EPSU-HOSPEEM Framework of Actions on Recruitment and Retention (2010)

Follow-up report on strategies, measures and initiatives used or implemented by social partners and governments in recent years in the key thematic areas covered

Final version (15 February 2016)

Table of contents

1. EPSU-HOSPEEM Framework of Actions on Recruitment and Retention (2010) 3
1.1 Summary information on the Framework of Actions on Recruitment and Retention 3
1.2. Rationale and aims of the follow-up report 3
1.3 Methodology used 4
1.4 Input received 4

2. Synthesis report on drivers, priorities, measures and role of social partners 5
2.1 Main drivers and key challenges for effective recruitment and retention in the health care/ hospital sector in a changed policy context 5
2.2 Issues and areas of priority concern for recruitment and retention in the hospital/health care sector when looking at social partner-based and government initiatives or measures 6
2.3 Main types of strategies, measures and/or good/existing practices initiated by social partners or governments 9
2.4 What is the role of social dialogue and collective agreements in view of the elaboration and implementation of effective R&R policies? 10

3. Conclusions and recommendations 12
3.1 What can HOSPEEM and EPSU members learn from this follow-up report to the FoA R&R? 12
3.2 Recommendations the EU-level hospital sector social partners address to policy makers 12

4. Annex: Compilation of input received from HOSPEEM and EPSU members 13
4.1 General aspects mentioned under the heading “Support the recruitment and retention in the hospital sector” [=> FoA R&R 3.1] – Issues not explicitly mentioned in sections 3.2 to 3.6 of the FoA R&R 14
4.1.1 Cross-cutting initiatives 14
4.1.2 Improved pay conditions 16
4.1.3 Other issues 18
4.2 Improvement of work organisation [=> FoA R&R 3.2] 18
4.2.1 Working time / work organisation 18
4.2.2 Ageing workforce 19
4.3 Development and implementation of workforce planning mechanisms [=> FoA R&R 3.3] 20
4.4 Encouragement of diversity and gender equality [=> FoA R&R 3.4] 22
4.5 Initial training, life-long learning (LLL) and continuous professional development (CPD) [=> FoA R&R 3.5] 25
4.6 Achievement of the safest possible working environment [=> FoA R&R 3.6] 29

1. EPSU-HOSPEEM Framework of Actions on Recruitment and Retention (2010)

1.1. Summary information on the Framework of Actions on Recruitment and Retention

On 17 December 2010, HOSPEEM and EPSU signed a Framework of Actions on Recruitment and Retention, two core issues in the hospital and healthcare sector[1]. **This document constitutes a strong basis** for social partners at European and national levels **to develop concrete actions to tackle staff shortages and qualification needs of the health workforce**. With this instrument, EPSU and HOSPEEM intended to help gear the attention of policy makers as well as of their members on a number of set-screws likely to make recruitment and retention (R&R) policies and measures more effective. One of the underlying ideas for the elaboration of the agreement was to develop joint model initiatives, supported by the **collection and dissemination of case studies and good practice examples**[2].

The **Framework of Actions on Recruitment and Retention (FoA R&R)** focuses on **5 thematic areas** considered important by the sectoral social partners in the hospital sector, namely:

- Improvement of work organisation (FoA R&R 3.2)
- Development and implementation of workforce planning mechanisms (FoA R&R 3.3)
- Encouragement of diversity and gender equality (FoA R&R 3.4)
- Initial training, life-long learning and continuous professional development (FoA R&R 3.5)
- Achievement of the safest possible working environment (FoA R&R 3.6)

These thematic areas are framed by an **introductory section** (FoA R&R 3.1) that highlights the need for well-equipped healthcare services and a well-trained and motivated workforce as well as the importance of valuing and recognising what health workers do to provide high quality care to patients and society. It also states that "*valuing and retaining the skills and experiences of older workers is equally crucial in transferring experience and the retention of knowledge"* and that *"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."*

In a **joint press release**[3] issued on 21 December 2010 by HOSPEEM and EPSU, workforce planning mechanisms, innovative workplace designs (also supported by ICT-instruments), investment in professional training, life-long learning and continuous professional development as well as improving the attractiveness of workplaces and jobs in the healthcare and hospital sector for both women and men, including by measures for improved work-life balance, are mentioned as key elements for effective recruitment and retention.

1.2. Rationale and aims of the follow-up report

Chapter 4 of the FoA R&R on the follow-up action reads as follows: "*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*."

[1] The document is available in the following 10 languages: EN, FR, DE, BG, CZ, ES, FIN, IT, PL and SV.
[2] See http://www.epsu.org/a/7161 and http://hospeem.org/?p=2794.
[3] The joint press release can be accessed from both EPSU's (http://www.epsu.org/a/7161) and HOSPEEM's website (http://hospeem.org/?p=753).

This report insofar has been elaborated to comply with this follow-up "obligation" set by the signatory parties in December 2010. Beyond this formal reason, the drafting of this follow-up report reflects the **political will and interest of both HOSPEEM and EPSU to update their knowledge in particular on social partner-based activities related to the topics covered by the FoA R&R and to mutually exchange good practices**, thereby also supporting cross-country learning and transferability of approaches and solutions where appropriate. Thirdly, EPSU and HOSPEEM have the intention to provide background information and give a social partner-based input into the DG SANTE study "Recruitment and retention of the health workforce in Europe". The final report was published in July 2015.

1.3. Methodology used

In September 2014, the HOSPEEM and EPSU Secretariats agreed on a **template aiming to facilitate the collection of information and help members report back and structure relevant information (including examples of existing good practices)**. This table is structured along the 5 thematic areas covered by the FoA R&R. HOSPEEM members and EPSU affiliates were asked to share information on relevant legislation and/or government policies, strategies and concrete measures agreed and implemented by social partners themselves, as well as studies, reports and other information material involving them. HOSPEEM members and EPSU affiliates were also asked to report the main challenges and difficulties faced with regard to recruitment and retention of health workers in their countries and share possible solutions.

The report on strategies, measures and initiatives to promote and safeguard effective recruitment and retention in the healthcare/hospital sector incorporates results of the study on "Recruitment and retention of the health workforce in Europe" commissioned by DG SANTE. In May 2014 the project partners had shared with the HOSPEEM and EPSU Secretariats a discussion paper entitled "General observations/first findings from literature review", also to help prepare a presentation at the meeting of the Sectoral Social Dialogue Committee for the Hospital Sector (SSDC HS) on 25 June 2014. Prior to the final project workshop held on 10 and 11 March 2015 in Leuven (Belgium), in which the HOSPEEM and EPSU Secretariats participated, a second discussion paper was circulated. Text elements from all three documents are copied into chapter 2 and selected aspects from the final report or from the two discussion papers are summarised with the aim to complement this synthesis report, based on written input into a survey and on presentations given from national social partners across the EU.

1.4. Input received

As of 30 November 2015, inputs were received from 20 social partners' organisations from 16 EU Member States: Austria (HOSPEEM); Belgium (EPSU); Cyprus (EPSU); the Czech Republic (EPSU); Denmark (EPSU); Finland (EPSU & HOSPEEM); France (EPSU & HOSPEEM); Germany (EPSU); Ireland (EPSU); Italy (EPSU & HOSPEEM); Latvia (HOSPEEM); Lithuania (HOSPEEM); the Netherlands (EPSU & HOSPEEM, channeled via StAZ); Norway (EPSU); Sweden (EPSU & HOSPEEM, largely based on a joint contribution) and the United Kingdom (EPSU & HOSPEEM).

2. Synthesis report on drivers, priorities, measures and role of social partners

The Danish Nurses Organisation in its reply to EPSU rightfully stresses that the "issues dealt with under the FoA R&R are influenced by a range of stakeholders nationally and internationally and (…) by a lot of factors, in particular government strategies and measures". The focus of this report, however, is on the role of the social partners in the hospital/health care sector (see section 2.4). This chapter also looks into the policy context, the main drivers and challenges (see section 2.1), into the thematic priorities when it comes to government and social partner-based initiatives/measures (see section 2.2) and into the main types of strategies/measures/practice initiated or run by social partners or governments (see section 2.3).

