on the development of the sectoral social dialogue committees, the European Commission organised an official signing ceremony of the agreement for the press.

Project on the implementation of Multi-Sectoral Guidelines on Third-Party Violence at Work

The organisations that were party to the multi-sectoral agreement decided to disseminate the Guidelines applying for funding from the European Commission for a project to assist with the translation of the Guidelines into all EU languages, for three regional seminars and a final conference.

HOSPEEM participated in the three workshops as well as in the final conference of this project. GHK Consulting was commissioned to assist in the moderation of these events and in the preparation of the reports.

The **regional workshops** took place in London on 9 May 2011, in Rome on 14 June 2011, and in Prague on 6 September 2011. Each of them was attended by participants from different European countries. In total in the events were involved 22 EU Member States + Croatia and Macedonia.

The participants in the seminars were given a background of the project with a comprehensive explanation of figures, challenges and aims. Each workshop was attended by experts on third-party violence who presented good practices to tackle it. The presentations were followed by a discussion and questions from the participants on possible ways to effectively replicate the good practices exchanged, and implement the Multi-Sectoral Guidelines at national level. Finally, in line with the aim of the workshops to disseminate the Guidelines, a specific slot was dedicated to national working groups to discuss on the status of implementation, quality of the translation and ideas on how the Guidelines could be further spread within the EU Member States.

Final Conference

The cycle of regional seminars was closed by a final conference held in Warsaw on 27th October 2011, which saw the participation of all the national social partners' organisations. The presentation of the project outcomes held by Tina Weber (GHK) was followed by examples of concrete steps taken by the participants towards the implementation of the Guidelines following the national workshops.

The next steps to undertake were discussed by the Secretariats of the European Sectoral Social Partners together with DG EMPL.

Follow-up

The progress report on the implementation of the guidelines, as well as the final joint evaluation, will be published by the the Cross-sectoral Social Partners in 2013.

Project to Strengthen Social Dialogue in the Baltic Countries

> In 2010/2011 HOSPEEM developed together with EPSU a project to strengthen Social Dialogue in the Baltic Countries: Estonia, Latvia and Lithuania. It was financed by the European Commission and supported by EPSU. The key result of the project was the “Riga Declaration” (in annex) signed by Baltic social partners, HOSPEEM and EPSU.

Participation in Project "Feasibility Study on the Establishment of a European Sector Council on Employment and Skills for Nursing and the Care Workforce" and monitoring of EU initiatives on skills development and forecasting

Throughout 2012 HOSPEEM contributed as a partner organisation to the ["Feasibility Study on the Establishment of a European Sector Council on Employment and Skills for Nursing and the Care Workforce"](#) run by the European Health Management Association. The study was run by European Health Management Association under the umbrella of the European Commission.

The objective of the study was to analyse the feasibility of establishing a European Sector Council on Employment and Skills for Nursing and the associated Care Workforce. The Council might be a platform at sectoral level where stakeholders could seek an insight into the likely developments in employment and skills needs for nursing and care staff, with the aim of assisting policy making with a European dimension.

The study was focused on possible scope, activities and mandate of the Council, including the labour market trends across the whole health workforce as well as the impact of global health workforce. It covered initial vocational education and training, continuing vocational education and the contribution of Higher Education.

In December 2012 HOSPEEM together with EPSU proposed criteria to assess the outcome of the study and possible next steps. Both organisations claim that the added value of creating the **European Sector Council on Employment and Skills for Nursing and the Care Workforce** has not been proven by the study. The final report will be published in 2013.

Support in elaboration and implementation of the Action Plan on EU healthcare Workforce

HOSPEEM and EPSU were invited by the European Commission to contribute to the elaboration and implementation of the Action Plan on EU healthcare Workforce.

The Action Plan is as a part of the so-called “Employment Package” issued by the European Commission to support the economic recovery across the EU by boosting jobs, in particular in the green economy, ICT, and health and social care.

HOSPEEM has also become a collaborative partner in Joint Action, one of the main pillars of the Action Plan, which enhances its relations with DG SANCO and the other stakeholders involved. HOSPEEM participated in working group meetings, had regular contacts with DG SANCO and invited DG SANCO officials in HOSPEEM-EPSU Social Dialogue meetings over 2012.

The Action Plan was adopted in April 2012. In September 2012 HOSPEEM together with EPSU adopted a Joint Statement (See in annex) aimed at highlighting key issues of the Action Plan of interests to both organisations and expressing their point of view on its critical aspects. By this statement the Social Partners welcomed the Action Plan of the European Commission and the strong focus of European employment and training policies on the healthcare sector. EPSU and HOSPEEM also expressed their interest in being consulted by the European Commission on further steps and for their members in being involved in the implementation of concrete future measures that are linked to the outcomes of their work and negotiations.

Project: “Promotion and support of the implementation of Directive 2010/32/EU on the prevention of sharps injuries in the hospital and health care sector”

> Clause 11 of the framework agreement on the implementation of Directive 2010/32/EU stipulates that the interpretation of the agreement could be referred by the Commission to the signatory parties, i.e. HOSPEEM and EPSU, for them to give their opinion. They therefore would need to know about the reality on the ground.

For this reason, both organisations on 17 April 2012 jointly requested the European Commission to provide them with financial support for a project aimed at promoting and supporting the implementation of Directive 2010/32/EU. The official notification of the approval of the project was issued by the Commission in August 2012.

> The project has been shaped in a way to allow HOSPEEM and EPSU to obtain first hand and early information on the realities of the implementation on the ground. It is aimed to increase awareness among their national members (in particular top and middle management, OSH representatives, shop-stewards), public authorities (Ministries, accident insurances, OSH institutions, etc) and other stakeholders on the possibilities and advantages of taking action to reduce risk exposure and accident rates with medical sharps. This will be done also by involving other interested parties (e.g. OSHA national contact points). A certain focus will be put on Member States having joined the EU in 2004 and 2007 as well as on candidate countries.

> The main deliverables of the project will be:

- A survey addressed to the social partners in the hospital sector across all EU Member States, on the state of play in the transposition and implementation of the Directive,
- Three regional seminars in Dublin, Rome and Vienna, followed by a final conference in Barcelona aimed to take stock of the findings gathered during the project and to feed this into the final report which will be published and presented to the European Commission,
- Setting up of a webpage dedicated to the project with documents (in particular guidance to those working on the ground) and links (to relevant pages and documents of other stakeholders):
<http://hospeem.org/activities/projects/hospeem-epsu-project-on-sharps-injuries/>

> The preparatory phase of the project carried out in 2012 comprised:

- October 2012: Kick-off meeting of a Steering Committee made up of representatives of the social partners jointly running the project. The Committee is in charge of giving orientations and guidance for the successful development of the actions.
- November 2012: Launch of the survey to EPSU and HOSPEEM members on the status of implementation of the Directive:
<http://hospeem.org/activities/projects/hospeem-epsu-project-on-sharps-injuries/>

VII. THE HOSPEEM - EPSU WORK PROGRAMME 2011 - 2013

> Reference Frame 1: HOSPEEM-EPSU Framework of Actions “Recruitment and Retention” (2010)

- Addressing challenges related to new skill needs and life-long learning to support a sustainable workforce management
 - Exchange on priority issues and objectives for revision of Directive on the Recognition of Professional Qualifications 2005/36/EC
 - Explore the possibility of a joint HOSPEEM-EPSU contribution to the consultation run by the European Commission (until first half of March 2011)
 - Discuss next steps in view of the Green Paper 2011 and the revision of the Directive announced for 2012 in the framework of a dedicated plenary meeting, building on the preparatory work as described above
 - Collect and exchange good practice concerning the identification of skill needs (also related to technology/ICT/e-Health) and measures to address them in order to improve workforce planning and to promote recruitment and retention policies

- Explore the added value of a joint HOSPEEM-EPSU initiative on the basis of the Framework of Action to address skill gaps and to promote the development of competencies and qualifications across professional careers to meet new needs of work organisation, service delivery and patient satisfaction
- Improve well-being of workforce at work, including work-life balance, in the context of an improved work organisation
 - This entails e.g. measures to improve the reconciliation of work and family obligations, working patterns, innovative work place design, technical equipment and devices alleviating physical strains, measures to prevent from and address mobbing and harassment
 - Identify effective solutions that exist and have been or are currently negotiated and jointly developed by social partners
 - Discuss their transferability and spreading in the framework of a dedicated plenary meeting including preparatory work
- Encourage diversity in and work towards a balanced health workforce
 - This comprises e.g. a better mix of younger and older staff, initiatives to increase number of male staff and to cater for special needs of migrant workers
 - Collect and exchange good practice of projects and policies in support of these objectives in view of producing information for decision makers and management staff
 - Assess which policies and instruments have been further developed or set up by social partners under different regulatory frameworks, in particular in the context of a dedicated plenary meeting including preparatory actions

> Reference Frame 2: European Action Plan on the Health Care Workforce

- Develop policies and instruments to address the challenges and new needs related to the ageing health care workforce
 - Collating case studies and collecting good practice based on the 2006 HOSPEEM-EPSU study “Promoting realistic active ageing policies in the hospital sector”
 - Update existing material and produce information for management and staff
 - Working towards a HOSPEEM-EPSU agreement on the ageing health care workforce to be prepared for a dedicated plenary meeting
 - Exchange on good practice models and key elements of the planned agreement with European institutions and other stakeholders related to actions/initiatives of the European Action Plan on the Health Care Workforce
 - Explore possibilities for dissemination of results under the European Year 2012 for Active Ageing and Solidarity between Generations

> Reference Frame 3: Follow up to documents adopted and implementation of agreements concluded between 2008 and 2010 in the context of the European Sectoral Social Dialogue

- EPSU-HOSPEEM Code of Conduct on Ethical Cross-border Recruitment and Retention (2008)
 - Collect and share information on follow-up and implementation by social partners in different member states to prepare assessment agreed upon for 2012 in HOSPEEM-EPSU work programme 2008-2010
 - Present examples in the context of a dedicated plenary meeting to discuss good practice and existing deficits including ways to address them
 - Explore the possibility to commission a study to map migration flows and to dress up related opportunities and challenges for migrant workers, local healthcare workforce and healthcare systems in receiving and sending countries
 - Focus on putting together, re-analysing and updating existing material
 - Possibility to issue an enquiry (questionnaire-based) for members and affiliates

- Framework Agreement on the prevention from sharp injuries in the hospital and health care sector (2010)
 - Collect during 2011 (Social Dialogue in Baltic States Project) and 2012 information on follow-up and implementation (successes and deficiencies) by social partners
 - Explore possibilities of setting up a project to organise a series of seminars on the implementation of the Directive 2010/32/EU during 2012, financially supported by the European Commission (leading partner: EPSU)

- Multi Sector Guidelines to tackle third party violence and harassment related to work (2010)
 - Collect information on follow-up and implementation (successes and deficiencies) by social partners in different Member States as well as of good practice examples
 - Participate in seminars to promote awareness raising and dissemination in 2011
 - Present suggestions for follow-up to plenary meeting

VIII. RELATIONSHIP WITH CEEP

HOSPEEM was created by the members of the European Centre of Employers and Enterprises providing Public services (CEEP) who felt that there was a need for a separate, distinct voice on health workforce issues at European level.

HOSPEEM is, since its creation, an individual member of CEEP. Between the two organisations there is a close link and they collaborate closely in the European arena on all issues that concern employment and health of the European workforce. The Secretary General of HOSPEEM is currently a member of the CEEP Board and participates in the CEEP Social Affairs Board and the General Assembly meetings.

IX. RELATIONSHIP WITH HOPE

> Since its creation, HOSPEEM has established a cooperation agreement with The European Hospital and Healthcare Federation – HOPE (in annex). In this agreement, both organisations recognise each other’s autonomy within their respective spheres of activities and competencies. The agreement also creates a framework for mutual support and lays the foundations for wider arrangements reinforcing the links between health professionals acting at European level. HOSPEEM and HOPE agree to be mutually supportive, constructive and have a close working relationship.

X. CONCLUSION

> In the past HOSPEEM has made giant strides in being accepted as an important voice on hospital and healthcare matters at European level and enhanced its position during a period of economic turmoil ensuring that the hospital and healthcare sector continue to be properly funded. HOSPEEM is now the first port of call when the European Commission wishes to discuss matters concerning hospital and healthcare workforce issues. Since its involvement in shaping and implementing the Sharps Directive HOSPEEM’s role as a European social partner significantly increased.

> As a recognised Social Partner, HOSPEEM has the key role accorded to European Social Partner organisations as legislators and influencers of European policy by the TFEU (Articles 153-155). This allows, and will continue to allow, HOSPEEM members a voice at the European top table. It is important that HOSPEEM continues to grow, and all HOSPEEM members will have to play important roles and give HOSPEEM their full support, if HOSPEEM is to thrive in representing its member’s views.

XI. ANNEXES



ANNEX A. HOSPEEM (European Hospital and Healthcare Employers' Association) response to the second-phase consultation "reviewing the working time directive" under article 154 of the TFUE

> Introductory comments

1. HOSPEEM welcomes the second stage consultation¹ published by the European Commission and the report on the implementation by Member States of Directive 2003/88/EC². The two documents provide a deep and interesting analysis on the implementation of the Directive and on the response of each Member State in complying with the Directive. The Consultation paper has pointed out the main issues of relevance and HOSPEEM is pleased to read from the consultation that the concerns raised with the response to the first consultation in May 2010 have been addressed by the European Commission.
2. As highlighted in HOSPEEM's response to the first phase consultation, the interpretation given by the European Court of Justice to cases SIMAP (C-303/98), Jaeger (C-151/02) and Dellas (C-14/04) has challenged the ability of health service employers to properly organise healthcare services in the EU 27, especially hospital services delivering 24/7 patient care, some highly specialised services and small and remote units.
3. HOSPEEM made clear in the previous response that more flexibility is needed in order to provide hospital managers with the necessary resources, in terms of staff, to organise health services efficiently. As underlined on several occasions³, the current and the future shortages of health professionals is one of the main issues of concern for our sector and it needs to be addressed in order to ensure that European healthcare services will be able to deliver high quality healthcare to an increasingly ageing European population.
4. HOSPEEM as a European Social partner is committed to develop strategies to encourage young people to undertake jobs in the health sector, in particular by enhancing the attractiveness of the health care sector as a place to work. This work needs to be supported by a European legislation that allows flexible and modern working patterns.

¹ COM (2010) 801 final Communication from the Commission to the Parliament, the Council and the Committee of the Regions Reviewing the Working Time Directive (Second-phase consultation of the social partners at European level under Article 154 TFEU)

² COM (2010) 802 final Report from the Commission to the Parliament, the Council and the Committee of the Regions on implementation by Member States of Directive 2003/88/EC ("The Working Time Directive").

³ "Report on the open consultation on the Green Paper on the European Workforce for Health", December 2009;

"Council conclusions on investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration", December 2010;
"HOSPEEM and EPSU Framework of Action on Recruitment and Retention", December 2010.

> **Developments since the Directive was introduced**

5. The 20th century working time directive is becoming increasingly irrelevant to the operation of hospitals in the 21st century.

Changes in working life

6. The Commission's communication acknowledges that the world of work has changed very significantly in the last twenty years. Evidence collected from Member States demonstrates that whilst hours worked have gradually been falling across Europe, this has more to do with an increase in part-time working than with a significant fall in full time hours of work. It is now possible for many people to perform work remotely or from home and to be contactable away from their place of work, potentially all the time, thereby blurring the boundaries between working time and personal time and bringing into question the concept of the "workplace".
7. The Commission's communication recognises that these developments are fundamentally altering the way in which working time is planned and organized and that legislation in this area needs to take account of these wider societal changes. We welcome this recognition, and are keen to work with the Commission and other social partners to update this area of European law so that it is fit for purpose in the 21st century.

The European workforce for health

8. The European Commission's Green Paper on the European Workforce for Health issued in December 2008, the follow-up report in December 2009 and the Council conclusions adopted in December 2010 all highlight the challenges facing European healthcare systems in the 21st century, such as increasing demand owing to the ageing population, coupled with an ageing workforce and shortages of healthcare workers. In some Member States, these shortages are severe and have been exacerbated by the consequences of the ECJ judgements on on-call time and compensatory rest, which require higher staffing levels than envisaged. There is an urgent need to invest in tomorrow's workforce by attracting, recruiting and retaining healthcare workers.
9. An important part of this strategy involves creating an attractive working environment that enables people to balance their work and family lives. Therefore, flexibility in working arrangements is an important element of this. The rigid rules enshrined in current working time legislation sometimes makes this more difficult because they assume working patterns which no longer reflect the reality of many people's lives. The recent sectoral social partner agreement "A Framework of Action on Recruitment and Retention", signed in December 2010 by HOSPEEM and EPSU, underlines the need to continually modernise working conditions, if the healthcare sector is to remain competitive in a challenging employment market.
10. The current economic climate and the need to deliver the "Europe 2020" targets mean that the healthcare sector has to operate as efficiently and effectively as possible if

high quality services are to continue to be delivered during a time of financial pressures. Working time legislation needs to support, not hamper, this strategy.

> Response to the consultation

Question 1

1. Should changes to EU working time rules be limited to the issues of on-call time and compensatory rest, or should they address a wider range of issues, such as some or all of those listed in section 5.2?

11. HOSPEEM believes that the major issues of concern for the hospital and healthcare sector are the issues of on-call time and compensatory rest. However, HOSPEEM does not exclude in principle that other issues could also be discussed for a revision of the Directive, bearing in mind that this should not jeopardise the possibility to reach an agreement on on-call and compensatory rest.
12. HOSPEEM recognises that the organisation of working time is a highly complex issue. It is also very sensitive, in particular considering the past attempts undertaken by the European Parliament and the Council to find a compromise for a revision. HOSPEEM is concerned that any further effort to find a solution through a co-decision procedure will fail again because of diverging views.
13. With regard to the two models presented by the Commission for reviewing the Working Time Directive, both these models have their attractions. A wide ranging review of the Working Time Directive would modernise and update it. It will also take into consideration changing work patterns and the modern way in which healthcare is organised in the 21st century. However, the danger of this option is that it may open up a whole new set of problems that we had not envisaged, including possible new ECJ rulings in the future.
14. On the other hand, a focused review of the Working Time Directive would be seen to be a tempting way forward because it may resolve the current problems. However, the criticism of this is that it would not modernise the Working Time Directive and might require further action to modernise the Directive at a later date.
15. HOSPEEM believes that the best way to resolve the problem is through negotiations and does not think it would be helpful in taking any action which would tie the hands of future negotiators. Therefore, HOSPEEM believes the best way forward is not to make any firm decision on these two options for the present.

Question 2

- 2. Bearing in mind the requirements of Article 153 TFEU do you consider that:*
- a) the options set out in section 5.1 regarding on-call time and compensatory rest,*
 - b) some or all of the options set out in section 5.2 regarding other issues raised by social partners and the current review,*

could provide an acceptable overall framework for addressing the concerns set out in your replies to the first phase consultation?

16. HOSPEEM recognises the hard work made by the European Commission in identifying the issues of concern for the European social partners and the solutions suggested to pave the way for a revision of the Directive 2003/88/EC.
17. HOSPEEM has addressed in the paragraphs below the core issues for our sector, giving its comments on the framework provided by the European Commission in its consultation paper.

The on-call time and compensatory rest

18. HOSPEEM especially welcomes the Commission's recognition that the SIMAP and Jaeger rulings on on-call time and compensatory rest have created significant difficulties in implementation for Member States, and that these difficulties are especially acute in sectors such as healthcare where it is essential for some services to be provided twenty four hours a day, seven days a week. HOSPEEM's view is that the case law results in a very rigid application of the rules which benefits neither workers nor patients. For example, services such as outpatient clinics or operating lists may be cancelled or disrupted the following morning if a health worker is obliged to take compensatory rest immediately as a result of having been called out for a relatively short period the previous night – even though they may have spent most of the night asleep and have had an adequate amount of rest.
19. HOSPEEM would welcome a solution to the issues of on-call time and compensatory rest which would allow greater flexibility in the calculation and timing of work and rest periods, so that services to patients can be planned more easily whilst still protecting the health and safety of staff. Our view is that the Directive's current provisions focus too narrowly on duration of hours worked and do not take into account the differing intensities of work during periods of working time. This is especially the case in healthcare services, where there may be unpredictable peaks and troughs in demand, particularly overnight and at weekends.
20. In revising the Directive, HOSPEEM would like to return to the fundamental principle which underpins it – the protection of workers (and by extension the public they serve) from excessive tiredness and its consequences, on the grounds of health and safety.
21. HOSPEEM supports the proposal made by the European Commission to *“introduce a derogation, limited to sectors where continuity of service is required, which would allow periods of on-call time to be counted differently (i.e. not always on a hour-per-hour basis: the ‘equivalence’ principle) subject to certain maximum weekly limits and provided that the workers concerned are afforded appropriate protection”* which could represent a good starting point for a discussion on a possible satisfying solution to the current impasse.

22. HOSPEEM also welcomes the Commission's proposal to leave *"to social partners the flexibility to find solutions at local or sectoral level and identify the most appropriate method for counting on-call time"*. It would give to the appropriate level or sector the possibility to assess the extent of risk involved and the degree of flexibility needed (e.g. taking into account the differing intensities of work during periods of working time. This is especially the case in healthcare services, where there may be unpredictable peaks and troughs in demand, particularly overnight and at weekends).
23. HOSPEEM supports Commission's statement which underlines that more flexibility is needed with regard to compensatory rest, in a range of specific situations.
24. It should be left to the social partners to decide on the flexibility needed, which is required to deal with on the one hand, by the specific workload and on the other hand, the work-life balance of the employee.

The opt-out

25. HOSPEEM agrees with the analysis provided by the European Commission. It is not realistic to ask Member States to renounce to the use of the opt-out, especially as 16 Member States now make use of this derogation. HOSPEEM supports the retention of the opt-out. However, HOSPEEM believes that alternative solutions, including more flexible forms of work organisation, individualised working hours and more flexibility on compensatory rest would reduce the need to use the opt-out.

Question 3

3. *Are the EU social partners, at cross-industry or sectoral level, willing to enter into negotiations on all or part of the issues raised in this communication with a view to concluding an agreement that would make it possible to amend the Directive by using the possibilities provided under Article 155 TFEU?*

26. HOSPEEM believes that social partners are in the best position to resolve this contentious issue. The Working Time Directive has a cross-industry application and affects many sectors of the economy in the EU. Given these facts, HOSPEEM views is that the cross-industry social partners are the obvious candidates to negotiate an agreement on the amendment of the Directive.
27. Should negotiations at cross-industry level not be possible HOSPEEM will consider if other options are available.

> Conclusions

28. HOSPEEM would like to see the outstanding issues on on-call and compensatory rest resolved as a matter of urgency, as it is detrimental to the efficient functioning of European healthcare systems. The problems caused by the European Court of Justice with the SIMAP, Jaeger and Dellas rulings must be resolved.

29. Furthermore, HOSPEEM would like to reiterate its position on the opt-out, which is a fundamental instrument of flexibility for the hospital sector and any attempt to restrict it would cause huge consequences for the operation of the healthcare services in the EU 27.
30. Finally, HOSPEEM is convinced that the instrument of social dialogue between social partners, as envisaged under article 155 of the Treaty on the functioning of the European Union, is the best solution to address the concerns raised.
31. Cross-industry social partners should be given the opportunity to resolve the problem. If they are unable to do so, HOSPEEM will consider if other options are available.

ANNEX B. HOSPEEM-EPSU contribution to public consultation on the directive on the recognition of professional qualifications (2005/36/EC)

1. Explanatory note on the joint HOSPEEM-EPSU contribution

1.1 Joint HOSPEEM-EPSU response

HOSPEEM, the European Hospital and Healthcare Employers' Association, and EPSU, the European Public Service Union, have decided to submit a joint response to this consultation.

It has to be read as complementary to the response sent by EPSU on the 15th of March 2011 and to replies of individual EPSU or HOSPEEM members.

This joint reply reflects the issues, concerns and proposals on which full or broad consensus between the European social partners for the hospital and health care sector could be reached.

1.2 Guiding principles for EPSU and HOSPEEM in view of updates and revisions of directive

EPSU and HOSPEEM agree that three key objectives are paramount and need to be guaranteed when updating and revising Directive 2005/36/EC:

- Health and safety of patients
- Quality of service provision in health and social care
- High level of qualification and professional standards for the health care workforce, concerning in particular professions benefitting from automatic recognition, but also those falling under the general system.

1.3 Relevant instruments available in the framework of the European sectoral social dialogue

In recent years the European social partners have elaborated and adopted two instruments also dealing with the transnational dimension of professional qualifications, skills, competencies and continued professional development:

- The HOSPEEM-EPSU Code of Conduct on ethical cross-border recruitment and retention (2008) (<http://www.epsu.org/a/3718>), signed in April 2008, committing their affiliates to implement it and to monitor outcomes by 2012. It has inspired and guided to a considerable extent the elaboration of a WHO Code of Conduct with a global scope.
- The HOSPEEM-EPSU "Framework of Actions 'Recruitment and Retention'" defines training, up-skilling and continuous professional development as one of the priority concerns for the future work of European social partners in the hospital sector. The document (<http://www.epsu.org/a/7158>) has been finally adopted and signed in December 2010, following two years of detailed work and extensive exchange between

HOSPEEM and EPSU. Our joint work programme 2011-2013 contains concrete activities underpinning and promoting the objectives and principles agreed.

Both instruments help orienting EPSU's and HOSPEEM's work and exchange on professional qualifications and continued professional development. They also contribute to other key challenges for the health and social care sector, such as recruitment and retention, ageing and cross-border mobility and migration of the health care workforce.

1.4 Further involvement of social partners in process towards Green Paper and revised directive

HOSPEEM and EPSU have been looking into the topic of the recognition of professional qualifications in the first meeting of the Sectoral Social Dialogue Committee in 2011 and since then continued exchange and discussion, both within and across the employers' and employees' groups.

According to the HOSPEEM-EPSU Work Programme 2011-2013 related work will predominantly take place during 2011 and in early 2012. It is the priority issue for the first semester 2011. HOSPEEM's and EPSU's interest and attention, however, will definitively reach beyond the current phase of evaluation, consultation and revision. Once adopted, the social partners in the health and social care sector at different levels (enterprise, sectoral, national, European) will be involved in the implementation and the monitoring of the economic and social impacts of the new legal framework. .

This is why the European social partners in the hospital sector would like to emphasise their interest in being involved and their availability to participate throughout the further consultation and legislative process to update and revise Directive 2005/36/EC.

1.5 Benefits and challenges related to the realisation of the fundamental freedom of movement

EPSU and HOSPEEM are in support of instruments and initiatives that help to realise the fundamental right of free movement of workers in the internal market including the EU system for the recognition of professional qualifications. Updated, clear and targeted rules and an effective and clear legal Community framework for the recognition of professional qualifications are in the common interest of both health and social care professionals and employers in the sector.

The European social partners in the hospital sector acknowledge that the cross-border recognition of professional qualifications can (and actually does) contribute to improving the short- and medium-term professional prospects as well as the economic situation of those women and men moving or migrating (including their family members, accompanying them

abroad or staying back home). Both European social partners, however, are also aware of perceivable negative impacts of mobility and migration on health systems and "remaining" health professionals, employers and patients, in a number of EU MS, in particular in Central and Eastern Europe. These countries are increasingly confronted with a mobility-/migration-driven lack of highly qualified or specialised personnel. They intend to address related challenges. The situation is unlikely to substantially improve in the near future; it

rather risks deteriorating, at least in some countries. The “sending countries” have to face severe economic consequences due to “brain drain” and a range of impacts for their societies as a whole and in particular for the families of those moving or migrating to another country, be it on a temporary or permanent basis.

2. EPSU’s and HOSPEEM’s reply to the consultation paper by DG MARKT

General remark: EPSU and HOSPEEM would welcome the evaluation and revision of the current European legal framework focusing on a range of core issues directly linked to the process of and the conditions for the cross-border recognition of professional qualifications and operated in line with the three guiding principles EPSU and HOSPEEM have identified, cf. 1.2.

Why simplification?

Question 1: Do you have any suggestions for further improving citizen’s access to information on the recognition processes for their professional qualification in another Member State?

EPSU and HOSPEEM would like to see the Internal Market Information System (IMI system) developing to facilitate the process of cross-country recognition of professional qualifications online and to assume the function of a “one stop shop”. Its use could/should become mandatory for all competent authorities and professionals, especially for those in the health care sector.

By developing the IMI system as an online tool it would develop into the main source for exchanging information between the competent authorities of the Member States on the one hand and become instrumental in speeding up the recognition process and the free movement of health care professions, both for those falling under the system of automatic recognition (such as nurses, midwives and doctors) and for others under the general system (such as radiographers and biomedical scientists).

Question 2: Do you have any suggestions for the simplification of the current recognition procedure? If so please provide suggestions with supporting evidence.

In HOSPEEM and EPSU’s view harmonised standards for health professionals and automatic recognition have provided a simple, swift means of recognition for health professionals across Europe and should continue to be supported, and implemented, although some modernisation is required.

Following this line an online IMI system, also accessible for individual professionals in order to submit the documents required for the recognition, could both simplify and speed up the process. It is important to stress that a simplification and “bundling” based on this technical tool would nevertheless need to be set up without compromising on patient safety or data protection.

Making best practice enforceable

Question 3: Should the Code of Conduct become enforceable? Is there a need to amend the contents of the Code of Conduct? Please specify and provide the reasons for your suggestions.

HOSPEEM and EPSU oppose the idea of making the Code of Conduct enforceable. Making it enforceable would not only fail to respect the subsidiarity principle, but also not comply with the established distribution of tasks and responsibilities. A code of conduct is about procedures that in the context of a directive are neither supposed to be harmonised across the EU nor to become legally binding.

The necessary rights and rules on legal recourse for EU citizens seeking recognition of their professional qualifications and thereby encountering difficulties or being rejected are to be stipulated in the directive itself.

Mitigating unintended consequences of compensation measures

Question 4: Do you have any experience of compensation measures? Do you consider that they could have a deterrent effect, for example as regards the three years duration of an adaptation period?

EPSU and HOSPEEM underline that compensation measures, defined on case by case basis, are the appropriate instrument in case an applicant does not (yet fully) comply with the requirements for automatic recognition of the directive. As they consider this condition essential, our members wish to keep the current compensation measures as a benchmark to ensure safe and high quality work and health care.

EPSU and HOSPEEM underline that the requirement to undergo compensation measures is important especially in cases where qualifications and roles differ within and between health professionals in the country of origin of the health care workers and the country of her/his current employment.

Question 5: Do you support the idea of developing Europe-wide codes of conduct on aptitude tests or adaptation periods?

At least for the time being, there is still scepticism by affiliates if the appropriate format is a “Code of Conduct”, also given the complex nature of the matter and differences as to objectives and design parameters of national systems of education, professional training and CPD/LLL.

HOSPEEM and EPSU, however, would welcome the dissemination of guidelines and examples of proven good practice, that competent authorities and other stakeholders will be invited to make use of. This instrument would need to be available in different languages of the EU as well as in a language comprehensible to actors “on the ground” to serve the purpose.

Question 6: Do you see a need to include the case-law on “partial access” into the Directive? Under what conditions could a professional who received “partial access” acquire full access?

There is first a need to distinguish between the professions benefitting from automatic recognition and other professions in and outside the health and social care sector, comprising e.g. specialist nurses.

For the former, EPSU and HOSPEEM are against using/extending the option of “partial access” for healthcare professions, as the precondition for automatic recognition is to fully satisfy the minimum requirements as defined. This is consistent with the claim that patients’ health and safety should be one of the guiding principles when applying and modernising the pertinent European legal framework. In view of the latter HOSPEEM and EPSU support joined-up strategies and policies to define a broad trunk of common knowledge, skills and competences to be acquired and tested and warns against trends to further push differentiation for the basic level(s) of education and training for professions split up into specialisations, a development also concerning e.g. the nursing profession.

EPSU and HOSPEEM recall that applicants can apply for “accreditation of prior learning” or similar systems in cases where their qualification is considered insufficient by the competent authority of the host country. We suggest there would be difficulties adjusting work and responsibilities at work for individuals with partial access. It would be expensive and time consuming to set up a system providing for sufficient supervision and training opportunities and also challenging to plan and manage work in health care, particularly acute/emergency care, with an even more differentiated workforce with a certain number of colleagues with only partial access.

Facilitating movement between non-regulating and regulating member states

Question 9: To which extent has the requirement of two years of professional experience become a barrier to accessing a profession where mobility across many Member States in Europe is vital? Please be specific in your reasons.

This requirement does not apply to most healthcare professions under Directive 2005/36/EC, but in those instances that it does, we would like to keep it.

Question 10: How could the concept of “regulated education” be better used in the interest of consumers? If such education is not specifically geared to a given profession could a minimum list of relevant competences attested by a home Member State be a way forward?

For professions under the scheme of automatic recognition this concept is not relevant.

A European Professional Card

Question 11: What are your views about the objectives of a European professional card? Should such a card speed up the recognition process? Should it increase transparency for consumers and employers? Should it enhance confidence and forge closer cooperation between a home and a host Member State?

We don't think this is the best solution to the issues raised in the consultation document. The technical applications and communications available at present should make co-operation between Member States comparatively easy. However, we fear that not all features might be eventually achieved. In line with what has been said above in relation to questions 1 and 2, EPSU and HOSPEEM advocate devoting energy and putting resources into further developing and "upgrading" the IMI system. This would serve a triple aim as it would 1) exactly serve the core purposes of the directive, 2) directly benefit different stakeholders and 3) present a modern ICT-based solution (that can also be extended, updated and upgraded quite easily, quickly and consistently across Europe).

EPSU and HOSPEEM state that at the moment those not involved in the Steering Committee set up by DG MARKT on exploring its feasibility, usefulness and use know too little information about concrete features, conditions and options for the use of such a card

Should a European Professional Card be introduced economic (which costs; whom to bear them), legal (period of validity; data protection) and technical (fraud/risks of counterfeiting; option to update information easily and quickly) challenges must be considered.

Question 12: Do you agree with the proposed features of the card?

See our response to question 11.

Question 13: What information would be essential on the card? How could a timely update of such information be organised?

See our response to question 11.

Question 14: Do you think that the title professional card is appropriate? Would the title professional passport, with its connotation of mobility, be more appropriate?