2.1. Main drivers and key challenges for effective recruitment and retention in the health care/hospital sector in a changed policy context

In the table sent out (see section 1.3), EPSU and HOSPEEM members were asked to report back on main challenges regarding R&R in the hospital/healthcare sector in their country.

It is important to note that since the adoption of the EPSU-HOSPEEM Framework of Actions "Recruitment and Retention" the full effect of the economic crisis and related austerity programmes entailing cuts in the budgets of the national health systems, of hospitals and other health care institutions have left a clear imprint on health and hospital policies. They have insofar also strongly changed the context for the implementation of recruitment and retention strategies and measures in a number of countries throughout Europe.

Based on existing research (see in particular: European Commission: "Recruitment and Retention of the Health Workforce in Europe: Final Report"[4]) and on information received from national social partners, the following issues can be identified on the one hand as main challenges, but on the other hand also as key drivers for recruitment and retention policies and initiatives of governments, social partners and other relevant actors:

- Health care system reforms
- Restructuring of legal retirement systems requiring longer work careers
- Cuts or freezes in health budgets on the level of health systems[5] and of single institutions
- Staff shortages in a range of health professions in many EU MS. "*This is mainly reported in higher-income countries such as Australia, Austria, Germany, Norway, Switzerland and the UK*." (EC 2015:10)
- "*Difficulties in recruiting and retaining personnel in certain professions, specialities or field of practice*" (EC 2015:10), as reported in some countries.
- Attrition in several health professions and in a number of countries, either "*due to career orientation, (early) retirement or emigration*. *This is mainly reported in Central and Eastern European countries (e.g. Bulgaria, Hungary, Poland and Romania) […] and more recently in countries severely hit by the economic crisis such as Greece, Ireland, Portugal and Spain*" (EC 2015:10)
- Outward cross-border mobility of health professionals/recruitment and employment of migrant health workers
- "*Imbalances in the geographical distribution of health professionals […]* "(EC 2015:10)

[4] Cf. http://ec.europa.eu/health/workforce/key_documents/recruitment_retention/index_en.htm (EC 2015) for Final Report, Executive Summary, Case Studies and other annexes. The study was published in July 2015.
[5] See e.g. a paper finalised by the EPSU Secretariat in November 2013 (http://www.epsu.org/a/9895).

Comparing the HOSPEEM-EPSU "findings" with those from the EC-funded project, the researcher team identifies the following motivations and rationales for measures and initiatives in the field of R&R. *"Most recruitment and retention interventions, irrespective of the great differences between the countries, are triggered by* ***similar motivations and rationales****, including: 1) Observed or forecasted shortages of a category of personnel. This is mainly reported in higher-income countries such as Australia, Austria, Germany, Norway, Switzerland, the UK and Brazil; 2) High attrition rates due to career reorientation, (early) retirement or emigration. This is mainly reported in Central and Eastern European countries (e.g. Bulgaria, Hungary, Poland, Romania) and South Africa and more recently in countries severely hit by the economic crisis such as Greece, Ireland, Portugal and Spain; 3) Difficulties in recruiting and retaining personnel in certain professions, specialties or fields of practice, which is reported in all countries; 4) Imbalances in the geographical distribution of health professionals. This is also reported in all countries."* (EC 2015 / Discussion Paper 2:3, shared with relevant stakeholders including HOSPEEM and EPSU in March 2015).

In an exchange on the draft report at the **SSDC HS on 15 June 2015**, participants from both EPSU affiliates and HOSPEEM members pointed to **important challenges for effective R&R policies experienced at the hospital/workplace level**: 1) increased workloads, work-related stress and burnout of staff implying an increased pressure on the remaining workers (ex. from France); 2) ensuring safe and adequate staffing levels (input from Germany and Ireland); 3) need to have the right skill mix and the appropriately qualified staff (input from the Netherlands); 4) access to CPD – positively interrelated to higher rates of retention – being dependent on the status of "employee" (ex. from the Czech Republic) and importance of having access to CPD (ex. from France); 5) imbalances of the distribution of health workers with a strong concentration in urban areas (ex. from Romania); 6) trans-border migration to countries with more attractive pay and working conditions and career development possibilities (ex. from Romania).

Looking at the broader political and economic context as well as at spending trends, that will also have an impact on the resources available for recruitment and retention measures, also for measures and initiatives carried by social partners, the **crisis has after its onset induced "an immediate spending hike**, due in most cases to the denominator effect of a contracting GDP, spending trends started to flatten. In 2011, only the Netherlands spent a greater share of its GDP on health than in 2009. Between 2008 and 2011, the growth rate of health spending over GDP turned negative in Ireland and Greece and was halved or almost halved in Lithuania, the UK, and the Netherlands. The slowdown was milder in Italy and Sweden, where spending, however, had also been growing more slowly. France, Romania, and especially Germany even managed to speed up their spending expansion." (Stamati/Baeten 2015:17)[6]

There is finally another **"policy framework" that will most likely gain in importance in the next years when it comes to (public) health budgets**, namely the procedures of the **European Economic Governance** that is likely to have more impact on health policies and health systems, at least in the eurozone. "In the wake of the crisis, especially in the Eurozone, the EU institutions acquired new powers to supervise national budgetary and economic policies. Within these policies, health systems are particularly targeted from a public finance perspective." (ibid:21). "Health care has been subsequently included in the Annual Growth Surveys since 2012." (ibid:24) "The economic and financial crisis triggered in 2008 provoked a radical change in the way the EU engages in national health system reforms. Not only did the EU acquire unprecedented powers to intervene in national health care policies, but our analysis also shows that reforming health systems is at the core of reforms put forward by the EU institutions to consolidate public

[6] Stamati, Furio/Baeten, Rita (2015): Health care reforms and the crisis. This publication can be downloaded from the ETUI webpage, https://www.etui.org/Publications2/Reports/Health-care-reforms-and-the-crisis.

expenditure." (ibid:29) "When we look at the content of the EU guidance, we see that the focus of CSRs is mainly, but not exclusively, on fiscal consolidation." (ibid)

2.2. Issues and areas of priority concern for recruitment and retention in the hospital/health care sector when looking at social partner-based and government initiatives or measures

"Building on an extensive literature review the project consortium could identify **aims by which recruitment and retention interventions are motivated**. Four major objectives were mentioned most frequently: 1) Improvement of access to health professionals in rural/remote areas; 2) Attracting and retaining nurses and physicians to understaffed specialties/areas of practice: primary care, mental health, emergency services; 3) Reduction of attrition and turnover; and 4) Prevention of (unplanned/unnecessary) early retirement. In addition to this, "the implicit goal of efforts to improve recruitment and retention is to maintain/improve the availability and accessibility of health services and to reduce the costs associated with preventable attrition." (EC 2015 / Discussion Paper 1:3, shared with relevant stakeholders including HOSPEEM and EPSU in May 2014).

When looking at the **scope and thematic focus of measures in the field of R&R**, one witnesses a partially huge difference between the countries for which both secretariats received input. The **main issues/topics reported** are the following:

- Increasing the financial attractiveness of jobs in the hospital/healthcare sector, with the aim of having a positive impact both on recruitment and on retention (see sub-section 4.1.1)
- Improving the attractiveness of professions and jobs in the sector – for young workers, for those returning to the labour market and/or the sector and to lower qualified works –, based on a better recognition/status and professional training/LLL/CPD and partially in the context of Action Plans (see sub-sections 4.1.2 and 4.5)
- Improving the work organisation (see section 4.2) based on adapted working time models, more autonomy for individuals and teams to (co-)define them, improved possibilities to reconcile work and family life/care obligations. There are also initiatives to build up a "life-phase working time budget" to be used for further training (see section 4.5)
- Addressing the challenges of an ageing workforce and changes in the retirement age (see section 4.2)
- Improving workforce planning mechanisms both at national/regional level but also at local level, building on dedicated institutions (such as observatories, tripartite agreements and works councils) and on tools (see section 4.3)
- Promotion of diversity and prevention of discriminations/unjustified differentiated treatment (age; gender; race), the pursuit of these aims often building on national level policies/initiatives that are then underpinned by sectoral, but even more often by local ones (see section 4.4)
- Improvement of the acquisition or the updating of professional qualifications, skills and competences. This is realised by giving access to different forms of training (to stay fit for practice or to be able to comply with requirements for registration/re-registration), in some cases supported by financial initiatives to pursue the different forms of training. Measures here also cover initiatives to improve the permeability of training pathways and to facilitate upwards professional mobility (see section 4.5). There are also examples for the financial support for specialised training by health professionals/workers.
- Initiatives to advance the prevention and/or the reduction of the number of work accidents, occupational diseases and or the extent of violence/third party violence/harassment at the workplace. They are often being embedded in national policies/strategies on OSH that are also aiming at a reduction of sickness leave and occupational diseases (see section 4.6).