See our response to question 11.

Abandon common platform, move towards European curricula

Question 15: What are your views about introducing the concept of a European curriculum – a kind of 28th regime applicable in addition to national requirements? What conditions could be foreseen for its development?

Common minimum requirements have been developed, approved and fixed to allow for the automatic recognition for the seven professions currently falling under this scheme. In this context the route of developing European curricula based on a common set of competencies to become a 28th regime does not apply. In the health and social care field this idea therefore has relevance for specialisations of professions under the above-mentioned scheme and for professions falling under the general system. If initiatives towards elaborating a concept of a European curriculum are taken HOSPEEM and EPSU would like and need to first evaluate the concrete proposal. Only then a position could be developed and further work explored, not least as developing such a 28th regime i.e.

entails the risk of undermining attempts in member states to improve the educational level for specialist professions.

Offering consumers the high quality they demand

Question 17: Should lighter regimes for professionals be developed who accompany consumers to another Member State?

Referring to our response under 3.2 HOSPEEM and EPSU oppose any kind of lighter regimes for health professionals of any kind as a general rule and this consequently also has to apply to those accompanying a patient/user abroad. These checks of qualification are important for the safety of the public.

Making it easier for professionals to move temporarily

Question 20: Should Member States reduce the current scope for prior checks of qualifications and accordingly the scope for derogation from the declaration regime?

No, we think the current checks should remain in place. However if the IMI system is to develop into a system with updated information also (partially) accessible to health and social care professionals this ICT-solution should help to simplify procedural requirements.

Retaining automatic recognition in the 21st century

Question 21: Does the current minimum training harmonisation offer a real access to the profession, in particular for nurses, midwives and pharmacists?

In EPSU and HOSPEEM's view the current minimum training harmonisation, in particular for the professions referred to in Question 21, have proven to be a solid and relevant basis that has not only offered real access to the profession, but also helped to advance the status of nurses and midwives. Directive 2005/36/EC has become a cornerstone for educational reform improving the quality of education/training and practice.

This reason, the need to ensure evidence-based practice and the rationales behind the guiding principles sketched out under 1.2 make HOSPEEM and EPSU oppose any downgrading of current minimum baseline criteria. Minimum requirements regarding training also have to be upheld to guarantee patient safety in the light of the Directive on the application of patients' rights in cross-border healthcare, finally adopted by the European Council on 28 February 2011.

EPSU and HOSPEEM across the board agree on the necessity and advantages of updating relevant annexes – e.g. Annex V in the case of nurses and midwives – with new topics and contents, i.e. knowledge, skills and competencies.

Question 22: Do you see a need to modernise the minimum training requirements? Should these requirements also include a limited set of competences? If so what kind of competences should be considered?

HOSPEEM and EPSU see no need to lower the minimum training requirements, as already also mentioned under Question 21. They, however, recommend updating annexes to the directive – Annex V in the cases of nursing and midwifery professions – with relevant research to better meet requirements of and current advancements in today's healthcare sector. In this regard they mention particular topics such as public health, health prevention, health promotion, eHealth, quality development and patient safety necessary in today's nursing education.

Question 23: Should a Member State be obliged to be more transparent and to provide more information to the other Member States about future qualifications which benefit from automatic recognition?

HOSPEEM and EPSU are of the opinion that the content of the education and training programmes should be disclosed to the competent authorities of other member states, including regular updates on relevant changes, via the IMI system.

Question 24: Should the current scheme for notifying new diplomas be overhauled? Should such notifications be made at a much earlier stage? Please be specific in your reasons.

EPSU and HOSPEEM are of the view that new diplomas should be notified once a new education/training programme is submitted for approval under the national accreditation programme. The competent authorities at all times should be up to date with current educations and curriculums. Such a system increasing transparency would also be advantageous for potential migrants.

Question 25: Do you see a need for modernising this regime on automatic recognition, notably the list of activities listed in Annex IV?

Yes.

Question 26: Do you see a need for shortening the number of years of professional experience necessary to qualify for automatic recognition?

No.

Continued professional development

Question 27: Do you see a need for taking more account of continuing professional development at EU level? If yes, how could this need be reflected in the Directive?

EPSU and HOSPEEM affiliates see the need for fundamental principles of CPD including a commitment to patient safety and quality of care to be referred to in Community legislation, and then followed through by Member States and the healthcare professionals.

More efficient cooperation between competent authorities

Question 28: Would the extension of IMI to the professions outside the scope of the Services Directive create more confidence between Member States? Should the extension of the

mandatory use of IMI include a proactive alert mechanism for cases where such a mechanism currently does not apply, notably health professions?

HOSPEEM and EPSU are in favour of such an automatic alert in case a health care professional is no longer authorised to exercise the profession/taken off the national register due to a range of legal reasons, including e.g. fraud (i.e. when having presented a false certificate to obtain recognition).

Question 29: In which cases should an alert obligation be triggered?

EPSU and HOSPEEM don't reply to this question.

Language skills

Question 30: Have you encountered any major problems with the current language regime as foreseen in the Directive?

It is obvious that an appropriate level of general language knowledge and of relevant technical language to communicate with colleagues and patients/users, as well as to create documentation in patients' records, is essential for safe and good health care services. In this context, however, what is needed is to find a balance between the conflicting objectives of free movement, patient health and safety, quality of health and social care and staff use according to needs and urgencies.

Current EU rules, however, do not allow language testing of EU health workers at the point of recognition, Article 53 of Directive 2005/36/EC. EPSU and HOSPEEM agree on the need for employers to do a language test at the point of employment of a migrant health care worker. In this context HOSPEEM and EPSU underline the responsibility of employers in ensuring someone is competent for the job she/he is recruited to (which includes ability to communicate effectively with colleagues and patients and to document the treatment and caring process to correctly inform the clinical decisions) as well as for proper induction for new staff from other countries. In EPSU and HOSPEEM's view language training – in particular work-place related knowledge – should become part of adaptation training, in the interest of both employers and employees and in the ultimate interest of patients/users and the health care system.

ANNEX C. HOSPEEM-EPSU Response to the European Commission's Green Paper on Reviewing the Directive on the Recognition of Professional Qualifications 2005/36/EC

1. Background note on the joint HOSPEEM-EPSU contribution

1.1 Joint HOSPEEM-EPSU response

HOSPEEM, the European Hospital and Healthcare Employers' Association, and EPSU, the European Public Service Union, have decided to submit a joint response to the Green Paper.

It has to be read as complementary to the response sent by EPSU on 20 September and to replies of individual EPSU or HOSPEEM members.

This joint reply reflects the issues, concerns and proposals on which full or broad consensus between the European social partners for the hospital and health care sector could be reached.

1.2 Guiding principles for EPSU and HOSPEEM

EPSU and HOSPEEM agree that three key objectives are paramount and need to be guaranteed when updating and revising Directive 2005/36/EC:

Health and safety of patients
Quality of service provision in health and social care
High levels of qualification and professional standards for the health care workforce, in particular for professions benefitting from automatic recognition, but also for those falling under the general system.

EPSU and HOSPEEM observe that the Green Paper does not always sufficiently take into account the principle of subsidiarity. Several of the measures that are proposed involve government regulation of how authorities at national level will handle assessment and recognition of professional qualifications, rather than leaving it for Member States (MS) themselves to decide at what level and in what way the issues should be handled. Therefore it is vitally important to involve competent authorities (CA) at all stages when designing and implementing changes to the rules on recognition of professional qualifications. For example, the assessment of how quickly and at what rate the various proposals in the Qualification Directive can be implemented within the healthcare sector, must be decided in consultation with the respective Member State and their competent authorities in the light of the conditions that apply there.

The Commission's Green Paper does not consider future costs arising from a review of the Professional Qualifications Directive. EPSU and HOSPEEM would like the Commission to be aware of potential costs for the healthcare sector which could result from proposed (legislative) changes.

1.3 Relevant instruments available in the framework of the European sectoral social dialogue

In recent years the European social partners have elaborated and adopted two instruments also dealing with the transnational dimension of professional qualifications, skills, competencies and continued professional development:

- The HOSPEEM-EPSU Code of Conduct on ethical cross-border recruitment and retention (2008), signed in April 2008, committed their affiliates to implement it and to monitor outcomes by 2012.

- The HOSPEEM-EPSU “Framework of Actions ‘Recruitment and Retention’” defines training, up-skilling and continuous professional development as one of the priority concerns for the future work of European social partners in the hospital sector. The document was adopted and signed in December 2010, following two years of detailed work and extensive exchange between HOSPEEM and EPSU. Our joint work programme 2011-2013 contains concrete activities underpinning and promoting the objectives and principles agreed.

Both instruments underpin EPSU’s and HOSPEEM’s work and exchange on professional qualifications and continued professional development. They also contribute to other key challenges for the health and social care sector, such as recruitment and retention, ageing and cross-border mobility and migration of the health care workforce.

1.4 The future health workforce

The European Commission’s Green Paper on the European Workforce for Health issued in December 2008, the follow-up report in December 2009 and the Council conclusions “Investing in Europe’s health workforce of tomorrow” adopted in December 2010 all highlight the challenges facing European healthcare systems in the 21st century, such as increasing demand owing to the ageing population and technological advances, coupled with an ageing workforce and shortages of healthcare workers. In some MS these shortages are severe.

The Commission has committed, in co-operation with MS, to develop by 2012 an Action Plan to address the gap in the supply of health workers. Work has begun on a Joint Action on forecasting health workforce needs and future workforce planning, and the social partners are involved in this initiative. In addition to attending the preparatory meetings organized by DG SANCO for the joint action, HOSPEEM and EPSU will, as a priority in our 2011/13 work programme, be looking jointly at the ageing healthcare workforce and sharing good practice on retaining older workers.

It is critical for MS to be able to attract and retain healthcare professionals, and we therefore agree that there should not be unnecessary barriers to free movement that would hamper MS in providing adequate healthcare for their populations. However we are also mindful that healthcare, by its very nature, carries a high degree of serious risk to the health and safety of patients from professionals who may lack training, clinical expertise, relevant experience or personal integrity. It is necessary therefore in this sector to balance the desire to streamline and simplify free movement with the need to maintain minimum quality and safety standards by checking the competence and suitability of professionals who will be providing services.

1.5 Benefits and challenges related to the realisation of the fundamental freedom of movement

EPSU and HOSPEEM are in support of instruments and initiatives that help to realise the fundamental right of free movement of workers in the internal market including the EU system for the recognition of professional qualifications. Updated, clear and targeted rules and an effective and clear legal Community framework for the recognition of professional qualifications are in the common interest of both health and social care professionals and employers in the sector.

The European social partners in the hospital sector acknowledge that the free mobility of the workforce and the cross-border recognition of professional qualifications can (and actually does) contribute to improving the short- and medium-term professional prospects as well as the economic situation of those women and men moving or migrating (including their family members, accompanying them abroad or staying back home).

Both European social partners, however, are also aware of perceivable impacts of mobility and migration on health systems and “remaining” health professionals, employers and patients, in a number of EU MS, in particular in Central and Eastern Europe. These countries are increasingly confronted with a mobility-/migration-driven lack of highly qualified or specialised personnel.

The situation is unlikely to substantially improve in the near future; it rather risks deteriorating, at least in some countries. The “sending countries” have to face economic consequences due to “brain drain” and a range of impacts for the healthcare sector as a whole and in particular for the families of those moving or migrating to another country, be it on a temporary or permanent basis.

1.6 Further involvement of social partners in process towards Green Paper and revised directive

HOSPEEM and EPSU have been looking into the topic of the recognition of professional qualifications in the first meeting of the Sectoral Social Dialogue Committee in 2011 and since then continued exchange and discussion, both within and across the employers’ and employees’ groups.

According to the HOSPEEM-EPSU Work Programme 2011-2013 related work will predominantly take place during 2011 and in early 2012. It is the priority issue for the first semester 2011. HOSPEEM’s and EPSU’s interest and attention, however, will definitively reach beyond the current phase of evaluation, consultation and revision. Once adopted, the social partners in the health and social care sector at different levels (enterprise, sectoral, national, European) will be involved in the implementation and the monitoring of the economic and social impacts of the new legal framework.

This is why the European social partners in the hospital sector would like to emphasise their interest in being involved and their availability to participate throughout the further consultation and legislative process to update and revise Directive 2005/36/EC.

2. New approaches to mobility

2.1 The European Professional Card

Question 1: Do you have any comments on the respective roles of the competent authorities in the Member State of departure and the receiving Member State?

EPSU and HOSPEEM share and support the Commission's view that the Internal Market Information System (IMI), if used by all Member States' competent authorities, could speed up the recognition process for the migrant health professional. We believe that it will be most beneficial to use the IMI system to support, include and transfer detailed information about the migrant and the recognition process.

- We reiterate our request, already expressed in the joint EPSU/HOSPEEM reply of 23 March 2011 to the consultation on the revision of Directive 2005/36/EC, to put resources into further developing and "upgrading" the IMI system.
- Such a solution corresponds with the core purposes of the directive, would directly benefit competent authorities and EU citizens and present a modern ICT-based solution (which can also be extended, updated and upgraded quite easily and quickly in a consistent manner across Europe, if need be).
- We are of the opinion that the IMI should become mandatory as the main source for the exchange of information and documents between Member States concerning the mutual recognition of professional qualifications in an online modality. This would facilitate the administrative process and cooperation as well as swift and targeted communication between the issuing and receiving Member State, in both the interest of the competent authorities and EU citizens aiming for a recognition of their professional qualification.

We note the Green Paper suggests greater emphasis and clearer defined responsibilities (if need be with deadlines for specific procedures and tasks) to be placed in the future on the role of the competent authorities in the member state of departure. This holds for the tasks of verifying documentation and providing this to their counterpart in the country where the health professional is seeking recognition. However, the counterpart in the receiving Member State must retain all competencies allowing for a clear and swift decision on the demand for recognition of professional qualifications.

Regarding the possible introduction of the European Professional Card (EPC), it should be ensured that if an EPC is issued by the competent authority in the Member State of departure, the applicant holds the correct qualifications and satisfies any conditions as required by the Directive (e.g. legal establishment, original diplomas, entitlement to practice, etc.). It should also be guaranteed that all conditions have been checked and that the information and documents provided by the applicant have been approved by the competent authority in the Member State of departure. We are concerned that there is less incentive for the "sending" authority to ensure that information is accurate than the "receiving" authority, who will have to deal with any problems whilst the migrant is on their country. The use of the EPC should be voluntary and not replace procedures already existing or to be set up and/or improved under the IMI.

Pending the results of the work of the Steering Group on the EPC set up by DG MARKT on exploring its feasibility, usefulness and use to be presented in early October 2011 it is not yet clear to EPSU and HOSPEEM whether the benefits of an EPC to European citizens will clearly outweigh both costs and additional resources or structures that would be needed to properly set up and operate a system to administer and to issue the EPC.

Should an EPC be introduced, EPSU and HOSPEEM would like to recall – in referring to our reply of 23 March 2011 to the consultation launched by the European Commission in January 2011 – that a range of economic (which costs?; whom to bear them?), legal (which contents?; which period of validity?; data protection) and technical (fraud/risks of counterfeiting; option to update information easily and quickly) challenges must be taken account of and satisfactorily solved. EPSU and HOSPEEM members report unresolved questions, e.g. as to administrative capacities, competencies and data protection standards of any potential organisation which will store updated and complete data on professional qualifications (and if need be CPD) of those asking for mutual recognition.

Question 2: Do you agree that a professional card could have the following effects, depending on the card holders' objectives?

See our reply to Question 1 about the need to conduct a thorough cost/benefit analysis before deciding whether or not a professional card would have any advantages

a) The card holder moves on a temporary basis

As to the two options sketched out under category a., should the EPC be introduced we oppose option 1. We want the requirement for prior notification and declaration with the relevant regulatory body to exercise a temporary or occasional activity in the health care sector or as a health professional to be upheld, both for reasons of patients' safety and of public security and health.

We would prefer neither option but if option 2 were introduced - i.e. the declaration regime to be maintained but the EPC could be presented in place of any accompanying document this should only be on the condition that there is compliance with requirements as mentioned in our reply to question 1. In addition issuing of an EPC would need to imply that the necessary documents referred to in Art. 7 of the current Directive have been made available and that they have been verified by the competent authority in the Member State of departure.

b) The card holder seeks automatic recognition of his qualifications (receiving Member State should take a decision within two weeks instead of three months)

EPSU and HOSPEEM support efforts by competent authorities in the Member States to come to agreements to shorten the regular/average delays to treat a request for recognition, where legally and administratively appropriate and feasible. We are however, of the opinion that the timescales suggested by the European Commission are too ambitious in cases where the competent authority has "justified doubts", if the recognition process is to comply with considerations of general interest, patient safety and public security and health.

c) The card holder seeks recognition of his qualifications which are not subject to automatic recognition (the general system): the presentation of the card would

accelerate the recognition procedure (receiving Member State would have to take a decision within one month instead of four months).

Again, we are of the opinion that the timescales suggested by the European Commission are too ambitious in cases where the competent authority has “justified doubts”, if the recognition process is to comply with considerations of general interest, patient safety and public security and health.

2.2 Focus on economic activities: the principle of partial access

Question 3: Do you agree that there would be important advantages to inserting the principle of partial access and specific criteria for its application into the Directive?