The research done in the context of the study financed by DG SANTE clearly identified the **two most targeted occupations** of R&R interventions, namely nurses[7] and physicians[8]. Other professions also covered are dentists, pharmacists and midwives. This has also been confirmed by the final report: *"[…] recruitment and retention interventions (…) tend to target the same occupational group and sub-groups, with doctors and nurses most frequently the target groups."* (EC 2015:10)

The differences as to the main fields for which R&R measures are being reported in the different countries seem to be linked to the financial situation of the health/hospital sector in a country as well as to strengths, deficits and/or specific needs of national health care systems. The variety of measures and existing practices collected also reflects the differences as to experiences, structures and capacities of the relevant actors – including social partners at national, sectoral and hospital level – to initiate, design and carry out R&R measures.

*"A provisional conclusion was that **different countries may promote opposite interventions**. The research identified five policy interventions for which the opposite ends on a scale of interventions are listed: "1) Increasing versus shortening nursing training duration; 2) Allowing flexible working time versus stimulating / demanding full time employment; 3) Limited working hours for staff that is almost retired versus raising the retirement age; 4) Support GP solo practices versus stimulating group practices; and finally 5) Allowing versus prohibiting/limiting dual practice."* (EC 2015 / Discussion Paper 1:4, shared with relevant stakeholders including HOSPEEM and EPSU in May 2014).

The focus in this report is on the role of the **social partners in the hospital/healthcare sector** (see section 2.4). When looking more in detail into the **initiatives carried out by social partners** the following **thematic priorities** stand out (based on input from 16 countries information was received about)

- Working conditions, work organisation, measures to address the challenges of an ageing workforce and related to the restructuring of legal retirement systems requiring longer work careers
- Initial professional qualification, life-long learning/continuous professional development, career progression
- Making employment in the health sector and jobs and careers there more attractive, also for young workers, employment of younger workers
- Measures and initiatives to improve the retention of the workforce, including on an improved work-life balance/measures to better reconcile work and family obligations/care work for family members
- Workforce planning instruments and arrangements
- Health and safety at the workplace, also to prevent (long) sick leave and occupational diseases
- Initiatives to improve the diversity of the workforce (e.g. in France and the UK) as well as gender equality (e.g. in The Netherlands)

[7] *"Registered nurses in general and some specialized fields of work (home care, emergency care, mental health, elderly care nursing), or sub-groups (students, older nurses, e.g. prevent unplanned early retirement, returners, e.g. nurses after maternity leave), men, ethnic minorities, migrants, diaspora and educators".* (EC 2015 / Discussion Paper 1:3, shared with relevant stakeholders including HOSPEEM and EPSU in May 2014)

[8] *"Physicians, with a focus on GPs/family medicine and some understaffed other specialties (mental health, geriatrics) or sub-group (students, educators)".* (EC 2015 / Discussion Paper 1:3, shared with relevant stakeholders including HOSPEEM and EPSU in May 2014)

The examples contained in section 4.5 “Initial training, life-long learning and continuous professional development” of the annex can complement, from a social partners’ perspective, the insights presented in the final report of the “Study concerning the review and the mapping of continuous professional development and lifelong learning for health professionals in the EU” (commissioned and financed by DG SANTE and published in January 2015)[9]. As of end 2015, HOSPEEM and EPSU are working towards a Joint Statement on CPD/LLL for all Health Workers to which examples and good practices of social partner-based initiatives should be annexed, too.

2.3. Main types of strategies, measures and/or good/existing practices initiated by social partners or governments

The research consortium asked by DG SANTE to deliver the report on “Recruitment and Retention of the Health Workforce in Europe” identified **five main types of interventions**[10] (EC 2015:11): 1) Education, e.g. changes in the structure, length and contents of curricula; 2) Regulation (e.g. policies and legislative changes (indirectly) focused on R&R; 3) Financial incentives, e.g. increased remuneration; 4) Professional and personal support, e.g. family friendly work conditions; and 5) Mix/other types of interventions (e.g. international recruitment)[11]. They found out that “*the most frequently reported types of interventions are educational, followed by professional and personal support. Interventions focusing on financial incentives have been developed in numerous countries, but these appear to be more effective when combined with other measures*” (EC 2015:11). Already in the initial phase of the project they had concluded that “*retention may not always be the prime objective of some interventions, but it is used as an indicator of positive change*” (EC 2015 / Discussion Paper 1:4, shared with relevant stakeholders including HOSPEEM and EPSU in May 2014).

A broad range of **social partner-based measures** (cross-sectoral and in particular those with a sectoral scope) as well as **initiatives done by single employers at a specific workplace, by employers’ organisations** (see e.g. “Sweden’s Most Important Jobs Initiative” by SALAR under section 4.1) **or by trade unions** (see e.g. initiatives on life-long learning for nurses by the Swedish Association of Health Professionals under section 4.5) was collected and documented.

From the examples shared by HOSPEEM members and EPSU affiliates it becomes obvious that **national legislation** often plays an important role, both as stand-alone regulatory framework and in an interplay with additional social-partner based measures. The legislation can refer to pay and working conditions (including questions of employment status, such as in Belgium) or define the framework conditions for the employment of health workers (e.g. based on a reduction of employers’ social contributions, again in Belgium). It can set out rules for the broader field of action of social partners, such as in the case of Norway (with the Work Environment Act) or for a specific issue to support effective R&R, such as the Labour and Care Law in The Netherlands.

What has been said about national legislation (and when thinking about e.g. health and safety at the workplace or working time also about EU-level legislation) can be said in the same way about **government policy**: It also often plays a supportive and enabling function for social partners’ initiatives that add on to it (also by financing specific programmes, see sections 4.5. and 4.6). The

[9] http://ec.europa.eu/health/workforce/key_documents/continuous_professional_development/index_en.htm
[10] Classified according to the “Global policy recommendations on increasing access to health workers in remote and rural areas through improved retention” issued in 2010 by the WHO.
[11] In the Annex 1 of the Discussion Paper of May 2014 a distinction is made between 1) interventions at policy level on the one hand and 2) interventions at organisational level on the other.

collation of existing practices mentions National Development Programmes or National Action Plans (e.g. in Finland, more generally for the field of social welfare and care, but also more specifically for nurses or in view of a higher attractiveness of workplaces and jobs in the health care sector). The compilation of relevant strategies and measures to make R&R in the hospital/healthcare sector more attractive also underlines the importance of **joint working groups bringing together representatives of governments and of the social partners** (and possibly also other stakeholders) **that are operating (for a longer time span) in an institutionalised setting**, such as in the case of the "NHS Working Longer Review Group" (see section 4.2). Another format is tripartite agreements, e.g. on a more inclusive working life (as renegotiated in Norway in 2014).