EPSU and HOSPEEM oppose partial access to any of the sectoral professions as it would go against the very logic and purpose of minimum requirements to be fulfilled, as currently defined in the Directive. The revision of Directive 2005/36/EU should not function as a backdoor method of downgrading the existing minimum requirements for automatic recognition for the sectoral professions in the health sector.

Introducing options for partial access would also create confusion for employers and patients about the scope of a professional’s competence. There should be no requirement on employers to structure roles specifically to accommodate “partial access” applicants.

We accept that the principle of partial access already exists in case law. However we consider there should be a derogation from the principle of partial access for healthcare professions, given the level of risk to the public’s health and safety from inadequately qualified professionals.

The Court of Justice recognised in their judgment that the protection of the recipients of services may justify proportionate restrictions on the freedom of establishment and the freedom to provide services, if such measures are necessary and proportionate in order to obtain the objective.

2.3 Reshaping common platforms

Question 4: Do you support lowering the current threshold of two-thirds of the Member States to one-third as a condition for the creation of a common platform? Do you agree on the need for an Internal Market test (based on the proportionality principle) to ensure a common platform does not constitute a barrier for service providers from non-participating Member States?

EPSU and HOSPEEM members are not fully convinced of the concept, purpose, potential and usefulness of reshaped common platforms as presented in the Green Paper.

2.4 Professional qualifications in regulated professions

Question 5: Do you know any regulated profession where EU citizens might effectively face such situations? Please explain the profession, the qualifications and for which reasons these situations would not be justifiable.

EPSU and HOSPEEM members are not aware of particular problems for health care professionals already working in another Member State that would face unjustified and disproportionate qualification requirements in a host Member State at such a level or of such a nature that they would not be in the position to overcome the difficulties by undergoing compensation measures. Any decision on compensation measures under the general system on recognition would need to consider patient safety and requirements of public health.

3. Building on achievements

3.1 Access to information and e-government

Question 6: Would you support an obligation for Member States to ensure that information on the competent authorities and the required documents for the recognition of professional qualifications is available through a central online access point in each Member State? Would you support an obligation to enable online completion of recognition procedures for all professionals?

EPSU and HOSPEEM support the proposal to build on the existing National Contact Points to facilitate online the completion of all procedures related to the recognition of qualifications. They should indeed provide a centralised information service covering the competent authorities, information on how they can be contacted, all relevant national regulations and documentation requirements relating to recognition of qualifications and registration (where relevant). We also support the intention to oblige competent authorities to enable online completion of recognition procedures for all professionals and to build up user-friendly e-government sites. However whilst we support migrants being able to apply for registration online, we believe that safeguards must be built in owing to the possibility of fraud and impersonation. CAs must have the discretion to ask to verify documentation in cases of justified doubt, and to check the applicant's identity.

3.2 Temporary mobility

3.2.1 Consumers crossing borders

Question 7: Do you agree that the requirement of two years' professional experience in the case of a professional coming from a non-regulating Member State should be lifted in case of consumer crossing borders and not choosing a local professional in the host Member State? Should the host Member State still be entitled to require a prior declaration in this case?

EPSU and HOSPEEM would not want to see any watering down of the requirement for health professionals to provide a prior declaration to the competent authority when seeking to work temporarily in another EU country, including when accompanying nationals of their home Member State. Once a professional is in a country s/he can potentially treat anyone and there is no guarantee that they will not stay longer than originally intended.

EPSU and HOSPEEM can't see that for the health and social care sector the requirement of two years' professional experience referred to under question 7 would constitute a disproportionately too high and non-justifiable barrier to cross-border professional mobility. For the sectoral professions – making up the large share of health care workers, the requirement of two years' professional experience is not relevant.

3.2.2 The question of “regulated education and training”

Question 8: Do you agree that the notion of “regulated education and training” could encompass all training recognised by a Member State which is relevant to a profession and not only the training which is explicitly geared towards a specific profession?

Certain basic skills, for example information technology or communication skills, have become increasingly important in the workplace and are important for many different occupations in society. Such basic skills should be taken into account in professional training in the future.

However this must not mean that these basic skills are given precedence over the requirements placed on professional healthcare training that is regulated in a Member State. Such training is regulated to ensure it meets the requirement to deliver the fundamental skills that the public has a right to demand from healthcare professionals. What is important in this context is that what the Green Paper describes as “general transferable skills” are described sufficiently clearly, so that it is easy to understand what they mean and to relate them to the context of the regulated professional training.

3.3 Opening up the general system

3.3.1 Levels of qualifications

Question 9: Would you support the deletion of the classification outlined in Art 11 (including Annex II)?

In answering this question the main criterion for HOSPEEM and EPSU is which possible advantages and disadvantages for health care employers and workers might be caused by deleting the existing grid with five levels of education. We oppose the immediate deletion of Article 11 without replacing it with an alternative system such as EQF that makes reference to the level of qualifications. Whilst the 5 levels of Article 11 are rudimentary, they do provide a benchmark and some level of consistency between member state competent authorities after more than five years of use. It would be extremely burdensome, especially given the lack of transparency about the detail of the curricula composing many training courses, for CAs to have to delve into this level of detail on a case by case basis for each and every application.

We can see that there might be value replacing the five levels in the long term with the eight level framework of the European Qualifications Framework (EQF). Immediately using the 8 level structured EQF based on learning outcomes would clearly be premature not least as the EQF is expected to only be implemented as early as 2012 by the first EU Member States. It would still need to be shown for the EQF or some other assessment to

be an effective alternative to the current system. The Commission mentions that it is currently awaiting the outcomes of a study on the EQF commissioned by DG MARKT (p. 11). We are looking forward to seeing the results that should be available during autumn 2011.

3.3.2 Compensation measures

Question 10: If Article 11 of the Directive is deleted, should the four steps outlined above be implemented in a modernised Directive? If you do not support the implementation of all four steps, would any of them be acceptable for you?

As EPSU and HOSPEEM do not agree with the immediate deletion of the Article 11 we are only answering this question very cursorily, referring to step 1 (p. 11). HOSPEEM and EPSU call on the European Commission not to alter the compensation measures defined in Article 14. A difference in the duration of training of at least one year – currently in itself a justification for compensation measures, Article 14 (1) – does not represent an un-justified restriction to the free movement of workers in the health and social care sector.

3.3.3 Partially qualified professionals

Question 11: Would you support extending the benefits of the Directive to graduates from academic training who wish to complete a period of remunerated supervised practical experience in the profession abroad?

EPSU and HOSPEEM are of the opinion that the issue of extending the benefits of the Directive to graduates from academic training who wish to complete a period of remunerated supervised practical experience in the profession abroad does not fall under the scope of Directive 2005/36/EC. This piece of European legislation has been designed for and is geared towards professionals - including those in the health care sector – who are fully qualified and fit for practice in one Member State and then seeking recognition of their professional qualifications of a completed education and training process in another Member State. We are therefore against extending the procedural safeguards of the Directive to the group of persons referred to in this question.

This issue should not, as a matter of principle, be dealt with under Directive 2005/36/EC. In addition to the principle there may be practical issues if the benefits of the Directive were to be extended to graduates as suggested, because it could enable trainees who fail to meet the required standard in one MS to finish their training in another MS with less stringent standards, with potential risks to patient safety.

3.4 Exploiting the potential of IMI

Question 12: Which of the two options for the introduction of an alert mechanism for health professionals within the IMI system do you prefer?

· Option 1: extending the alert mechanism as foreseen under the Services Directive to all professionals, including health professionals? The initiating MS would decide to which other MS the alert should be addressed.

· Option 2: Introducing the wider and more rigorous alert obligation for MS to immediately alert all other MS if a health professional is no longer allowed to practise due to a disciplinary sanction? The initiating MS would be obliged to address each alert to all other MS.

HOSPEEM and EPSU would prefer option 2.

However there is the need to have sufficient clarity between competent authorities on what kind of disciplinary case would trigger an alert and at what point an alert should be issued, as the criteria and practice differ between Member States. Currently there is no common view on what proactive information exchange and early warning means across the EU27. MS CAs should have appeal mechanism in place for registrants.

3.5 Language requirements

Question 13: Which of the two options outlines above do you prefer?

· Option 1: Clarifying the existing rules in the Code of Conduct.

· Option 2: Amending the Directive itself with regard to health professionals having direct contact with patients and benefiting from automatic recognition.

In this context it is not always easy to find a good balance between individual interests of free movement on the one hand and collective requirements of safety and quality as well as general interest considerations on the other.

The current rules lack coherence and may lead to conflicting demands and paradoxical results, as Article 53 of Directive 2005/36/EC clarifies that professionals must have the language knowledge necessary to perform their activities in the host Member State. This requirement, however, is not part of the recognition process. In addition, language control can only currently take place after the end of the (automatic) recognition procedure and deficits in language skills cannot be a reason for refusing recognition.

EPSU and HOSPEEM believe that language requirements should be justified and proportionate, in view of the activity that the professional wishes to carry out. Health professionals should have written and oral skills enabling them to do the required documentation and reporting about the caring process and to inform clinical decisions - this is essential for quality and safety.

· EPSU and HOSPEEM therefore supports the proposal to amend the directive itself in view of language requirements (i.e. does not consider option 1 appropriate) without agreeing with the way option 2 is designed and formulated in the Green Paper (pp. 14 and 15).

· EPSU and HOSPEEM reject the distinction proposed in the Green Paper between health professionals having direct contact with patients and others not having it. We think that this distinction is neither practicable nor relevant. Health professionals without (regular) contact with patients need to have an appropriate level of knowledge of the official language in a given Member State to properly fulfil all her/his tasks, too.

· We think the Directive should be amended to make it clear that the competent authority can, if they deem it appropriate, require evidence of language skills as part of the recognition procedure.

· Employers must retain the ability to assess candidates' suitability for a particular job, and language competence may form part of that assessment. We would not want to see anything in the Directive which emasculates employers' crucial responsibility to recruit

people who are “fit for purpose”. We think there is an important distinction to be made between the role of the CA, which is to recognise the migrant’s qualification and establish that they are fit to practise the profession, and that of the employer which is to ensure that the person they are recruiting is suitable for the job for which they have applied.

· We are concerned therefore at the Commission’s suggestion that there should be a “one-off” control of language skills, if this means that employers would be unable to test because the CA had already done so. It would be for each MS and for employers to decide how and in what form this would work in practice for each profession and at what level such an assessment should take place, depending on the local licensing arrangements.

4. Modernising automatic recognition

4.1 A three-phase approach to modernisation

Question 14: Would you support a three-phase approach to the modernisation of the minimum training requirements under the Directive consisting of the following phases:

- The first phase to review the foundations, notably the minimum training periods, and preparing the institutional framework for further adaptations, as part of the modernisation of the Directive in 2011-2012;*
- The second phase (2013-2014) to build on the reviewed foundations, including, where necessary, the revision of training subjects and initial work on adding competences using the new institutional framework;*
- The third phase (post-2014) to address the issue of ECTS credits using the new institutional framework?*

EPSU and HOSPEEM are broadly in favour of the 3-phase approach and of a gradual move towards outcome (competence) based training. However we feel the proposals in the Green Paper are vague and that the timescales are unrealistically short, given that designing an outcome/competence based approach which harmonises assessment processes and standards across many different Member State healthcare systems will be challenging. It is important that any updating of the current text of the directive contains a requirement for the Commission to work with professional associations, competent authorities and educators to carry out the work

outlined in phases 2 and 3”. We would like to add to this list the social partners in the relevant sectors, including in health and social care.

EPSU and HOSPEEM would like to recall that changes to the institutional framework to replace the current comitology system by either implementing acts or delegated acts in line with the Lisbon Treaty, as foreseen for the first phase (Green Paper, p. 15), need to be processed in the framework of a transparent system that includes a close cooperation with Member States and the competent authorities and still need to be more concrete and precise in view of the revision of Directive 2005/36/EC.

Regarding the first phase of modernisation, we agree with the need to confirm the current and where appropriate also to strengthen the minimum education and training requirements for the sectoral professions under the automatic recognition regime. The minimum requirements are considered as a benchmark ensuring quality education for key

health professions – ensuring evidence-based practice, research and quality of care – and a qualified health care workforce able to deliver safe and high quality patient care.

As to nursing, EPSU and HOSPEEM consider it is important to keep the reference to the number of 4.600 hours for nurses as a verifying element in each nursing curriculum. Also, the number of hours and the % of theory and practice must remain to safeguard quality and safety in patient care (i.e. the duration of the theoretical training representing at least one- third and the duration of the clinical training at least one half of the minimum duration of the training, Article 31 (3)). The same holds for midwives where in our view the wording of Article 40 needs to be kept as it stands.

EPSU and HOSPEEM see the need for updating the training subjects described in Annex V as regards scientific and educational developments to reflect current advancements in nursing – these comprise issues such as evidence based nursing, patient health education, multicultural nursing; eHealth and ICT developments – and reorganisation of health care systems/services (such as e.g. community based care) during the second phase. In updating the legislation, requirements of knowledge about national healthcare laws, healthcare services and language skills could also be incorporated.

Concerning the third phase sketched out in the Green Paper (p. 15), we are open to introducing competences into Annex V. The use of the ECTS system could be useful once the definition of an ECTS credit is widely harmonised and recognised. Any use of the ECTS, however, must not lead to changes of the minimum requirements for sectoral professions and the relative weight of theory and practice (see above).

4.2 Increasing confidence in automatic recognition

4.2.1 Clarifying the status of professionals

Question 15: Once professionals seek establishment in a Member State other than that in which they acquire their qualifications, they should demonstrate to the host Member State that they have the right to exercise their profession in the home Member State. This principle applies in the case of temporary mobility. Should it be extended to cases where a professional wishes to establish himself? Is there a need for the Directive to address the question of continuing professional development more extensively?

EPSU and HOSPEEM are in favour of extending the principle currently applicable to temporary mobility that also professionals seeking establishment in a Member State other than that in which they acquire their qualifications should have to demonstrate to the receiving Member State that they have the right to exercise their profession/to practise in the home Member State (this comprises issues such as meeting any recent practice, continuing professional development (CPD) and fitness to practice requirements of the member state where they qualified). Whilst we welcome the Green Paper's proposal that professionals who have failed to undertake sufficient continuing professional development in order to remain on the register in their home MS should be prohibited from practising in other MS, we are concerned that this does not go far enough. Indeed it seems perverse that practitioners from MS where there is no requirement to demonstrate continuing competence in order to stay on a professional register should be able to have their qualification recognised in other MS, whereas practitioners from MS with stricter rules will, under the Commission's proposals, be debarred.

EPSU and HOSPEEM support the suggestion that in order for health professionals to keep their skills updated and remain safe to practice, the Directive should include a reference to Member States having systems for CPD in place to ensure the continuing competence of health professionals. CPD has already been made mandatory for nurses in 18 Member States (see: Nursing and Midwifery Council, September 2010, EU National reports on the implementation of Directive 2005/36/EC for the profession of nursing). The reference to the Continuing Professional Development Framework should be made as part of Article 22. This approach would not create difficulties as there are considerable variations on how Member States understand and organise CPD and there would not be any obligations for harmonisation of structures, contents and outcomes;

4.2.2 Clarifying minimum training periods for doctors, nurses and midwives

Question 16: Would you support clarifying the minimum training requirements for doctors, nurses and midwives to state that the conditions relating to the minimum years of training and the minimum hours of training apply cumulatively?

EPSU and HOSPEEM support retaining minimum training requirements for each profession with reference to a minimum number of years and/or hours. Whether or not the years and hours requirements should apply cumulatively should be decided in collaboration with each profession. It is also important that training for health professions should not be merely academic/theoretical but should include a minimum amount of time spent performing appropriate activities in a clinical setting.

4.2.3 Ensuring better compliance at national level

Question 17: Do you agree that Member States should make notifications as soon as a new program of education and training is approved? Would you support an obligation for Member States to submit a report to the Commission on the compliance of each programme of education and training leading to the acquisition of a title notified to the Commission with the Directive? Should Member States designate a national compliance function for this purpose?

EPSU and HOSPEEM share the view presented in the Green Paper (p. 17) that in order to facilitate free movement of health professionals it is important for competent authorities to notify the Commission in a timely (as soon as they are accredited by an accreditation institution or approved by other public bodies) and transparent fashion of any new diplomas/degrees and their content, which meet the requirements for recognition of the different sectoral professions and of other health professions under the general system.

4.4 Nurses and midwives

Question 20: Which of the options outlined above do you prefer?

- *Option 1: Maintaining the requirement of 10 years of general school education.*
- *Option 2: Increasing the requirement of 10 years to 12 years of general school education.*

Many HOSPEEM and EPSU affiliates would support option 2, increasing the requirement of 10 years to 12 years of general school education, as regards the admission requirements for nurses. This is the requirement currently existing in most Member States and reflects considerable changes during the last decades in the roles of and the demands to these professions.

However, HOSPEEM and EPSU are not calling for option 2, as we consider that Member States that prefer keeping the requirement of 10 years of general school education, for whatever reason, should not be forced by Directive 2005/36/EC to change their system.

4.8 Third country qualifications

Question 24: Do you consider it necessary to make adjustments to the treatment of EU citizens holding third country qualifications under the Directive, for example by reducing the three years rule in Art 3 (3)? Would you welcome such adjustment also for third country nationals, including those falling under the European Neighbourhood Policy, who benefit from an equal treatment clause under relevant European legislation?