Closely linked to government policies is guidance issued by **national institutes**, e.g. for occupational health (see again the example of Finland) or other forms of support they provide. Another example is the work of **paritarian institutions linked to national work accident and/or occupational diseases insurance schemes**, such as of the Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege (bgw), a social-partner based and managed agency operating in the general interest to promote the prevention and reduction of health and safety risks at the workplace in the context of the work accident and occupational disease insurance in Germany. In the same vein it is possible to mention the activities of **multi-stakeholder observatories**, such as in France, e.g. on professions and jobs in the public sector or on the professions and jobs in the sector of not-for-profit provision of health and social services (see section 4.3) or in England (see section 4.4). Similar activities are reported for the Netherlands, e.g. in the context of a research programme on the health labour market or regular reports with research and data about work absence in the hospital sector (see section 4.3).

2.4. What is the role of social dialogue and collective agreements in view of the elaboration and implementation of effective R&R policies?

The compilation of examples of R&R measures based on input from HOSPEEM members and EPSU affiliates provides **ample evidence for the crucial role of employers** (and their members) **and trade unions** (and their members or elected staff representatives) for initiating, designing and carrying out measures to improve the recruitment and/or the retention of health workers (in general and focusing on specific professions or professional groups). As being summarised above (see 2.3) and illustrated in the Annex, these stand-alone or complementary initiatives cover the whole range of fields of action comprised in the EPSU-HOSPEEM Framework of Actions "Recruitment and Retention" signed at the end of 2010.

Based on input from 16 countries information was received about in the EPSU-HOSPEEM joint survey, it is safe to state that the **aspects regularly and systematically addressed by the social partner-based measures** – besides their core field of competence and action, i.e. pay and working conditions (including the work organisation) – are 1) "better reconciliation of work and family life" (e.g. in France and the Netherlands), 2) "definition of new job profiles/facilitating the labour market inclusion of formally lower qualified workers/improving the employability of workers" (e.g. in the Netherlands), 3) "addressing the challenges of an ageing workforce by prolonging healthy and safe working careers" (e.g. in Germany, in the Netherlands and the UK), 4) "reduction of long sickness absences" (e.g. in Norway), 5) "improving and broadening channels of consultation and information of workers (e.g. in England and the Netherlands) and, 6) "encouraging of workforce diversity and gender equality" (e.g. in France and the UK), 7) "improving levels and outcomes of and access to initial professional qualification and continuous professional development" (e.g. in Belgium, Cyprus, Finland, France, the Netherlands, Norway, Sweden) and

last but not least 8) “improving the health and safety of workers (and patients) at the workplace” (e.g. in Denmark, France, Germany, the Netherlands and Norway). The last two aspects – dealing with professional qualifications, skills and competences on the one hand and with the health and safety at the workplace and the prevention and reduction of occupational hazards on the other – seem to stand out a little bit as to their relative importance.

The **R&R strategies or measures initiated by social partners at different levels often build on national legislation or other regulation in place as well as on “enabling” government policies**. Examples for such an “add on approach” have been identified for Belgium (see in sub-section 4.1.2), the Netherlands (see in sections 4.2 and 4.4: combination of work and care obligations; see in section 4.6: prevention and reduction of violence/aggression at the workplace) and the United Kingdom (see in section 4.4: diversity and gender equality policies and social partner-based initiatives).

There are **nation-wide and sectoral initiatives** as well as **projects and measures set up and run at the workplace level**. The report clearly focuses on the first two categories, also for the sake of an improved possibility of mutual exchange and learning which is more difficult on the basis of purely organisation-/workplace-specific arrangements.

The Dutch social partners in the hospital sector conclude that local approaches and initiatives to tackle diversity issues, especially in bigger cities are much more appropriate to achieve the results needed compared to (a few) sector-wide initiatives of which also some have been run.

3. Conclusions and recommendations

3.1 What can HOSPEEM and EPSU members learn from this follow-up report to the FoA R&R?

- The outcome from the survey done in 2014 in order to be able to update and improve information related to a key joint document signed by HOSPEEM and EPSU, the Framework of Actions "Recruitment and Retention", provides ample evidence for the crucial role of employers (and their members) and trade unions (and their members or elected staff representatives) for initiating, designing and carrying out measures to improve the recruitment and/or the retention of health workers (in general and focusing on specific professions or professional groups).
- Their stand-alone measures or the initiatives that complement government policy and/or legislative initiatives cover the whole range of fields of action comprised in the EPSU-HOSPEEM Framework of Actions "Recruitment and Retention" signed at the end of 2010. Concluding from the sample of measures we have knowledge about it seems that the two aspects that stand out as their relative importance are "professional qualifications, skills and competences" and "health and safety at the workplace/prevention and reduction of occupational hazards". The R&R strategies or measures initiated by social partners at different levels often build on national legislation or other regulation in place as well as on "enabling" government policies. There are nation-wide and sectoral initiatives as well as projects and measures set up and run at the workplace level.
- Since the adoption of the EPSU-HOSPEEM Framework of Actions "Recruitment and Retention" at the end of 2010 the full effect of the economic crisis and related austerity programmes entailing cuts in the budgets of the national health systems, of hospitals and other health care institutions have left a clear imprint on health and hospital policies. They have also strongly changed the context for the implementation of recruitment and retention strategies and measures in a number of countries throughout Europe.

3.2 Recommendations the EU-level hospital sector social partners address to policy makers

- National legislation or other regulation in place as well as government policies need to be enabling to complementary or stand-alone R&R initiatives – in particular on a sectoral level and adapted to the situations and needs on a local and workplace level – social partners on a range of issues (cf. sections 2.3 and 2.4 and the illustrations in the Annex).
- National government and competent public bodies should take up the "business case" made with this report and the study commissioned by DG SANTE containing evidence that investment into sustainable workforce policies – of which R&R policies are a core element – pays off in a mid- and long-term perspective. They entail reduced costs due to reduced turn-over and attrition rates, fewer cases of occupational diseases and early retirement due to high workload and stress and improvement of occupational health and safety conditions.
- They should support a mix of R&R interventions and the role of social partners in designing, implementing and monitoring them by means of "working in partnership arrangements".

4. Annex: Compilation of input received from HOSPEEM and EPSU members

The annex contains the **detailed information** as received from HOSPEEM members and EPSU affiliates in 2014 and 2015. The contributions have been attributed to a thematic area. Main insights from our own survey and work with HOSPEEM members and EPSU affiliates in 2014 and 2015 are synthesised in chapter 2 and complemented by results from the DG SANTE Study.

Introductory remarks:

- *It is to be noted that there are several cases where a specific measure or practice could be attributed to more than one thematic area as it combines different aspects.*
- *It is also important to highlight that not all measures listed in the Annex are not supported or a priority to the same extent by national member organisations of HOSPEEM and EPSU, even though this is the case for the very large of the examples presented.*
- *Finally the compilation of illustration of R&R measures is of a non-exhaustive nature, not least due the fact that from a number of countries inside and outside the EU no examples were sent to either the HOSPEEM or the EPSU Secretariat.*
- *The examples are listed by topic and then by country (in the order of the country plates).*

4.1. General aspects mentioned under the heading "Support the recruitment and retention in the hospital sector" [=> FoA R&R 3.1] – Issues not explicitly mentioned in sections 3.2 to 3.6 of the FoA R&R

4.1.1. Cross-cutting initiatives

- Mielekäs Programme (*FIN; government and social partners*)
  - Initiated by the Ministry of Social Affairs and Health in Finland and coordinated by the Finnish Institute of Occupational Health
  - Aims to increase the attractiveness of the social and health sector by actively searching for, finding and highlighting workplaces that have successfully created and developed practices increasing the attractiveness of work in the sector and the well-being of workers.
  - Shifting the focus from the common problem-oriented view on well-being at work to finding and leveraging good practices and spreading them.
  - Directed towards employees, students, management and supervisors in the fields of social and health care
  - Workplaces have been recognised for their efforts and successes in creating processes to increase the well-being and commitment of their staff.
  - Workshops are organised in order to spread good practices to other workplaces and to create a forum workplaces and educational institutes can share and develop good practices together and take advantage of the results of the programme.
  - A practice-oriented review of academic literature will search for evidence of practical interventions that have increased the well-being of workers and the meaningfulness of work
  - A practical guide for workplaces will be published
  - Webpage: www.mielekäs.fi - http://www.ttl.fi/partner/mielekas/english/sivut/default.aspx

- "National Development Programme for Social Welfare and Health Care (KASTE 2012-2015)", with one of the priorities being the availability and stability of a motivated and satisfied social and health care workforce.
  http://www.stm.fi/en/strategies_and_programmes/kaste *(FIN [hospitals]; government policy)*

- "Welfare Service Development Programme 2011-2015 (HYVÄ-programme)", implemented by the Ministry of Employment and the Economy, with the adequacy of the health and social-care workforce as one of the main priorities (Ministry of Employment and the Economy 2013):
  https://www.tem.fi/en/current_issues/pending_projects/strategic_programmes_and_flagship_projects/welfare_service_development_programme_-_hyva *(FIN [hospitals]; government policy)*

- Attractive working places in health care [STM:n Mielekäs-ohjelma (2014-2015): nostaa esiin ja palkitsee vetovoimaisia sosiaali- ja terveydenhuollon työpaikkoja (only in FIN)]
  http://www.ttl.fi/partner/mielekas/Sivut/default.aspx *(FIN [hospitals]; government policy)*

- Nursing Action Plan 2009-2011 to increase the effectiveness and attractiveness of nursing care by means of management: http://www.hotus.fi/hotus-en/expertise-evidence-based-health-care *(FIN [hospitals]; government policy)*

- [2013] Job Life Cycle Model
  - A working group of social partners prepared the Job Life Cycle Model in order to support people to work longer. It is a model for workplaces.
  - The model is based on the social partners' agreement of the extension of work careers (2012) and their framework agreement (2011).
  - The model stresses that the management of age, work ability and occupational well-being are important parts of good management.
  - There are seven central areas included in the model: age management, planning and extending careers, managing competence and professional skills, flexible working hours, work modification, medical examinations at the workplace, promoting healthy habits and life management.

  More information: http://www.yhteiskunta-ala.fi/@Bin/1353132/Job+Life+Cycle+Model.pdf (*FIN; social partners*)

- [2012] Creation of the programme "Jobs for the future" whose purpose is to facilitate the employability and the access to qualifications of young people with low levels or no formal qualifications - Law of 26 October 2012 (*F, legislation*)

- [2013] On 9 September 2013, signature of a framework agreement with the State on "Jobs for the future". FEHAP committed to recruit 1,500 young people. The State committed to grant additional funds dedicated to the training of young people with a "Job for the future" contract (*F, government and social partners: employers*)

- [2013] Creation of the programme "Generation Contract" - Law of 1 March 2013: Objectives set by the legislator: 1) Recruitment of young people; 2) Recruitment and retention of seniors (*F; legislation*)

- [2014] Branch Agreement of 3 September 2014 linked to generation contracts (deemed unwritten because of the opposition majority of the trade unions of the branch) (*F, social partners*)

- As part of its CSR policy (Corporate Social Responsibility), FEHAP commits in the social field to implement a useful tool for human resources (HR) policy of the institutions for the recruitment and retention and to build an employer brand FEHAP (*F; social partners: employers*)

- SALAR's "Sweden's Most Important Jobs Initiative" (*S; social partners: employers*)
  - The aim of this initiative is to increase knowledge about and give a more nuanced picture of jobs in the welfare sector, as well as of municipalities and county councils as employers. The idea is to attract young people to the important welfare jobs and to make staff feel proud of the important jobs they do.
  - SALAR has produced a communication platform that forms the basis for the work to be done. It includes the main messages, target groups, arguments, graphic profile and information channels. The work focuses on three main areas
    - producing reports/facts
    - that can help to shape opinion and
    - tools for employers that help to facilitate recruitment
  - 3 main messages of "Sweden's Most Important Jobs Initiative" – the jobs of the future are in the welfare sector:
    - The welfare services of the future need to have the very best expertise so as to be able to address the most important and challenging issues of our age.

  - Many of the most interesting, stimulating and meaningful jobs on the labour market are in the welfare sector. It also has the most engaged staff on the labour market, who make a difference every day.
  - The welfare sector is a sector that is developing. We must also raise our game so as to attract the most suitable staff.
- More information: www.sverigesviktigastejobb.se

- [2014] NHS Health Education England: National Strategic Framework to develop the healthcare support workforce "The talent for care"
  - The framework has three main areas for action:
    - Get in - improving opportunities for people to start their career in a support role.
    - Get on - supporting people to be the best that they can be in the job they do.
    - Go further - providing opportunities for career progression, including into the registered professions.
  - More information: http://www.nhsemployers.org/news/2015/03/health-education-england-strategies-call-for-development-of-the-support-workforce/ http://eoe.hee.nhs.uk/files/2014/11/HEE_Talent-for-Care-A-National-Strategic-Framework-Nov-2014.pdf (*UK; government and social partners*)

- [2015] NHS Employers "Staff retention: a checklist for good practice "
  More information: http://www.nhsemployers.org/your-workforce/retain-and-improve/managing-your-workforce/retention-checklist (UK; social partners)

4.1.2. Improved pay conditions

- [2006-] "Attractiveness bonus, with a lump-sum element and a individual variable element (0,53% of gross annual wage) (*B [hospitals in private sector]; legislation*)

- Pay supplements for working time at irregular working hours (for 6 different categories and with rates ranging from 20% to 56%; Saturday: +26%; 20h-6h: +35%; all hours after midnight: +35%; Sunday and holiday work: +56%) (*B [hospitals in private sector]; legislation*)

- [2002-] Benefit to workers with a low salary (< 29,338.86€ gross wage per year), with certain conditions to be fulfilled (*B [hospitals in private sector]; legislation*)

- [2002-] Reference wage grid/scale for health care assistants[12] (*B [hospitals in private sector]; social partners*)

- Agenda for Change Recruitment and Retention Premia and Unsocial Hours Provisions (UK NHS Agreement covering staff working in the NHS in the UK) (*UK; government and social partners*)
  - This agreement sets out a system to pay for staff working unsocial hours which described as anytime on weekdays between 8pm and 6am and Saturdays, Sundays and Public Holidays.

[12] *Aides-soignants; barème 1.35 pour le salaire brut sans les suppléments du week-end et jour férié en tant qu'aide-soignant(e) diplômé(e) et selon les années d'ancienneté*), *introduit par la Commission Paritaire* 330 (*secteur du personnel infirmier, soignant et paramédical est la 330 Maisons de Repos (MR), Maison de Repos et de Soins (MRS) en gros Maisons de Repos pour des Personnes Agées (MRPA) et Hôpitaux*)

- Agenda for Change also sets out the way in which long and short-term recruitment and retention premia can be applied to roles where there are problems recruiting or retaining staff.

- Unsocial Hours
  - Unsocial hours payments were introduced to meet the variable hours needed to run seven-day services. Overtime and unsocial hours payments also recognise fluctuations in the demands on the service by incentivising and rewarding NHS staff when working over their contracted hours, weekends and night shifts.
  - Unsocial hours payments have become a significant part of most NHS nurse, midwife, radiographer and ambulance staffs' salaries - one-third in most cases. Without them, many would struggle to get by.
  - The payment of unsocial hours premia is an 'enabler' to these services running 24/7. It is widely acknowledged that they are essential to recruiting and retaining staff who have these working patterns.
  - Working unsocial hours has severe effects on home, family and personal health. There is a lot of research highlighting the negative health effects of working unsocial hours, including the impact on mental health, issues with body clocks, increase in blood pressure, lack of sleep and concerns about staff making mistakes when they are tired. Pay enhancements help to compensate for the sacrifices and impact of working unsocial hours.
  - The growing picture of staff working longer hours in order to deliver the best care they can for patients, increase in workloads and the stagnation in basic pay mean staff are having to supplement their basic pay with additional incomes (unsocial hours payments / special duty and shift premia), due to the holding down of NHS basic pay rates. This becomes particularly apparent with staff on the lower bands where, due to the holding down of basic pay rates, staff are now reliant on unsocial hours payments to make ends meet.
- Recruitment and retention premia
  - There is scope within the Agenda for Change agreement for employers to look at pay and reward to retain staff. Agenda for Change allows the provision of national and local Recruitment and Retention Premia (RRP) on a short term or long term basis.
  - Recruitment and retention premium is an addition to the pay of an individual post or specific group of posts where market pressures would otherwise prevent the employer from being able to recruit staff to and retain staff in, sufficient numbers for the posts concerned, at the normal salary for a job of that weight.
  - Recruitment and retention premia may also be awarded on a national basis to particular groups of staff on the recommendation of the NHS Pay Review Body (NHSPRB) where there are national recruitment and retention pressures. The Review Body must seek evidence or advice from NHS employers, staff organisations and other stakeholders in considering the case for any such payments.
  - Recruitment and retention premia falls into two categories of long or short term RRP.
  - Short-term recruitment and retention premia apply where the labour market conditions giving rise to recruitment and retention problems are expected to be short-term and where the need for the premium is expected to disappear or reduce in the foreseeable future.
  - Long-term recruitment and retention premia apply where the relevant labour market conditions are more deep-rooted and the need for the premium is not expected to vary significantly in the foreseeable future.
  - The maximum RRP is 30% but NHS Trusts that are Foundation Trusts have additional freedoms set out in Agenda for Change.