EPSU and HOSPEEM are in favour of maintaining the rules currently in place as to the treatment of EU citizens having initially acquired qualifications in a third country, in order to maintain the integrity of the harmonised education standards for health professionals across Europe and trust and public confidence in the system. Directive 2005/36/EC currently states – Article 2 (2) – that Member States should not accept these qualifications from EU citizens, if they are from the professions with harmonised training, unless they meet the minimum training requirements. It also allows these EU citizens to benefit from procedural safeguards under the general system in the sense that three years' lawful and effective professional experience in a Member State allows for treating their initial third-country qualification as if it had been obtained in a Member State. EPSU, and some HOSPEEM members, are in favour of changes that would help third country nationals to become established on the European job market and in the healthcare sector.

We wrote (p. 2 of the joint HOSPEEM-EPSU response in March 2011): “Both European social partners in the hospital sector, HOSPEEM and EPSU, are also aware of perceivable negative impacts of mobility and migration on health systems and “remaining” health professionals, employers and patients, in a number of EU MS, in particular in Central and Eastern Europe.

These countries are increasingly confronted with a mobility-/migration-driven lack of in particular highly qualified or specialised personnel. Large differences in salaries, working conditions and career opportunities can exacerbate this problem. They intend to address related challenges.

The situation is unlikely to substantially improve in the near future; it rather risks deteriorating, at least in some countries. The “sending countries” have to face severe economic consequences due to “brain drain” and a range of impacts for their societies as a whole and in particular for the families of those moving or migrating to another country, be it on a temporary or permanent basis”.

ANNEX D. HOSPEEM-EPSU Code of conduct and follow-up on Ethical cross-border recruitment and retention in the hospital sector

INTRODUCTION

> HOSPEEM and EPSU recognize the inequalities and unnecessary burdens on healthcare systems, caused by unethical recruitment practices in the EU. The European social partners in the hospital sector want to address this situation and developed this code of conduct, the aim of which is to promote ethical and stop unethical practices in cross-border recruitment of health workers.

To achieve this, employers and workers must co-operate and work with governments, regulatory and professional bodies and other relevant stakeholders at local, regional and national level in order to protect the rights of workers, and ensure that employers get highly qualified staff. Those stakeholders should all work together to maintain accessible, high-quality and sustainable public health services, and make certain that transparency, justice and equity govern the way human resources are managed in the health care sector in Europe.

Healthcare services are an essential part of the European Social model and therefore all relevant actors must be committed to their fair and effective functioning. This implies a multi-faceted strategy that has to take into account the various challenges different countries are experiencing in terms of healthcare shortages and the reasons why healthcare workers decide to migrate. Strategies which promote adequate workforce supply in all countries should be supported. EPSU and HOSPEEM therefore want to encourage, and as far as possible contribute to, the development and implementation of policies at local, national and European level with the purpose to enhance work force retention and promote accessible and high-quality health care in developed and developing countries.

On the other hand, the European social partners in the hospital sector acknowledge the possible mutual benefits of migration for workers and employers in sending and receiving countries, deriving from the exchange of practices, knowledge and experience.

In order for cross-border recruitment to be successful and beneficial for employers and workers concerned, an appropriate framework to support ethical recruitment and retention practices should be in place. This framework needs to look against the background of the ILO-conventions and the existing legislation and the collective agreements at the issues mentioned in the principles and commitments below but also at subjects like registration and migration procedures. It has to involve different actors, such as regulatory bodies, national, regional and local public authorities. The social partners commit to work in partnership with those different actors, within their respective competencies, in order to make the process socially responsible and effective.

An important step is to establish in the European hospital sector social dialogue a full commitment to promote ethical recruitment practices at European, national, regional and local level through the present code of conduct.

1. HIGH QUALITY HEALTH CARE, ACCESSIBLE FOR ALL PEOPLE IN THE EU

Access to health care is a fundamental human right. Everyone within the EU must have access to high quality health care, which is accessible, affordable and based on solidarity principles. National member states must be able to maintain a financially sustainable and effective healthcare system, which also depends on an adequate supply of well-trained and committed health workers.

2. REGISTRATION AND DATA COLLECTION

To assess the impact of any policy on ethical recruitment, employers and trade unions need to have access to reliable and comparable data and information on migration and migrant health workers. The collection and analyses of these data is a shared responsibility of the national governments and social partners.

3. WORKFORCE PLANNING

Effective planning and human resources development strategies at local, regional and national level are necessary to ensure a balance between supply and demand of health care personnel while offering long-term prospects for employment to healthcare workers.

4. EQUAL ACCESS TO TRAINING AND CAREER DEVELOPMENT

In order to ensure patient safety, adapt to new, changing treatment regimes and technologies, and maintain high quality healthcare staff, it is crucial to invest across the EU in basic and post-basic educational programmes, life-long learning and continuing education of staff. Employers and workers should cooperate to facilitate skills and career development, based on qualifications, training, experiences, and skills requirements. Where appropriate, specific competence development like necessary language training needs to be put in place to enable new employees to discharge their duties.

5. OPEN AND TRANSPARENT INFORMATION ABOUT HOSPITAL VACANCIES ACROSS THE EU

Information on hospital vacancies and recruitment procedures should be available and accessible for instance by publication through internet channels, e.g. via EURES.

6. FAIR AND TRANSPARENT CONTRACTING

Workers and employers need to be protected from false information, misleading claims and exploitation. Prior to appointment, employers need to provide accurate information on trial periods, status on termination of contract, job descriptions, required skills and qualifications, training opportunities, terms of employment (including the existence of collective agreements), pay, and workers' rights and obligations. Workers need to provide

to employers correct information on their formal training and education, their qualifications and experience, their language skills, and give references when asked.

7. REGISTRATION, PERMITS AND RECOGNITION OF QUALIFICATIONS

Information should be made available to the migrant health workers about the formal requirements to live and work in the host country prior to their arrival. Cooperation between social partners and regulatory bodies will be encouraged.

8. PROPER INDUCTION, HOUSING AND STANDARDS OF LIVING

A sound and comprehensive induction policy developed by employers and workers must be in place for all internationally recruited workers to ensure that recruited staff is able to settle into their new environment as quickly as possible. The policies should take into account the national, regional and local circumstances, and the specific background of recruited staff. The induction itself should at least include an in-house training on the work practices and relevant regulatory framework, but also information on local housing and community facilities.

9. EQUAL RIGHTS AND NON-DISCRIMINATION

Migrant health workers have the right to fair treatment and a safe and healthy working environment, including the same employment and working conditions, social benefits and professional obligations as nationals of similar professional status and similar positions. This comprises an equal application of national legislation, collective agreements, health and safety standards and the principles as stated in the EU antidiscrimination directives (2000/43 EC 2000/78 EC) and the EU-Treaty like the right to equal pay. Migrant health workers also should enjoy within the country the same legal protection of employment.

10. PROMOTING ETHICAL RECRUITMENT PRACTICES

Employers should commit to continuous promotion of ethical recruitment practices. When using the services of external agencies in this regard, only agencies with demonstrated ethical recruitment practices should be used for cross-border recruitment. In case exploitative practices occur, such as bringing workers into the country with false promises social partners need to offer the employed migrant health workers the necessary support and/or protection and take sanctions against these agencies such as removing them from agreed lists.

11. FREEDOM OF ASSOCIATION

Migrant hospital workers as all workers should have the right to affiliate to a trade union and/or a professional association in order to safeguard their rights as workers and professionals.

12. IMPLEMENTATION, MONITORING AND FOLLOW-UP

Social partners have to act according to their commitments. The implementation, monitoring and follow-up procedure is of crucial importance for the effectiveness of the Code of Conduct.

Therefore HOSPEEM and EPSU agree to effectively implement, through their respective members: the Code within a period of 3 years after adoption. In this period, social partners in the hospital sector will monitor the situation and report at least once a year back to the Social Dialogue Committee about the progress made. By the end of the fourth year a report will be issued on the overall implementation.

Moreover, EPSU and HOSPEEM note that the current code of conduct is not addressing all challenges related to workforce retention in the hospital sector. They are therefore committed to develop further activities in the area of retention within their 2008-2010 work programme.

Brussels, 07 April 2008



Godfrey Perera
Secretary General of HOSPEEM



Carola Fischbach-Pyttel
Secretary General of EPSU

ANNEX E. HOSPEEM-EPSU Joint Declaration on Health Services - 14 NOVEMBER 2007

The launch of the European Social Dialogue in the Hospital Sector in September 2006 is a crucial step in the development of industrial relations in Europe, as it gives the recognised social partners EPSU and HOSPEEM the possibility to take joint actions on the field of human resources, employment and social policies by using the social dialogue instruments. It also gives employers and workers the possibility to give direct formal input on EU policies affecting the hospital sector and its workers.

The establishment of social partner relations in the hospital sector comes at an appropriate time. More and more European institution activities address health care including hospital care. Important developments include the discussions on the exclusion of health from the services directive, the European Court of Justice Rulings on patient mobility and recently the European Commission Consultation on Health Services.

As key stakeholders, EPSU and HOSPEEM have given their input to this consultation on behalf of our members. However, as employers' and workers' representatives we also want to take up our responsibilities as European social partners according to the provisions of article 138 of the European Treaty. Policy initiatives on the field of cross-border health care have many social aspects and will affect management and labour. Therefore, we call on the Commission to consult us timely if and when it is planning to launch further initiatives in the field of health services.

As EPSU and HOSPEEM we are ready to contribute to the present and future debates on health care, while promoting our members' interests. In this document we present and establish our common positions on health services in Europe.

- 1.** HOSPEEM and EPSU fully support the principles as set out in the articles 152 and 153 of the Treaty, and consider these articles to be the starting point and basis for any Community action on health. The European Community should thus fully respect the subsidiarity principle in any EU initiative on the field of health and/or health services. We are of the opinion that the funding, organization and delivery of health services should fall under the competence of individual Member States. We also emphasize that it is the role of the European Community to promote public health, and that it should aim to improve health care for all patients. It is not for the European Institutions to impose market and/or competition mechanisms in the health care sector, which could have as consequence the lowering of standards and increasing costs of health care systems and thus diminishing the accessibility to care.
- 2.** Health services, including hospital services, are essential in guaranteeing human rights. It is part of the Member States' public responsibilities to promote the general interest including a high level of public health. Health care should therefore be organised on the basis of common European social values including solidarity, social justice and social cohesion. They should also follow the principles of general interest, like universality, accessibility and quality. It is essential that EU-internal

market or competition rules do not limit the EU Member states' autonomy in the implementation of these national responsibilities.

- 3.** To maintain and improve the level of services, Member states should maintain their autonomy to plan services and organize resources at a local, regional and national level. This includes the possibility to manage the concrete delivery of services to patients by effective planning and organizing. Without proper coordination, a high rate of cross-border patient mobility can seriously harm the possibilities for governments and authorities to organize the care in a financially sustainable way. It could also endanger equal access to health care. Authorities therefore should be encouraged to coordinate both the incoming and outgoing patient movements by setting up transparent and fair procedures for cross-border care including referral systems, authorization procedures and financial compensation schemes.
- 4.** It is important that local and regional health care facilities meet the health care needs of the population and ensure patient safety. Patient care is paramount and this will be difficult to guarantee without a well-trained and motivated workforce. Health care authorities and providers should take all actions necessary to promote high quality health care staff, be it in the recruitment, the training or the employment of health workers. In cases of cross-border mobility of health workers, adequate monitoring and registration systems should be established in order to enable work force planning, assist a quick exchange of information and facilitate the mutual recognition of qualifications. Cross-border health workers should have the rights and responsibilities according to the legislation and the collective agreements of the country in which they do their work.
- 5.** Cross-border health care should only take place if that is in the best interest of the patient. As the care provision should in principle be liable to the rules and regulations of the country in which the care is provided, information about health care standards, the delivery of services and its regulatory framework should be made available to patients, so that patients are fully aware of potential problems and complications of receiving treatment in another country. In cases of crossborder cooperation between health care authorities and facilities, other settlements, such as bilateral agreements, could prevail in order to meet national requirements and obligations towards patients and workers.
- 6.** Health services are a key element of the European Social Model, especially in relation to social and territorial cohesion. They have a critical role to play in the economic and social development of Europe, including in the achievement of the Lisbon objectives. At the same time, a common European approach is needed to safeguard, support and nourish healthcare services so to ensure that they continue to serve the public interests, while able to respond to the challenges generated by globalisation. For those reasons, HOSPEEM and EPSU strongly believe that:

- Sufficient legal clarity for authorities and providers is needed to guarantee an appropriate delivery of services at national, regional and local level, and to avoid further interventions by the European Court of Justice;
- The principle of subsidiarity should be fully respected in the financing, planning and operation of healthcare services at national, regional and local level;
- A common evaluation needs to be carried out about the interface between the private sector and public services, ensuring, for instance, that public/private partnerships would not be detrimental to high quality, effective and solidarity based healthcare services
- Healthcare systems should be governed by the awareness that forward-looking and long-term investments in the service-provision would result in considerable improvements in the population's health status and consequently lead to (financial) benefits and savings that are favourable to the community as a whole. Health should be considered as a growth factor.

HOSPEEM and EPSU believe that in order to assess the impact of any Community action in the field of cross-border healthcare on respective national health systems, a clear methodology is required. This should be conceived in consultation with the European social partners. A possible impact assessment should look in close partnership with the European Social partners in the hospital sector and their members at the impact of a European action on the financial sustainability as well as on the accessibility and quality of health services. The EU must focus on promoting and ensuring high quality health care based on common values and principles, as agreed in principle by the Council of Ministers in June 2006.



Godfrey PERERA
Secretary General of HOSPEEM



Karen JENNINGS
President of EPSU
Standing Committee Health and Social Services

ANNEX F. HOSPEEM POSITION STATEMENTS ON THE PROPOSAL FOR A DIRECTIVE OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL ON THE APPLICATION OF PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE

The **European Hospital and Healthcare Employers' Association** (HOSPEEM) was formed in 2005 in order to represent the interests of European Hospital and Healthcare Employers on workforce and industrial relations issues. HOSPEEM was created by the members of the European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest (CEEP) who felt that there was a need for a separate, distinct voice on health workforce issues at European level. As CEEP has a remit covering the whole public sector, CEEP's hospital and healthcare members established HOSPEEM as a sectoral association. CEEP has an observer status within HOSPEEM. HOSPEEM is a full member of CEEP.

HOSPEEM has members across the European Union both in the state or regionally controlled hospital sector and in the private health sector. HOSPEEM members are health employer organisations with the powers to negotiate on pay and on terms and conditions of service with their respective Trade Union partners. HOSPEEM members are also concerned with ensuring good employment practice for healthcare staff.

Since July 2006, HOSPEEM has been officially recognised by the European Commission as a European Social Partner in the Hospital Sector Social Dialogue alongside the European Federation of Public Service Unions (EPSU). The Sectoral Social Dialogue Committee was then officially launched in September 2006.

THE DIRECTIVE

> On the 2nd July 2008, the European Commission published its proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare. This follows the open consultation that the Commission ran between September 2006 and January 2007 which came in response to a series of European Court of Justice (ECJ) Judgments on health services in the European Union. The ECJ-Judgements stated that, under certain conditions, EU citizens were entitled to access healthcare in another Member State and be reimbursed for this treatment by their national health systems. The judgments have created uncertainty surrounding the interpretation of case law at European level for patients and for the national healthcare systems.

HOSPEEM supports the desire to establish legal certainty regarding patients' rights in relation to healthcare treatment in other EU Member States, thus avoiding the situation whereby the ECJ exercises political authority in the field by virtue of its rulings in individual cases. However, the Directive goes beyond the rulings of the ECJ, both in relation to the scope and the content of the Directive, most notably in relation to prior authorisation systems.

HOSPEEM questions that Article 95 of the EC Treaty, relating to internal market harmonisation, is the proper legal basis for a Directive on the application of patients' rights

in cross-border healthcare. In contrast to the view of the European Commission, HOSPEEM sees a fundamental conflict between Article 95 and the principles enshrined in Article 152 of the EC Treaty which outline the responsibilities of the Member States to fund, organise and deliver health services.

SUBSIDIARITY

> HOSPEEM members believe that the principle of subsidiarity is very important in healthcare in order to ensure that patients receive the best care and that healthcare is available to everyone. Healthcare was originally included in the Services Directive but was removed following strong representation from many quarters including European citizens, European health organisations and other interested parties. At the time of negotiations on the Services Directive, the specific character of social and health services was an important argument for excluding these services from the Directive.

In HOSPEEM's view, it was right that health was recognised as a complex arena and different to other services of general interest that are offered throughout the European Union. According to Article 152 of the EC Treaty, the European Commission has always had limited competence in the field of health. The funding, organisation and delivery of health systems has been in the competence of individual Member States. Whilst acknowledging that there are issues to address in relation to cross border healthcare following the series of judgments by the ECJ, HOSPEEM fully supports the principles established in Article 152 of the EC Treaty.

HOSPEEM believes that any action which appears to undermine the principle of subsidiarity could have long term, serious, unintended consequences for the health sector in the respective Member States. In line with this argument, HOSPEEM takes the strong view that developments in healthcare should be based on political consensus rather than on an expansion of internal market rules.