4.1.3. Other issues

- [2006-] Status of employee for personnel involved in giving medical care (*B [hospitals in private sector]; legislation*)

- [1997-] Reduction of employers' social contributions (that are paid in a fund jointly managed by employers and trade unions) for the creation and financing of new employment, so-called "*Maribel social*" (*B [hospitals in private sector]; legislation and social partners*)

- Attribution of tax incentives/compensation payments for expenses certain employees are paying, for example for buying and laundering their own uniforms (in the case of nurses, physiotherapist, pharmacists or of other hospital staff) as an instrument for staff retention (*IRL; government/fiscal policy*)

- [2014-] As a reaction to concrete proposals by FP CGIL to reverse negative impacts on the availability and quality of health care services due to cuts in health budgets and legislative changes to reduce the role of social partners, the Ministry of Health a coordinating unit responsible for the coordination of the regulation of professional life and the organisation of the health care providers. It should help steer processes on the innovation and restructuring of the work organisation in health, involving most health professions, with the aim to safeguard the health of citizens. (*I; government policy*)

4.2. Improvement of work organisation [=> FoA R&R 3.2]

4.2.1 Working time / work organisation

- [2005-] Reduced working time at the end of the working career, ranging from 96 hours per year (45+) to 288 hours per year (55+) for personnel involved in care (and personnel assimilated to it) and from 38 hours (50+) per year to 152 hours (55+) per year for other personnel (*B [hospitals in private sector]; legislation*)

- The Labour Code on working time (implementing the Working Time Directive) as well as collective agreements contain the possibility of self managed working time and rest periods according to the needs of workers, but with the necessary statement "if it allows operating conditions". With reduced staffing in hospitals the operating conditions rarely allow this. *(CZ; hospitals)*

- Shift planning in the care-sector: Ergonomic, autonomy and well-being [Innovatiiviset työajat hoitoalalle] *(FIN [hospitals]; government/Finnish Institute for Occupational Health)*
  http://www.ttl.fi/fi/tutkimus/hankkeet/innovatiiviset_tyoajat_hoitoalalle/Sivut/default.aspx
  http://www.ttl.fi/fi/tutkimus/hankkeet/innovatiiviset_tyoajat_hoitoalalle/Documents/Tyovuorosuunnittelu_hoitoalalla_tiivistelma_engl.pdf

- See for an example from Norway (*N; legislation*) section 4.6

- *Introductory remark for the Netherlands by Dutch social partners:*
  - *The Working Time Directive has been further adjusted to the sectoral and national needs by the Collective Agreement.*
  - *Recently several agreements on life-phase and age have been removed and replaced by agreements on employability and work-life balance for all healthcare staff (not just*

the older staff) to reach a more all-encompassing approach towards employability

- Combination of work and care: early October 2014 the Dutch Parliament agreed on an adjustment of existing law concerning the combination of work and care (Labour and Care Law). It creates for example more space for employees to ask the employer to be more flexible on the working times and the working place. The improved law concerns the whole Dutch labour market but is extra relevant for the health care sector. Research shows that this sector deals with the highest percentage of informal caregivers. (*NL; legislation and government policy*)

- To maintain an acceptable balance between private and work life the social partners agreed on a maximum amount of overtime. The maximum amount (measured over 3 months) may not exceed more than 10%. The maximum amount of hours per shift may not exceed 10 hours or 12 hours including overtime. In addition to the Labour and Care Law an employee has the right to paid leave for 11 consecutive weeks if caring for someone terminal or in case of palliative care. This concerns: the husband or relationship partner, a resident child, adoption or foster child or a resident parent of the employee. The rightfully build up holidays during this period are considered to be used during these weeks. (*NL; collective labour agreement*)

- Project[13] on informal care. In this project, a couple of portraits of informal caregivers have been made. The aim was to give examples on how organizations can support their employees who are also informal caregivers at home. (See this website http://www.mantelzorgportretten.nl/mzp for more information in Dutch) (*NL; social partners*).

- Job creation: by combining simple tasks into a new function, jobs are created for people with a distance to the labour market. In this way, current staff can focus on their main tasks. Two pilots with job creation have been executed and several successful meetings have been organised. More information on website http://www.staz.nl/actueel/nieuws/2014/2014-10-31_Film_en_handreiking_Functiecreatie_ziekenhuizen.shtml (*NL; social partners*)

- "Improvement board": development and implementation of an instrument to strengthen labor relations in the organisation, the "improvement board". With the improvement board, teams can identify bottlenecks and solutions and they can make their improvements visual. (*NL; social partners*)

- Strengthening internal labor relations and new/innovative ways of working or organising work: Availability of small funding opportunities for initiatives coming from hospitals on strengthening internal labor relations and new/innovative ways of working or organising work in order to foster these developments (*NL; social partners*)

4.2.2 Ageing workforce

- Pilots with new ways of scheduling: three pilots have been introduced to create new ways of staff scheduling that are more effective for the organisation and are more respectful regarding work-life balance and employability of the employee. For example, employees get the possibility to have influence on their own work schedule by using an online tool,

[13] This project and others in the list submitted by the Dutch social partners in the hospital sector are mainly projects executed by the Dutch Association for professional associations in the health sector (StAZ). More information can be found on their webpage: http://www.staz.nl/.

where they can indicate their wishes and preferences regarding their work schedule. By using this tool, a staff schedule can be created that is optimal for everyone. (*NL; social dialogue*)
[N.B.: This example is put here but also under 4.3]

- Tool '*Mijn PLB*' (*PLB = Persoonlijk levensfasebudget*): Hospital staff in the Netherlands has a couple of PLB hours each year that can be used to improve their employability. The hours can be used for education and professional development, but also for other ways of improving their employability. The tool '*Mijn PLB*' gives inspiration on how to use the PLB hours. More info:
http://www.staz.nl/versterken_arbeidsverhoudingen/instrumenten/mijn_plb.shtml (*NL; social dialogue*)
[N.B.: This example is put here but also under 4.5]

- Care4Age: An instrument (game) to raise awareness on the influence of age and life-phase on the organisation. (*NL; social dialogue*)

- [2012-/2014-] NHS Working Longer Review Group (*UK; social partners and government*)
  - NHS Working Longer Review Group was set up as part of the Proposed Final Agreement on the Future of the NHS Pension in 2012 to try to identify the impact a raised retirement age might have on NHS services and staff.
  - [2014] After a period of research and data analysis the NHS Working Longer Review Group submitted its first report and 11 recommendations for further action to the UK Health Ministers (for England, Wales, Scotland and Northern Ireland) in March 2014.
  - The recommendations are based on four key themes:
    - Data challenge
    - Pension options, retirement decision making and their impact on working longer
    - The importance of appropriate working arrangements and the work environment
    - Good practice occupational health, safety and wellbeing
  - [2014-2016] The Group has now been formally commissioned to deliver a body of work, designed to support staff and employers to work to a new, raised retirement age based on the recommendations made in our report to the Health Departments. It will work with partner organisations to deliver this work programme over the next three years. Key deliverables planned for the remainder of 2014/2015 include:
    - Factsheets for employers and employees to improve knowledge and understanding of the flexibilities available to members in the NHS Pension Scheme.
    - An online library resource hosting new and existing research on working longer and the ageing workforce.
  - In addition the group is also currently supporting a piece of research funded by the Medical Research and Economic Research councils in the UK into retirement decision making and is also planning to work in depth with a few sample employers to understand their needs locally in developing suitable working and planning arrangements for an ageing workforce.
  - More information: http://www.nhsemployers.org/WLG

4.3. Development and implementation of workforce planning mechanisms [=> FoA R&R 3.3]

- [2014] Competence foresight in local government services
  - The primary objective of the project was to develop frameworks for competence foresight as well as incorporating the foresight perspective closely into the strategy work

and human resource planning of local government sector organisations
    - More information: http://shop.kuntatyonantajat.fi/uploads/osaamisen-ennakointi-raportti-eng_.pdf (*FIN; social partners: employers*)

- [2012] Introduction in the Labour Code of the use of telework - Law of 22 March 2012 (*F, legislation*)

- National Observatory of employment and professions of the hospital public service, created by Decree No. 2001-1347 of 28 December 2001 (ONEMFPH). It has expertise in 4 fields, it has the mission to 1) monitor employments in the hospital public service; 2) contribute to the development of a strategy of planning and forward-looking management; propose policy priorities, in particular for training, 3) assess the evolution of professions, functions and qualifications, 4) identify new professions and their characteristics. More information: http://www.sante.gouv.fr/l-observatoire-national-des-emplois-et-des-metiers-de-la-fonction-publique-hospitaliere-onemfph.html (*F, government*)

- National Observatory of employment and professions for the associative sector of medical and social health (*F, government*)

- [2010-] Setting up of a national joint (paritarian) committee on employment and professional training, building on regional commissions (*F, government and social partners*)

- Elaboration of information on workforce planning [in the context of forward-looking planning of jobs]: Workforce planning is one of the practices that allows acting on 1) the number of jobs necessary to the quality of services and on patient safety; 2) the improvement of employees' working conditions; 3) the prevention of stress at work. (*F; trade union*)

- [2014] Conciliation private/professional life - Law of 4 August 2014 for actual equality between women and men: In case of multiple births, the parental leave may be extended until children go to pre-school. For multiple births of at least three children or simultaneous arrival of at least three children adopted or entrusted for adoption, it may be extended five times in order to end at the sixth anniversary of the children (*F; legislation*)

- Tripartite agreement – Agreement on a More Inclusive Working Life (IA agreement), first launched in 2001, and recently renegotiated in 2014.
    - The IA Agreement is an instrument aimed at preventing sick leave, increasing focus on job presence and preventing “expulsion” and increasing recruitment to working life of persons who do not have established employment.
    - Through the agreement, focus has been placed on reducing sickness absence and the use of disability pensions, increasing the retirement age and ensuring the recruitment of people with impaired functioning capacity and other vulnerable groups to the employment market. (*N; social dialogue*)

- The Law on the Works Council (WOR in Dutch) gives works councils the right to assent on several topics. This includes (amongst other topics) the working hours. (*NL; legislation and government policy*)

- Pilots for new ways of scheduling: three pilots have been introduced to create new ways of staff scheduling that are more effective for the organisation and are more respectful regarding work-life balance and employability of the employee. For example, employees get the possibility to have influence on their own work schedule by using an online tool,

where they can indicate their wishes and preferences regarding their work schedule. By using this tool, a staff schedule can be created that is optimal for everyone. (*NL; social partners*)
[N.B.: This example is put here, but also under 4.2.2]

- Research programme on the health labour market: Produces data on the health labour market and gives information about the last developments in this labour market. (*NL; social partners*)

- Regular reports with research and data about work absence in the hospital sector. (*NL; social partners*)

4.4. Encouragement of diversity and gender equality [=> FoA R&R 3.4]

- [2011/2012-] NHS England's Equality Delivery System (existing) (*ENG, social partners*)
  - At the heart of the EDS is the recognition that every patient has different needs and circumstances, and that those can be best met by delivering a personal form of care, using and supporting the diverse talents and experiences of the workforce.
  - The EDS also recognises that staff have similarly diverse needs and circumstances.
    - Some staff may experience difficulties in developing their careers in the NHS.
    - Some staff may feel excluded from some occupations or grades.
    - Bullying and harassment in the workplace can have a greater adverse impact upon some types of staff than others.
    - Staff disciplinary processes can focus on particular types of staff.
    - Where this happens, staff moral and engagement is adversely affected, recruitment and retention strategies become more difficult and consequently service provision is also impacted.
  - The EDS is a toolkit to help all staff and NHS organisations understand how equality can drive improvements, strengthen the accountability of services to those using them, and bring about workplaces free from discrimination.
  - There are three goals and outcomes of the EDS2 [2014-]: 1) staff and staff experience; 2) patient care; 3) services delivery.
    - The outcomes (see for an example the 6 goals and outcomes under the category "staff and staff experience") are designed to protect staff against discrimination in as wide a sense as possible, from recruitment practice, through pay and performance management to opportunities for development.
    - Within each outcome organisations have to rate their performance against each of the protected characteristics of UK equality legislation.
    - Organisations should include staff representatives in the ratings exercise and the NHS TUs have developed training and support packages to enable their representatives to engage in this work to best effect.
    - It is then expected that an action plan to make improvements in key areas will be drawn up and that continuous improvement will be seen in each subsequent rating.
  - Since 2011, the EDS has been used by the majority of NHS organisations. At a time of great change in the NHS, many saw the EDS as critical in keeping equality high on the agenda. The EDS also encouraged the active engagement of local people and communities, local voluntary and community sectors, and local NHS workforces in the review of services and workforce practices.
  - Its use has resulted in significant improvements in the way services are planned and

delivered, and workplaces are organised.
  - The EDS has worked best when organisations made it work for them, and implemented it flexibly to suit local needs and circumstances.
  - When EDS was first introduced it was not compulsory for all NHS organisations, although many chose to use it as a way of demonstrating that they were meeting their statutory equality duties. In summer 2014 NHS England consulted on a new standard contract for all NHS organisations and other providers of NHS services and is now recommending that compliance with EDS2 is a requirement of that contract. This will mean that all organisations and third or independent sector bodies providing NHS will have to undertake EDS2 performance ratings and action planning in order to be awarded their contract and receive payment for the services they provide.
  - Information on EDS2 [2014-]: http://www.england.nhs.uk/ourwork/gov/equality-hub/eds/

- [2015-] NHS Race Equality Scheme (proposal) (*ENG; social partners*)
  - NHS England is also to introduce a Race Equality Standard (RES) in the NHS Standard Contract to complement and enhance the EDS2 as far as race is concerned.
  - Consultation and work with stakeholders, including NHS Trade unions and the Social Partnership Forum is currently ongoing around this and the new RES should be introduced in 2015.
  - It is envisaged that the RES will ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and fair treatment in the workplace.