Member States should be able to retain the right to plan services and manage resources in order to ensure the financial viability of their health systems. HOSPEEM members believe it is important that when patients go abroad for treatment then their home health system, as the financier of the care, is able to decide what treatment is most appropriate. HOSPEEM members believe that if European health systems are not able to plan the provision of services and the workforce that is needed to deliver this healthcare, then patients may suffer.

On that basis HOSPEEM finds, that it should be left for the individual Member States to define what can be regarded as hospital care and therefore subject to prior authorisation procedures.

HOSPEEM is pleased that the draft Directive states that for cross border hospital care, Member States will be able to impose the same conditions that apply domestically (for example, consulting a general practitioner) before receiving hospital care. We do however feel that there is work to be done on the definition of what constitutes hospital care.

Developments in most European Countries means, that more and more treatments which previously required admission to a hospital, are now being done as one-day treatments. Moreover, there are great differences between the Member States both in terms of definitions on the national health baskets but also in relation to treatments, which are done as one-day treatments. This means that the technical list of other treatments which can also be defined as hospital treatment, that the Commission intends to develop, potentially will be very difficult to complete and update. On that basis, HOSPEEM finds that it should be left to the individual Member States to define what can be regarded as hospital care and is therefore subject to prior authorisation procedures.

The draft Directive proposes the introduction of an implementing committee which will, amongst other things, define what constitutes hospital care in the European Union. HOSPEEM feels that this committee could further erode subsidiarity. Again, HOSPEEM members feel it is important that each health system defines what constitutes hospital care.

The draft Directive also introduces the concept of reference networks which will share expertise on highly specialised care. HOSPEEM would like to see more information on how the reference networks will be defined and how they will fit with the principle of subsidiarity. If not properly managed in practice, the concept of reference networks could indeed become detrimental to social and territorial cohesion.

PRIOR AUTHORISATION PROCEDURES

> HOSPEEM takes the view that further clarification is needed about the authorisation process for cross-border healthcare. For healthcare to be delivered effectively, HOSPEEM believes that patients should be required to go through prior authorisation procedures in their home state before seeking hospital care in another Member State and then asking to be reimbursed for this care. The Directive makes it very difficult for Member States to ask for prior authorisation for hospital treatment abroad.

At a first glance, the possibility of getting treatment in another Member State without need for prior authorisation could be seen as a greater choice for the patient. In reality, this choice could result in a lowering of healthcare standards for other patients. While the referral process ensures that the patients are properly diagnosed and that there is a need for treatment, the need for prior authorisation procedures is related to Member States ability to plan the delivery of services - the management of the workforce needed to deliver these services and keeping track of the development.

As healthcare employers, HOSPEEM members know the importance of workforce planning. It is important to understand how long it takes to train doctors, nurses and other healthcare professionals and that any significant increase or decrease in the numbers of patients in any Member State is likely to create serious problems in managing the workforce. If, due to the affects of the Directive, the workforce of health systems can not be managed properly, then it could mean that patients have to wait longer for certain treatments or that certain treatments will not be delivered at all. This will certainly not benefit the patients in that country.

HOSPEEM is concerned that the Commission has underestimated the impact its proposals will have on human resources, financial planning and the training of the workforce. The movement of health professionals requires a strong set of measures. EPSU and HOSPEEM launched in April 2008, a code of conduct and follow up on ethical cross-border recruitment and retention in the hospital sector to tackle some of these issues. We believe the Social Partners remain the best placed to deliver adapted solutions in this field.

Prior authorisation procedures also provide an opportunity for patients and their healthcare funding organisation, to assess the risks of treatment abroad, determine what the care package will involve, what it will cost and what the outcomes potentially will be. It is important not to undermine such a system that could result in a worsening of quality of services provided to both local and foreign patients.

HOSPEEM also believes that when patients are granted prior authorisation to go to another Member State for hospital treatment, then they should pay for the care directly and then be reimbursed by the home healthcare system, rather than the home healthcare system reimbursing the cross-border provider directly.

For HOSPEEM, the Member States' right to ask for prior authorisation for hospital care is essential both for the healthcare providers and for the patients.

HEALTH INEQUALITIES

> As hospital and healthcare employers, HOSPEEM welcomes any action which will benefit patients within the constraints of affordability for each Member State and which does not threaten the viability of health systems. However, HOSPEEM does not believe that patients will necessarily be healthier as a result of this directive.

While patient's rights to treatment abroad have been enshrined in European law, HOSPEEM believes that the Commission's proposals have the potential to create health inequalities. The Commission estimates that currently about 1% of public healthcare budgets are spent on cross-border healthcare with over 90% of healthcare provided to patients being delivered by their domestic healthcare system.

Although all patients have the right to access healthcare in other Member States, only the mobile and well informed patients will be able to use this right. For many patients treatment abroad is not a real option, either because they are too sick to travel, they can not afford it, language problems, or they prefer to stay close to home and family etc. As a result, HOSPEEM fears that these benefits will not be available to all patients and will create inequality in healthcare. On current figures, that means over 90% of EU patients will not make use of the new rights. HOSPEEM's view is that only strong patients, who have the financial and social capacity to move between States, will benefit as a result of this directive.

HOSPEEM takes the view that serious consideration should be given to the fact that an increasing number of the patients currently not moving across borders (over 90% of EU patients) is made up of older people, meaning not strong patients. Demographic change

and the ageing population in Europe means there will be a growing number of older people in the years to come. This seems to contradict the effort deployed by the Commission and strongly supported by HOSPEEM, to invest in solutions to the problem of the ageing EU population. Moreover, being the provider and employer in healthcare services, HOSPEEM members increasingly experience the need to create a proper infrastructure for long term and elderly care and would see a political effort in that sense at EU level, much more effective than in the field of patients' mobility.

It is essential to deal with the threat that cross-border healthcare could reduce the healthcare offered to citizens in Member States if a high number of patients 'exit' a health system to seek healthcare abroad. This could lead to a situation where offering certain treatments is not possible because there are not enough people requiring the treatment to make it viable, both in terms of medical expertise and finance. Although the treatment may be available quicker and to a high standard in another Member State, patients may not be able to access the treatment close to their home and family.

OVERARCHING VALUES

> HOSPEEM fully supports the joint statement made by the EU health ministers in June 2006 about the shared overarching values of universality, access to good quality care, equity and solidarity. However, HOSPEEM has specific concerns about putting these values in a cross-border healthcare directive. HOSPEEM is particularly concerned about the issue of universality because as healthcare employers and providers, we know how challenging it is to deliver a universal system in individual countries, let alone in the whole EU. There is a great danger that this could lead to future ECJ cases, when the aim of this directive is to resolve issues raised by previous ECJ Judgments.

NATIONAL CONTACT POINTS AND THE COLLECTION OF DATA

> The directive foresees the establishments of contact points for cross-border healthcare in the Member States. This will cause heavy administrative burdens and high costs for healthcare providers as well as for the institutions organising domestic healthcare systems. Even though these contact points seem to be essential for the management of increased cross-border healthcare, the administrative and financial impacts have to be fully considered. These additional costs are likely to take away funding from patient care.

The Commissions proposals also require Member States to collect new data on cross-border healthcare. Collecting data is also time consuming and expensive. The burden to collect this will fall on employers and HOSPEEM is again concerned that it will also take away precious resources from already overburdened health budgets. HOSPEEM therefore questions the necessity of collecting new data and how it will be used.

PATIENT SAFETY AND ADDITIONAL COST ISSUES

> HOSPEEM believes that the safety of patients is paramount. It is therefore concerned about the situation a patient might find themselves in when things go wrong with their treatment. We have concerns about after care services, for example homecare,

physiotherapy, further hospital care where the patients have returned to their home state, after treatment in another Member State. HOSPEEM asks for further clarity on the issue of aftercare services, continuing care, malpractice etc., including the issue of how the home state will be reimbursed for the potential additional costs.

HOSPEEM takes the view that cross border healthcare could raise issues around patient safety which may not necessarily benefit patients. We would therefore like the Commission to consider action on the movement of dangerous professionals crossing borders. In countries that are receiving healthcare staff, there are issues for employers around the protection of patients and action to prevent dangerous healthcare professionals moving from one Member State to another. HOSPEEM finds this issue to be of great importance and recommend that the Commission should address this in future initiatives.

An increase in cross-border healthcare treatment will raise issues about the communication and the training of staff. Increased patient mobility will result in increased demands on the healthcare professionals. If staff do not speak the language of the patients they are treating this could lead to an increased need (and therefore increased cost) for language and interpretation skills. During patient care it is imperative that good communication exists and language could be a barrier to this happening successfully. Staff may also require increased training and new skills in order to better treat patients from different cultural backgrounds which will all be an additional expense for employers. HOSPEEM finds that more clarity is needed on how these additional costs can be met.

CONCLUSION

> HOSPEEM supports the Commission's efforts to provide legal clarity on patients' rights on cross border treatment and believes that patient safety must be paramount. It is imperative that existing health systems which are already under pressure are not overburdened by any new proposals that come from the Commission to resolve the issues created by the ECJ judgments. HOSPEEM considers it essential that high quality healthcare is available to all Europe's citizens and not just to those who have the ability to exercise their rights.

HOSPEEM wants to ensure that all the ramifications of the Commission's proposals are properly considered so that patients really do benefit from them. HOSPEEM will look to work closely with the European Commission, the Council and the European Parliament so that the views of European hospital and healthcare employers are taken into account. In that respect, HOSPEEM hopes that the co-decision procedure will provide a text that will be genuinely helpful to all EU patients and healthcare providers.

ANNEX G. HOSPEEM–EPSU FRAMEWORK AGREEMENT ON PREVENTION FROM SHARP INJURIES IN THE HOSPITAL AND HEALTHCARE SECTOR

Preamble:

1. Health and safety at work is an issue, which should be important to everyone in the hospital and healthcare sector. Taking action to prevent and protect against unnecessary injuries if properly carried out, will have a positive effect on resources;
2. Health and safety of workers is paramount and is closely linked to the health of patients. This underpins the quality of care;
3. The process of policy making and implementation in relation to medical sharps should be the result of social dialogue;
4. HOSPEEM (*European Hospital and Healthcare Employers' Association*) and EPSU (*European Public Services Union*), the recognized European Social partners in the hospital and healthcare sector, have agreed the following:

General Considerations:

1. Having regard to the Treaty establishing the European Community and in particular Articles 138 and 139 (2) thereof;
2. Having regard to Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work⁴;
3. Having regard to Council Directive 89/655/EEC of 30 November 1989 concerning the minimum safety and health requirements for the use of work equipment by workers at work⁵;
4. Having regard to Directive 2000/54/EC of the European Parliament and of the Council of 18 September 2000 on the protection of workers from risks related to exposure to biological agents at work⁶;
5. Having regard to the Community strategy 2007-2012 on health and safety at work⁷;

⁴ OJ L 183, 29.6.1989. p.1.

⁵ OJ L 393, 30.12.1990. p.13.

⁶ OJ L 262, 17.10.2000. p.21.

⁷ COM(2007) 62 final, 21.2.2007.

6. Having regard to the Directive 2002/14/EC of the European Parliament and of the Council of 11 March 2002 establishing a general framework for informing and consulting employees in the European Community;
7. Having regard to the resolution of the European Parliament of 6 July 2006 on protecting European healthcare workers from blood-borne infections due to needlestick injuries (2006/2015(INI));
8. Having regard to the first and second stage consultation of the European Commission on protecting European healthcare workers from blood-borne infections due to needlestick injuries;
9. Having regard to the outcomes of the EPSU-HOSPEEM technical seminar on needlestick injuries of 7 February 2008⁸;
10. Having regard to the hierarchy of general principles of prevention laid down in Article 6 of Council Directive 89/391/EEC as well as to the preventative measures defined in articles 3, 5 and 6 of Directive 2000/54/EC;
11. Having regard to the joint ILO/WHO guidelines on health services and HIV/AIDS and to the joint ILO/WHO guidelines on post-exposure prophylaxis to prevent HIV infection;
12. With full respect to existing national legislation and collective agreements;
13. Whereas action needs to be taken to assess the extent of the incidence of sharp injuries in the hospital and healthcare sector, scientific evidence shows that preventive and protection measures can significantly reduce the occurrence of accidents and infections;
14. Whereas a full risk assessment process is a precondition to take appropriate action to prevent injuries and infections;
15. Whereas the employers, and workers' health and safety representatives need to cooperate to prevent and protect workers against injuries and infections from medical sharps;
16. Whereas healthcare workers are primarily but not exclusively concerned by sharp injuries;
17. Whereas students undertaking clinical training, as part of their education, are not considered as workers under this agreement, they should be covered by the prevention and protection measures outlined in this agreement, with liabilities being regulated according to national legislation and practice;

⁸ OJ L OJ L 80, 23.3.2002, p. 29–34.

Clause 1: Purpose

The purpose of this framework agreement is:

- To achieve the safest possible working environment;
- To prevent workers' injuries caused by all medical sharps (including needlesticks);
- To protect workers at risk;
- To set up an integrated approach establishing policies in risk assessment, risk prevention, training, information, awareness raising and monitoring;
- To put in place response and follow-up procedures;

Clause 2: Scope

This agreement applies to all workers in the hospital and healthcare sector, and all who are under the managerial authority and supervision of the employers. Employers should deploy efforts to ensure that subcontractors follow the provisions laid down in this agreement.

Clause 3: Definitions

Within the meaning of this agreement:

1. **Workers:** any persons employed by an employer including trainees and apprentices in the hospital and healthcare sector-directly related services and activities. Workers who are employed by temporary employment business within the meaning of Council Directive 91/383/EC supplementing the measures to encourage improvements in the safety and health at work of workers with fixed-duration employment relationship or a temporary employment relationship⁹ fall within the scope of the agreement.
2. **Workplaces covered:** healthcare organisations/services in public and private sectors, and every other place where health services/activities are undertaken and delivered, under the managerial authority and supervision of the employer.
3. **Employers:** natural/legal persons/organisations having an employment relationship with workers. They are responsible for managing, organising and providing healthcare and directly related services/activities delivered by workers.
4. **Sharps:** objects or instruments necessary for the exercise of specific healthcare activities, which are able to cut, prick, cause injury and/or infection. Sharps are considered as work equipment within the meaning of Directive 89/655//EEC on work equipment.
5. **Hierarchy of measures:** is defined in order of effectiveness to avoid, eliminate and reduce risks as defined in article 6 of Directive 89/391/EEC and articles 3, 5 and 6 of Directive 2000/54/EC.
6. **Specific preventative measures:** measures taken to prevent injury and/or transmission of infection in the provision of hospital and healthcare directly related

⁹ OJ L 183, 29.6.1989, p.1.

services and activities, including the use of the safest equipment needed, based on the risk assessment and safe methods of handling the disposal of medical sharps.

7. **Workers' representatives:** any person elected, chosen or designated in accordance with national law and/or practice to represent workers.

8. **Worker's health and safety representatives** are defined in accordance with Article 3(c) of Directive 89/391/EEC as any person elected, chosen or designated in accordance with national law and/or practices to represent workers where problems arise relating to the safety and health protection of workers at work.

9. **Subcontractor:** any person who takes action in hospital and healthcare directly related services and activities within the framework of working contractual relations established with the employer.

Clause 4: Principles

1. A well trained, adequately resourced and secure health service workforce is essential to prevent the risk of injuries and infections from medical sharps. Exposure prevention is the key strategy for eliminating and minimizing the risk of occupationally acquired injuries or infections.

2. The role of health and safety representatives is key in risk prevention and protection.

3. The employer has a duty to ensure the safety and health of workers in every aspect related to the work, including psycho-social factors and work organisation.

4. It shall be the responsibility of each worker to take care - as far as possible - of their own safety and health and that of other persons affected by their actions at work, in accordance with their training and the instructions given by their employer.

5. The employer shall develop an environment where workers and their representatives are participating in the development of health and safety policies and practices.

6. The principle of the following specific preventative measures indicated in clauses 5 –10 of the present agreement means never assuming that there is no risk. The hierarchy of general principles of prevention according to article 6 of Directive 89/391/EEC and articles 3, 5 and 6 of Directive 2000/54/EC is applicable.

7. Employers and workers' representatives shall work together at the appropriate level to eliminate and prevent risks, protect workers' health and safety, and create a safe working environment, including consultation on the choice and use of safe equipment, identifying how best to carry out training, information and awareness-raising processes.

8. Action needs to be taken through a process of information and consultation, in accordance with national laws and/or collective agreements.
9. The effectiveness of awareness-raising measures entails shared obligations of the employers, the workers and their representatives.
10. In achieving the safest possible workplace a combination of planning, awareness raising, information, training, prevention and monitoring measures is essential.
11. Promote a "no blame" culture. Incident reporting procedure should focus on systemic factors rather than individual mistakes. Systematic reporting must be considered as accepted procedure.

Clause 5: Risk Assessment

1. Risk assessment procedures shall be conducted in compliance with articles 3 and 6 of Directive 2000/54/EC, and Articles 6 and 9 of Directive /89/391/EEC.
2. Risk assessment shall include an exposure determination, understanding the importance of a well resourced and organised working environment and shall cover all situations where there is injury, blood or other potentially infectious material.
3. Risk assessments shall take into account technology, organisation of work, working conditions, level of qualifications, work related psycho-social factors and the influence of factors related to the working environment. This will:
 - Identify how exposure could be eliminated;
 - Consider possible alternative systems;

Clause 6: Elimination, prevention and protection

1. Where the results of the risk assessment reveal a risk of injuries with a sharp and/or infection, workers' exposure must be eliminated by taking the following measures, without prejudice to their order:
 - Specifying and implementing safe procedures for using and disposing of sharp medical instruments and contaminated waste. These procedures shall be regularly reassessed and shall form an integral part of the measures for the information and training of workers referred in clause 8;
 - Eliminating the unnecessary use of sharps by implementing changes in practice and on the basis of the results of the risk assessment, providing medical devices incorporating safety-engineered protection mechanisms;
 - The practice of recapping shall be banned with immediate effect;

2. Having regard to the activity and the risk assessment, the risk of exposure must be reduced to as low a level as necessary in order to protect adequately the safety and health of the workers concerned. The following measures are to be applied in the light of the results of the risk assessment:

- Place effective disposal procedures and clearly marked and technically safe containers for the handling of disposable sharps and injection equipment as close as possible to the assessed areas where sharps are being used or to be found;

- Prevent the risk of infections by implementing safe systems of work, by:

- a. Developing a coherent overall prevention policy, which covers technology, organisation of work, working conditions, work related psycho-social factors and the influence of factors related to the working environment;

- b. Training;

- c. Conducting health surveillance procedures, in compliance with article 14 of Directive 2000/54/EC;

- Use of personal protective equipment;

3. If the assessment referred to in clause 5 reveals that there is a risk to the safety and health of workers due to their exposure to biological agents for which effective vaccines exist, workers shall be offered vaccination.

4. Vaccination and, if necessary, revaccination shall be carried out in accordance with national law and/or practice, including the determination of the type of vaccines.

- Workers shall be informed of the benefits and drawbacks of both vaccination and non-vaccination;

- Vaccination must be offered free of charge to all workers and students delivering healthcare and related activities at the workplace;

Clause 7: Information and awareness-raising

As sharps are considered as work equipment within the meaning of Directive 89/655/EC, in addition to information and written instructions to be provided to workers specified in article 6 of Directive 89/655/EC, the employer shall take the following appropriate measures:

- To highlight the different risks;

- To give guidance on existing legislation;

- To promote good practices regarding the prevention and recording of incidents/accidents;

- To raise awareness by developing activities and promotional materials in partnership with representative trade unions and/or workers' representatives;

- To provide information on support programmes available;

Clause 8: Training

In addition to measures established by article 9 of Directive 2000/54/EC, appropriate training shall be made available on policies and procedures associated with sharps injuries, including:

- The correct use of medical devices incorporating sharps protection mechanisms;
- Induction for all new and temporary staff;
- The risk associated with blood and body fluid exposures;
- Preventive measures including standard precautions, safe systems of work, the correct use and disposal procedures, the importance of immunisation, according to the procedures at the workplace;
- The reporting, response and monitoring procedures and their importance;
- Measures to be taken in case of injuries;

Employers must organise and provide training which is mandatory for workers. Employers must release workers who are required to attend training. This training shall be made available on a regular basis taking into account results of monitoring, modernisation and improvements.

Clause 9: Reporting

1. This includes the revision of the reporting procedures in place with health and safety representatives and/or appropriate employers/workers representatives. Reporting mechanisms should include local, national and European wide systems.
2. Workers shall immediately report any accident or incident involving sharps to the employers and/or the person in charge, and/or to the person responsible for safety and health at work.

Clause 10: Response and Follow-up

Policies and procedures shall be in place where a sharp injury occurs. All workers must be made aware of these policies and procedures. These should be in accordance with European, national/regional legislation and collective agreements, as appropriate.

In particular the following action shall be taken:

- The employer takes the immediate steps for the care of the injured worker, including the provision of post-exposure prophylaxis and the necessary medical tests where indicated for medical reasons, and appropriate health surveillance in accordance with clause 6 §2,c
- The employer investigates the causes and circumstances and records the accident/incident, taking -where appropriate- the necessary action. The worker must provide the relevant information at the appropriate time to complete the details of the accident or incident;

· The employer shall, in cases of injury, consider the following steps including counselling of workers where appropriate and guaranteed medical treatment. Rehabilitation, continued employment and access to compensation shall be in accordance with national and/or sectoral agreements or legislation;

Confidentiality of injury, diagnosis and treatment is paramount and must be respected;

Clause 11: Implementation

This agreement will be without prejudice to existing, future national and Community provisions which are more favourable to workers' protection from medical sharps' injuries. The signatory parties request the Commission to submit this framework agreement to the Council for a decision in order to make this agreement binding in the member states of the European Union.

If implemented through Council decision, at European level and without prejudice to the respective role of the Commission, national courts and the European Court of Justice, the interpretation of this agreement, could be referred by the Commission to the signatory parties who will give their opinion.

The signatory parties shall review the application of this agreement five years after the date of the Council decision if requested by one of the parties to the agreement.

Brussels, 17 July 2009



Godfrey PERERA
Secretary General of HOSPEEM



Karen JENNINGS
President of EPSU
Standing Committee
Health and Social Services

ANNEX H. MULTI-SECTORAL GUIDELINES TO TACKLE THIRD-PARTY VIOLENCE AND HARASSMENT RELATED TO WORK



EPSU, UNI europa, ETUCE, HOSPEEM, CEMR, EFEE, EuroCommerce, CoESS - 16 July 2010

(I) INTRODUCTION

1. The aim of the Guidelines is to ensure that each workplace has a results-oriented policy which addresses the issue of third-party violence. The Guidelines set out the practical steps that can be taken by employers, workers and their representatives /trade unions to reduce, prevent and mitigate problems. The steps reflect the best practices developed in our sectors and they can be complemented by more specific and/or additional measures.
2. According to EU and national law, both employers and workers have obligations in the field of health and safety. Although, the duty to ensure the health and safety of workers in every aspect related to the work lies with the employer¹⁰, the employee also has a responsibility to take care, as far as possible, of their own health and safety and that of other persons affected by their actions at work, in accordance with their training and the instructions given by their employer. Employers also have an obligation to

¹⁰EU law includes the following Directives:

- ✓ Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work. Article 5 (4) states *"The workers' obligations in the field of safety and health at work shall not affect the principle of the responsibility of the employer."*
- ✓ Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin
- ✓ Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation
- ✓ Directive 2002/73/EC of 23 September 2002 amending Council Directive 76/207/EEC on the implementation of the principle of equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions

consult workers and/or their representatives and allow them to take part on all questions relating to health and safety at work. This reflects awareness that, in practice, a joint approach to health and safety is the most successful.

3. The signatory social partners from the local and regional government, healthcare, commerce, private security, education sectors¹¹ are increasingly concerned about the impact of third-party violence on employees because it not only undermines an individual's health and dignity, but also has a very real economic impact in terms of absences from the workplace, morale and staff turnover. Third party-violence can also create an environment that is unsafe and even frightening to the public and service users and therefore has a wide negative social impact.
4. Work-related third-party violence and harassment can take many forms. It could:
 - a) Be physical, psychological, verbal and/or sexual
 - b) Be one-off incidents or more systematic patterns of behaviour, by an individual or group
 - c) Originate from the actions or behaviour of clients, customers, patients, service users, pupils or parents, members of the public, or of the service provider
 - d) Range from cases of disrespect to more serious threats and physical assault;
 - e) Be caused by mental health problems and/or motivated by emotional reasons, personal dislike, prejudices on grounds of gender, racial/ethnic origin, religion and belief, disability, age, sexual orientation or body image.
 - f) Constitute criminal offences aimed at the employee and his/her reputation or the property of the employer or client which may be organised or opportunistic and which require the intervention of public authorities
 - g) Deeply affect the personality, dignity and integrity of the victims
 - h) Occur at the work place, in the public space or in a private environment and is work related.
 - i) Occur as cyber-bullying/cyber-harassment through a wide range of information and communication technologies (ICT).
5. The issue of third party violence is sufficiently distinct from the question of violence and harassment (among colleagues) in the workplace, and sufficiently significant in terms of its impact on the health and safety of workers and its economic impact to warrant a distinctive approach.
6. Although there are sectoral and organisational differences with regard to third-party violence faced by workers in different occupations and workplaces, the key elements of good practice and steps to tackle it are common to all working environments. These elements are: a partnership approach; clear definitions; prevention through risk assessment, awareness raising, training; clear reporting and follow-up; and appropriate evaluation.

¹¹ See annex for details

7. With the support of the European Commission the multi-sectoral social partners organized two major conferences in Brussels on 14 March 2008 and 22 October 2009 at which the employers' and trade unions' research into third-party violence was presented along with case studies and joint conclusions. These Guidelines build on these initiatives. They complement the cross-sectoral Framework Agreement on Harassment and Violence at Work of 26 April 2007.
8. The way in which particular services are organised and provided reflects national, regional and local circumstances. Where social partners are already implementing the measures set out in these Guidelines the main action to take will be to report on progress made.
9. The multi-sectoral social partners recognize that the employers and workers have professional, ethical and legal obligations to third parties as well as to each other. .

(II) AIM

1. The aim of these Guidelines is to support action(s) by employers, workers and their representatives / trade unions to prevent, reduce and mitigate third-party violence and its consequences.
2. The multi-sectoral social partners recognize that practical measures for the prevention and management of work related harassment and/or third party violence have yet to be developed in many workplaces. These measures should:
 - a) Increase awareness and understanding of employers, workers, their representatives and other public authorities (e.g. health and safety agencies, police, etc) of the issue of third party violence
 - b) Demonstrate the commitment of social partners to work together and share experiences and good practice in order to help each other prevent and manage problems of harassment and/or violence instigated by third parties in order to reduce the impact on employees' health and well-being, sickness absence and productivity
 - c) Provide employers, workers and their representatives at all levels with Guidelines to identify, prevent manage and tackle problems of work related harassment and violence instigated by third parties.

(III) STEPS TO IDENTIFYING, PREVENTING, REDUCING AND MITIGATING WORK-RELATED HARASSMENT AND VIOLENCE BY THIRD-PARTIES

1. The likelihood of third-party harassment and/or violence occurring can be reduced through raising awareness of the issue to employers, employees and service users and ensuring that managers and workers receive appropriate guidance and training.
2. The most successful initiatives to tackle violence involve both social partners from the very beginning and involve a 'holistic' approach, covering all aspects from awareness raising over prevention and training to methods of reporting, support for victims and evaluation and ongoing improvement.
3. Employers should have a clear policy framework for the prevention and management of harassment and violence by third parties which should be incorporated into their general health and safety policies. These policies should be developed by the employers in consultation with workers and their representatives, in accordance with national legislation, collective agreements and/or practice. In particular health and safety risk assessments of workplaces and individual job functions should include an action-oriented assessment of the risks posed by third-parties.
4. The multi-faceted nature of third party violence means that policies must be tailored to each work environment. As a matter of good practice policies should be kept under regular review in order to take account of experience and related developments in legislation, technology, etc. Over time research, experience and technological advances should provide better solutions than are currently available.
5. A suitable policy framework for an employer is underpinned in particular by the following elements:
 - a) On-going information and consultation with managers, workers and their representatives / trade unions at all stages
 - b) A clear definition of third-party violence and harassment, giving examples of different forms this can take
 - c) Appropriate information to clients, customers, service users, members of the public, pupils, parents and/or patients outlining that harassment and violence towards employees will not be tolerated and that if appropriate legal action will be taken
 - d) A policy based on risk assessment which can take into account the various occupations, locations and working practices, allow the identification of potential problems and the design of appropriate responses and practices, for example:
 - ✓ Managing expectations by providing clear information regarding the nature and level of service clients/customers/service users/pupils and parents should expect and the provision of procedures for third parties to express dissatisfaction and for such complaints to be investigated
 - ✓ Incorporating safer environments into workplace design
 - ✓ Provision of suitable 'tools' to safeguard employees, e.g. communication channels, monitoring, security measures, etc
 - ✓ Cooperation agreements with the relevant public authorities such as police, justice, social services and inspectorates

- e) Appropriate training for management and employees which will include general safety in relation to work tasks and the working environment, and which may incorporate more specific skills such as techniques to avoid or manage conflict.
 - f) A procedure to monitor and investigate allegations of harassment and/or violence from third-parties, and to inform the victims of the progress of any relevant investigation and action.
 - g) Clear policies on the support to be provided to employees who are exposed to harassment and/or violence by third-parties, which, for example and depending on the circumstances, could involve medical (including psychological), legal, practical, and/or financial support (e.g. additional insurance cover which goes beyond statutory obligations)
 - h) Clear requirements regarding the reporting of incidents by employees and on the measures taken to protect these employees from possible reprisals and address issues to other public, authorities e.g. police, health and safety agencies, etc, within national practices and procedures.
 - i) Clear policies on when it is appropriate to file complaints, report a crime or share information regarding perpetrators of third-party violence with other employers and public authorities, respecting personal integrity, confidentiality, legal obligations and data protection principles.
 - j) A transparent and effective procedure for recording facts and figures for monitoring and ensuring follow up of the policies put in place
 - k) Measures to ensure that the policy framework is well-known and understood by management, workers and third-parties
6. In this regard the multi-sectoral social partners highlight the importance of working with other appropriate partners at the national or local level to identify and prevent violence and harassment by having consistent policy approaches.

(IV) IMPLEMENTATION AND NEXT STEPS

Implementation and follow-up of the Guidelines will comprise three stages.

Stage 1 – Commitment and dissemination

The signatory social partners will disseminate the Guidelines and take measures to assess and address the issue of third-party harassment and violence using the identified policy framework in Section 3 above.

- ✓ Jointly request the European Commission to support a project to disseminate and promote the Guidelines, including through workshops to be organised before the end of 2011
- ✓ Encourage the promotion of the Guidelines in Member States at all appropriate levels taking account of national practices, through joint and/or separate actions. Given the interest of the matter under consideration, the social partners will also transmit this document to all relevant players at European and national levels. They will also invite their members outside the EU to make use of the Guidelines.

Stage 2 – Awareness Raising

The national social partners will publicise the issue of third-party harassment and violence and develop and share best practice in this field within their sectors. This may include any means appropriate to the current state of knowledge and experience of the phenomenon of third party violence in the Member State and/or sector and taking into account work already undertaken in this area, including the possibilities of:

- ✓ Further research
- ✓ Publications
- ✓ Conferences drawing together interested parties to share good practice and/or work towards solutions to the problem

Stage 3 - Monitoring and follow-up

The signatory social partners will:

- ✓ Give a progress report in 2012 to their respective sectoral social dialogue committees and entrust the European Social Dialogue Committees of the respective sectors to prepare a joint report.
- ✓ When preparing the next EU social dialogue work programme, the social partners will take account of these Guidelines.
- ✓ Multi-sectoral meetings of follow-up will be organized as appropriate and a final joint evaluation will take place in 2013

ANNEX I. RECRUITMENT AND RETENTION, A FRAMEWORK OF ACTION

1. PREAMBLE

- 1.1 Access to health care services for all is a fundamental human right. This right forms an essential part of the European Social model. All relevant actors must be committed to the effective functioning of health care services. This implies a multifaceted approach that has to take into account the various challenges different countries are experiencing in terms of health care shortages. These challenges are multiple and complex covering:
- 1.2 The ageing population which increases the demand for healthcare services and social services coupled with an ageing workforce and difficulties in recruiting and retaining health care workers.
- 1.3 Given the demanding nature of the work ensuring an optimal working environment is particularly important in the health sector to enable patients to receive high quality care.
- 1.4 The financial and economic crisis affects the Health Care sectors in different ways in different countries. As applied in some member states, cuts in health care resources are short-sighted measures with detrimental consequences for public health, the availability of health care staff and infrastructures. To maintain and further improve the services, Members States should maintain their autonomy and capacity to plan services and organise resources at local, regional and national level, with a view to securing and building the overall sustainability of healthcare systems.

2. GENERAL CONSIDERATIONS

- 2.1 Member States are responsible for the organisation and delivery of healthcare systems and, as part of this, play a crucial role in the organisation and provision of professional training for healthcare workers in consultation with social partners and other stakeholders where appropriate. Member States also play a role in setting terms and conditions for healthcare workers through legislation on health and safety, working time, equal treatment and other measures. Social partners should work with national, regional and local authorities when developing policies relating to the healthcare workforce,¹² for example, to support lifelong learning training, internal job mobility, and provision of management and organisation skills.

¹² To take due account of the “Report on the open consultation on the Green Paper on the European Workforce for Health” http://ec.europa.eu/health/ph_systems/docs/workforce_report.pdf and the Green paper on the European Workforce for Health (COM (2008) 725 Final)

- 2.2 The social partners are committed to effective workforce planning through the EPSU-HOSPEEM “Code of Conduct and Follow-up on Ethical Cross-border Recruitment and Retention, which states:” Effective planning and human resources development strategies at local, regional and national level are necessary to ensure a balance between supply and demand of health care personnel while offering long-term prospects for employment to healthcare workers”.
- 2.3 EPSU and HOSPEEM believe that necessary measures should be taken to enhance the attractiveness of the health care sector as a place to work. The key to maintaining a sufficient workforce in the face of the impending retirement of the “baby boom”/post-war generation is, to educate, recruit and retain young practitioners while reinvesting in the mature workforce.
- 2.4 EPSU and HOSPEEM want to encourage and contribute fully to the development and implementation of policies at local, regional, national and European levels with the purpose of enhancing work force recruitment and retention, and promoting accessible and high-quality health care, in full respect of Member States responsibilities for the organization and delivery of healthcare of their citizens.
- 2.5 All employees have a right to be treated fairly and equitably and work in an environment free from all forms of discrimination.
- 2.6 We recognize the benefit of work / life balance, among others to meet the needs of certain groups of staff.

3. PURPOSE

- 3.1. **Support the recruitment and retention of workers in the hospital sector**
EPSU and HOSPEEM recognize the need to meet existing and future staff needs. To deliver the highest level of care to the patients and society, healthcare services need to be well-equipped, in particular in terms of a well-trained and motivated workforce. Investments in training and working conditions are therefore a necessity. This means that health care staff needs to be valued and receive recognition in their terms and conditions of work to be competitive with other sectors. Social partners in cooperation with the relevant member states’ authorities will take action to promote the health care sector and attract young people into employment in health services. Valuing and retaining the skills and experiences of older workers is equally crucial in transferring experience and the retention of knowledge. Social partners at all levels, in cooperation with member states’ authorities, should develop supporting infrastructures to facilitate work in a 24/7 service delivery context.
- 3.2. **Improve work organization**
Hospital organizations have to respond to the requirements of a 24 / 7 service delivery. This will always remain a feature in the hospital sector and has to be based on a workforce that is able to render the necessary range of services in a variety of

shifts. Work organization needs to take account of workers' and employers' needs and preferences. Workers and their representatives should have the opportunity to be involved in determining work organization, aiming at achieving a balance in accordance with employers' and workers' interests. Better work-life balance will lead to improved quality of work and job motivation. HOSPEEM and EPSU acknowledge the benefits¹³¹⁴ that can be gained from staff having planned and agreed hours of work and rest periods. Social partners will cooperate to promote the best way of delivering efficient health care, which will safeguard staff and patient health and safety.

Social partners should consider the implementation of innovative workplace designs, actively involving the health workforce and their representatives, such as self-rostering which could be supported by ICT-instruments.

3.3. **Develop and implementing workforce planning mechanisms**

Workforce planning mechanisms¹⁵ need to take account of present and future needs, to ensure that a sufficient number of staff with the requisite skills are available in the right place at the right time. Such measures need to adhere to ethical recruitment principles and respond to the changing demographic profile. Amongst other things, workforce planning may involve examining: the existing and future skill needs of the sector / organization, the availability of workers with regard to their competences / qualifications and the prospects to fill existing and potential skills gaps.

In the healthcare sector HOSPEEM and EPSU agree that full-time work is the general rule, without excluding the choice of working part time.

The social partners recognise the benefit that fixed-term and agency workers bring to the service and should map the potential to integrate them into the workforce.

3.4. **Encourage diversity and gender equality in the health workforce**

The healthcare workforce should reflect the diversity of the society it cares for.

In order to provide diversity and gender equality in the health care workforce, it is important that existing and future policies provide equal access to work/life balance, career and training facilities.

The majority of health care staff are women, a significant number of whom also currently have caring responsibilities. In order to facilitate the full participation of men and women in the healthcare labour market, health employers and social partners should take measures and develop policies which will improve the work-life balance of workers.

Action is necessary to gender balance the health care sector and to attract more men to take up employment in the health care sector. Social partners should, in addition, explore and promote policies and practices aimed at encouraging participation of under-represented groups in the healthcare workforce.

3.5. **Initial training, life-long learning and continuous professional development**

¹³ Danish Nurses Organization study 2010

¹⁴ UK Boorman report on health and well-being – 2010

¹⁵ WHO International recruitment of Health Personnel: Global Code of Practice

A well-trained and motivated workforce will produce better health outcomes and services. In order to facilitate a combination of work and learning, social partners have to take account of a range of options including secondments, on-the-job training, e-learning and other innovative career policies and training methods¹⁶.

Extending the available career opportunities for workers is critical in the retention of healthcare staff as it can help offer a long term career perspective.

EPSU and HOSPEEM will through their national member organizations promote and support initial training, life-long learning programmes and continuous professional development with a view of ensuring quality of training, up-to date knowledge and competences of staff. Open career paths are to facilitate entry routes for training and qualification of all categories of staff within and in between health care work places.

Social partners should support programmes that assist workers who have undergone training to find jobs corresponding to their newly acquired competences. Social partners should support the development of programmes and initiatives which could help workers to manage their professional lives and make informed decisions about their future career steps and training.

3.6. **Achieve the safest possible working environment**

A healthy and safe work environment will contribute to recruitment and retention. Workforce organization policies at all levels should, thus aim to diminish health and safety risks to enable healthcare workers to perform their jobs in the safest possible working environment.

Sharps Directive¹⁷

Member States have the legal responsibility to implement the directive. Social partners will play a full role to ensure the proper implementation of this Directive and review the effectiveness of policies introduced.

Multi Sector Guidelines to tackle third party violence and harassment related to work¹⁸

EPSU and HOSPEEM as social partners will commit to the efficient and full implementation of these guidelines in the health sector and work places.

The social partners in health recognize the negative impact that third-party violence and harassment can have on health workers. It undermines an individual's health, dignity and safety, but also has a very real economic impact in terms of absence from the work place, morale and staff turnover. Third- party violence can also create an environment which is unsafe and even frightening to the public, workers and service users and therefore has a wide negative social impact. It can also undermine the reputation of an organization both in terms of an employer and provider of services.

¹⁶ European funding mechanisms may play a role in supporting training and development opportunities for healthcare workers through instruments such as provided by the European Social Fund (ESF), the European Regional Development Fund (ERDF) and the European Globalisation Adjustment Fund (EGF)

¹⁷ Council Directive 2010/32/EU

¹⁸ European social Dialogue Multi-Sectoral Guidelines to tackle third-party violence and harassment related to work

As a result, social partners agree to work in partnership throughout the implementation and to identify, develop and share models of best practice.

4. IMPLEMENTATION

EPSU and HOSPEEM commit to implement the framework of actions on recruitment and retention and will:

- Collate case studies and consider joint EPSU / HOSPEEM model initiatives in line with chapter 3
- Consider follow- up action on implementation of the code of conduct on ethical cross border recruitment and retention
- Monitor European legislation and other pertinent policies which may impact on recruitment and retention fully.

Signed in Brussels on 17 December 2010

For
EPSU



A handwritten signature in black ink, reading 'Carola Fischbach-Pyttel'.

Carola Fischbach-Pyttel
General Secretary

For
HOSPEEM



A handwritten signature in black ink, reading 'Godfrey Perera'.

Godfrey Perera
General Secretary

ANNEX J. “RIGA DECLARATION” ON STRENGTHENING SOCIAL DIALOGUE IN THE HEALTH CARE SECTOR IN THE BALTIC COUNTRIES

Introduction

This declaration aims to highlight the critical role of health care for competitiveness and the well-being of citizens, the importance of retaining health care workers in order to ensure high quality patient care and emphasises the crucial role played by social dialogue in health care policy planning and reform and the determination and improvement of working conditions in the sector. The signatories to the declaration aim to highlight some of the most important challenges facing the health care sector in the Baltic countries at a time of tightening public budgets and sets out how social partners, members state governments and authorities at different levels and the European Commission can work together to tackle these issues. It calls for actions at all levels which should be developed and monitored in continuous collaboration. The goal of the declaration is to feed into bi-partite and tripartite dialogue at national and European level to further the improvement of patient care through effective policy in all spheres of decision making, underpinned by social dialogue and collective agreements at local and sectoral level.

The critical role of health care for the competitiveness of the Baltic countries and the well-being of its citizens

It has been widely acknowledged by the European Commission, the World Health Organisation and the OECD among others that ensuring strong health care provisions for all is critical for the competitiveness of nations by maintaining and enhancing the productive potential of the workforce as well as underpinning the health of nations and contributing towards greater social inclusion more generally. Health services are also a key element of the European Social Model, especially in relation to social and territorial cohesion and have a critical role to play in the social development of Europe and its Member States. Healthcare systems should be governed by the awareness that forward-looking and long-term investments in service provision would result in considerable improvements in the population's health status and consequently lead to (financial) benefits and savings that are favourable to the community as a whole. In most European states the health care sector play an important role for economic and employment growth in the last 10-15 years and there is still untapped potential. According to the World Health Organisation, in the period between 2005 and 2008 total (public and private) health care expenditure in the majority of Member States ranged between 5-11% of GDP, with some exceptions of countries spending above or below this amount. At the same time, hospital expenditure remained steady, ranging between 2-4% of GDP, again with some exceptions above and below this amount.

However, because of the financial and economic crisis, most Member States are now faced with difficult choices about cutting public expenditure. As a result, reforms in national healthcare systems have been initiated in many countries. The social partners organisations representing employers and trade unions in the health care sector in the Baltic countries express their concern about reductions in health care budgets and consider them to be short-sighted. In at least one country, Latvia, they 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%. The social partners call upon governments and the European Commission to recognise the detrimental long-term effects of either reductions in health care expenditure or reductions in the coverage of health insurance funding for treatment and services for the competitiveness of the Baltic economies as well as for the health and well-being of its citizens. They also call for social partners to be more closely involved in the planning of such reforms in order to avoid detrimental effects on service quality and staffing levels. It is their view that front line staff is best placed to provide information on potential efficiency savings and effective service planning.

National governments in the Baltic countries should recognise the contribution of publicly funded health care services in enhancing health equity and therefore provide for public investment to mitigate the effects of the financial and economic crisis.

It is part of the Member States’ public responsibilities to promote the general interest including a high level of public health. Health care therefore should be organised on the basis of common European social values including solidarity, social justice and social cohesion (cf. Council Conclusions of 2 June 2006 on common values and principles in European Union Health Systems), in a way to realise general interest principles – in particular universality, accessibility and affordability – and to promote safety, quality of health care institutions and services as well as patients’ rights.

The European Commission should promote public health and its aim to improve health care for all patients (cf. Charter of Fundamental Rights, Art. 35)

It should also make resources available from EU structural funds to address health inequalities in and between member states as well as for measures of professional training including continued professional development.

Retaining health care workers to ensure the future of the Baltic health care sector

Freedom of movement of workers is an important pillar of the European Union. However, in the Baltic countries, this has led, in recent years, to a significant number of highly qualified medical and nursing staff leaving to work in Western and Northern European countries, entailing a “brain drain” and “care drain” (e.g. in Estonia around half of the qualified nurses have left the country) in the last years, as reported during one of the seminars of this project). This has contributed to labour and skill shortages in some regions of the Baltic countries that are expected to become more dramatic in the future. This problem is also underlined by the Commission’s Green Paper on the European workforce for health in 2008, and it will increase in the context of an ageing population and due to freezes or cuts in public budgets against the backdrop of the financial and economic crisis and particular concerns specialist doctors and nurses.

In line with the Framework of Action on Recruitment and Retention signed by EPSU and HOSPEEM in December 2010, the Baltic social partners in the health care sector have sought to undertake measures to retain workers even in the context of limited resources. However, further efforts are required both by social partners and national governments to make the health care sector an attractive place to work. As underlined in the Framework of Actions, Member States are responsible for the organisation and delivery of healthcare systems and, as part of this, play a crucial role in the organisation and provision of

professional training for healthcare workers in consultation with social partners and other stakeholders were appropriate. The availability of ongoing training and career progression plays a critical part in recruitment and retention.

The recent Council Conclusions on Investing in Europe's health workforce of tomorrow – Scope for innovation and collaboration, adopted on 7 December 2010, therefore rightly 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. For HOSPEEM and EPSU this comprises the task to actually work towards improving the different conditions decisive for recruitment and retention of qualified health care workers by taking into account the needs of the 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. The signatories to this declaration furthermore endorse the request by the Council to Member States to consider how best to make use of EU tools for financing such training.

Patient care is paramount and this will be difficult to guarantee without a well-trained, motivated and well-remunerated workforce and without well-equipped and well-resourced health services. Health care authorities and providers therefore should take all actions necessary to develop forward-looking personnel strategies and to promote high quality health care staff, be it in the recruitment, the training or the employment of health workers and to invest in training, skills and good quality of work.

More concretely, national governments and relevant bodies should support politically and financially initiatives to invest in sufficient, motivated and well-skilled health professionals in order to protect the viability and accessibility of the health systems (cf. Conclusions of Ministerial Conference "Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration", La Hulpe, 9-10 September 2010). They should elaborate an action plan to support the development of health workforce policies in particular in the areas of the assessment of competence profiles and continuous professional development. This should be done in collaboration with social partners organisations.

The important role of social dialogue

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.

The recent project on "strengthening social dialogue in the health care sector in the Baltic countries" which was co-financed by the European Commission, run by HOSPEEM and supported by EPSU has contributed to a better understanding of respective social dialogue

structures. The signatories call on national governments and the European Commission to continue to support the improvement of social dialogue structures at all levels (national, regional and local) in order to assist the development of consensual solutions to key challenges facing the health care sector. HOSPEEM members and EPSU affiliates in the Baltic States and beyond therefore recall the need for EU institutions to build on social dialogue structures when developing healthcare policies, action programmes, etc. underpinned by the obligation to consult according to Article 154 TFEU. National governments and the European Commission need to recognise and respect this work and support the implementation of collective agreements and other agreements and outcomes of social dialogue.

The European Commission should continue its support for capacity building for social partners in the hospital and health care sectors in the new member states in view of improving the functioning of existing structures and raising awareness for the potential and benefits of social dialogue at different levels and on a range of topics.

Priorities for the European social dialogue

European social dialogue needs effective social dialogue in Member States, i.e. structures to feed information and concerns from the bottom up and to implement top down initiatives on the ground in the Member States and at workplace level. HOSPEEM and EPSU commit themselves to further support their affiliates in the Baltic states in view of full inclusion into European processes.

Without existing, representative and well-functioning national social dialogue structures it will also be impossible to implement European agreements at national, regional and local level.

Social partners at EU and national levels should reflect on joint actions in particular on the fields of professional training and continued professional development, health and safety, working conditions, staff planning, be developed and implemented by using the social dialogue within health care institutions as well as for the whole sector. In the context of social dialogue different instruments such as collective agreements, framework of actions, action plans, or code of conducts are at their disposal. In doing so, they should consider strong co-operation with national, regional and local authorities.

Riga, 26 May 2011

ANNEX L. HOSPEEM/HOPE CO-OPERATION AGREEMENT

NEW HOSPEEM/HOPE CO-OPERATION AGREEMENT

AIMS and SCOPE

This agreement affiliates HOSPEEM (European Hospital and Healthcare Employers Association) and HOPE (European Hospital and Healthcare Federation) as partners in the promotion of high quality hospital services all over Europe. It recognises the autonomy of the signatory parties within their respective spheres of activities and competencies, creates a framework for mutual support and lays the foundations for wider arrangements reinforcing the links between health professionals acting at European level.

HOPE recognises HOSPEEM's goal to establish, with its social partners, a European autonomous frame in order to develop management and labour relations in the field of the hospital and health care sector, which deserves a specific approach because of the nature of activities carried out. HOPE recognises HOSPEEM as the representative social partner in the hospital sector, as recognised by the European Commission in July 2006.

HOSPEEM recognises HOPE's mission which is to promote improvements on the health of citizens throughout the countries of the EU and a uniformly high standard hospital care throughout the EU and HOPE objective, among others, to act as a principal source on hospital and health affairs to the institutions of the European Union.

The signatory parties commit themselves to mutually supportive, constructive and close working together, always respecting each other's autonomy within their respective sphere of competencies, as identified above.

This implies the following:

DAY TO DAY MANAGEMENT

The two organisations commit to:

- Inform each other of their programme of meetings and send copies of agendas and reports to each other at least three working days before meetings about, respectively, HOSPEEM General Assembly and HOPE board of governors;*
- Respect the confidentiality of each other's papers and meetings and not disclose information obtained thereby to third parties without permission;*
- Keep in mind each other's concerns in the conduct of activities in their respective spheres of competencies*

MODIFICATIONS TO THE AGREEMENT AND TERMINATION

At least once a year the Secretary General of HOSPEEM and at least one vice Secretary General will meet the President and the CEO of HOPE to review the general relationship between the two organisations. The agreement between the two organisations will be automatically renewed unless either signatory party terminates this agreement by giving reasons in a written notice of at least three months.

Any breach of confidentiality may be construed by the other party as terminating the agreement.

*Godfrey PERERA
Secretary General of HOSPEEM*

President of HOPE

CONTACT

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HOSPEEM IS THE EUROPEAN AND HEALTHCARE EMPLOYERS' ASSOCIATION. IT REGROUPS AT EUROPEAN LEVEL NATIONAL, REGIONAL AND LOCAL EMPLOYERS' ASSOCIATIONS OPERATING IN THE HOSPITAL AND HEALTHCARE SECTOR AND DELIVERING SERVICES OF GENERAL INTEREST, IN ORDER TO COORDINATE THEIR VIEWS AND ACTIONS WITH REGARD TO A SECTOR AND MARKET IN CONSTANT EVOLUTION. HOSPEEM IS AN INDIVIDUAL MEMBER OF CEEP.