  N.B.: Observations for both EDS/EDS2 and RES (ENG; social partners)
  - *Throughout the development of EDS, EDS2 and the new RES, the NHS Trade Unions have sought hard to ensure that the lived experience of staff across the breadth of NHS services and job groups is reflected, considered and improved.*
  - *We anticipate that if these schemes are effective, improvements in national Staff Survey results will be observed and reports of discriminatory behaviors will reduce (particularly in performance management and disciplinary matters).*
  - *Ensuring compliance will be essential and we are yet to see how organisations' implementation of EDS and RES will be monitored and assessed.*
  - *Also, as EDS2 allows for action planning to be focused on a few key areas we need to be assured that organisations will view staff outcomes as equally deserving as patient related ones for further work.*
  - *The NHS TUs remain committed to working with NHS England on these initiatives to ensure that they have a positive impact on the workforce*

- A national interprofessional agreement (ANI) on diversity was concluded on 12 October 2006[14]: 1) This is the first text signed by the social partners (employers and trade unions'

[14] Textes de transposition de la directive européenne:
Loi no 2001-1066 du 16 novembre 2001 relative à la lutte contre les discriminations
Loi n° 2002-73 du 17 janvier 2002 de modernisation sociale
Loi n° 2004-1486 du 30 décembre 2004 portant création de la haute autorité de lutte contre les discriminations et pour l'égalité
Décret n° 2005-215 du 4 mars 2005 relatif à la Haute Autorité de lutte contre les discriminations et pour l'égalité
Loi n° 2005-843 du 26 juillet 2005 portant diverses mesures de transposition du droit communautaire à la fonction publique

organisations) in order to promote diversity in companies (*F; cross-sectoral social partners*). 2) This agreement follows the National Inter-professional Agreement on professional diversity and equality between men and women in 2004 and the National Inter-professional Agreement regarding the employment of older workers of 2005 (*F; cross- sectoral social partners*)

The CFDT uses this framework agreement in order to negotiate within the existing bodies at national and local level in the institutions. (*F, trade union*)

- [2010] Introduction – for some companies of an obligation to conclude an agreement or to develop an action plan as regards the equality between men and women - law of 9 November 2010 (*F, legislation*)

- [2014] Law of 4 August 2014 on the actual equality between women and men: 1) The employee partner of the pregnant woman or linked to her by a civil partnership of solidarity or cohabiting with her also is entitled for leave to go to maximum three of the compulsory medical examinations; 2) The law extends the protection against dismissal to employed fathers. Hence no employer can break the employment contract of an employee during the four weeks following the birth of his child; 3) The law foresees that a professional interview, dedicated to her career prospects, is systematically offered to the employee who returns to work after her maternity leave/ parental leave (*F; legislation*)

- Not least as a result of continued work and pressure of FP CGIL of Insertion of norms and special protection or promotion clauses in national collective agreements to prevent and address equal opportunities and to counter sexual harassment; in addition development of toolkits for practical action at workplace level. (*I; social partners*)

- Employers, public authorities and workplace organisations have a duty to work actively, in a targeted, planned manner to promote equality and prevent discrimination (duty to promote equality). The law forbids discrimination in the workplace on the basis of gender, ethnicity, disability, language, religion, sexual orientation and age. The ban on discrimination on the basis of gender, ethnicity and ability to function applies to all social areas. (*N; legislation*)

[N.B.: The ex. reflects diverging opinions/priorities between employers and trade unions.]

- The healthcare sector is very female-dominated. In order to meet future workforce demands, the sector must become more attractive to both men and women. Two major challenges must be addressed:
  - The gender pay gap. There is no general consensus in Norway neither on the actual situation nor the gap's causes – and hence, no systematic action to close the pay gap.
  - Part-time work. In the municipal sector, the social partners have agreed to work for more full time work (Declaration for full time in the municipalities). (*N; social dialogue*)

- The Labour and Care Law has influenced on the gender equality at the workplace. The law makes it easier to combine work and private lives. Since most informal caregivers are women, it stimulates the labour participation of especially women. (*NL; legislation and government policy*)

Loi n° 2008-496 du 27 mai 2008 portant diverses dispositions d'adaptation au droit communautaire dans le domaine de la lutte contre les discriminations (1)

- In addition to the Labour and Care Law, employees have the right on 28.8 hours of paid leave after their spouse or relationship partner gave birth. (*NL; collective labour agreement*)

- In the social statute of the collective labour agreement the aim is included for deducting obstacles for women aiming for higher positions. (*NL; collective labour agreement*)

- Local approaches and initiatives to tackle diversity issues, especially in bigger cities, achieving the results needed compared to (a few) sector-wide initiatives also run (*NL; social dialogue*)

- [2014] NHS Health Education England: "Widening Participation: It matters".
  - This strategic framework is largely about attracting people from a diverse range of backgrounds to pursue a career in healthcare.

  More information: http://nw.hee.nhs.uk/files/2014/11/r-HEE-Widening-Participation-Strategy_Booklet_20141014.pdf (*UK; government and social partners*)

4.5. Initial training, life-long learning (LLL) and continuous professional development (CPD) [=> FoA R&R 3.5]

- [1997-] Possibility to take initiatives at the hospital level, based on social dialogue, to invest money into LLL/CPD, exchange and coordination between employers and trade unions/work place representatives?, arrangements for the end of the working career (since 1997), in the context of the so-called "*Maribel social*" (*B [hospitals in private sector]; social partners*)

- [2001-] Professional training of 3 years (*formation des 600*) to become nurse (*praticien de l'art infirmier*) with payment of salary and financial support (to employer?) for (re-)employment of these workers and with an adaptation of the scale of numbers of years worked (*adaptation de l'ancienneté à reconnaître*) (*B [hospitals in private sector]; public policy*)

- [2006-] Bonus for the acquisition of a special qualification/title[15] (*B [hospitals in private sector]; legislation*)

- CPD programmes of the Nursing Services of the Ministry of Health of Cyprus for 2013-2014 (*CY; government policy*)[16]
  - Infection prevention and control, a 50 hour programme focused on the prevention and management of infections in health care setting (health-care associated infections)
  - Trauma management, a 180 hour programme
  - Vaccination, an educational programme specially developed for health care visitors. It consists of 24 hours

[15] These special qualifications/titles are: S*anté mentale, santé publique, gériatrie, soins intensifs et d'urgence, oncologie, imagerie médicale, stomathérapie et soins de plaies, assistance opératoire et instrumentation, perfusionniste, anesthésie*) or a special qualification (*santé mentale, gériatrie, soins de plaies, soins palliatifs, diabétologie, évaluation et traitement de la douleur*

[16] The assessment is carried out using different methods (final exams, case studies, presentations etc) and a diploma is presented to successful participants. Each programme is evaluated by the participants and restructured if necessary. Many of the above programmes are developed in collaboration with universities (Department of Nursing, Cyprus University of Technology) and the medical and public health services of the ministry of health.

- Nursing process, a 30 hour educational programme on nursing assessment (as part of nursing process)
- Intensive care nursing (adults, children, infants), a 9 month programme specially developed for those nurses working in Intensive Care Units.
- Training Programme for newcomers in the public hospitals nurses, a 20 hours induction programmes
- Perioperative nursing, a 9 month programme for perioperative nurses
- Pre-hospital care, a 9 month programme for ambulance nurses

- Organisation of in-service education programmes (*CY; social partners/employers*)[17]

- [2013-2015] HYVÄ Programme
  - One main priority of the programme is ensuring the availability of competent and skilled labour force in the healthcare sector.
  - More information: http://www.tem.fi/files/37111/TEM_HYVA-esite_ENGLANTI_web_28062013.PDF (*FIN; government initiative*)

- [2007-] Law No. 2007-148 of 2 February 2007 related to the modernisation of the public service, particularly on "Life-Long Learning"[18] 1) Sets the rate of contribution to the FPTLV, actions and organisation; 2) The workers/employees benefit each year from a training meeting with their supervisor aimed at determining their training needs. (*F, legislation*).

  The CFDT uses this framework agreement in order to negotiate within the existing bodies at national and local level in the institutions (*F, trade union*)

- In the private health sector different agreements exist[19]: The branch agreement No. 2005-01 of 7 January 2005 regarding the Long-Life Learning (LLL); 2) Several branch agreements negotiated on FPTLV; 3) Training Tutorate No. 2005-02 of 7 January 2005 related to the implementation of learning and training of tutors and mentors (replaced by agreement No. 2005-08 dated 23 June 2005); 4) Training Tutorate N° 2005-08 dated 23 June 2005 linked to the implementation of the learning and training of tutors; 5) Branch

[17] After the introduction of the new amendments of 2012 Law concerning the License to Practice of all nurses and midwives, the employers are obliged to actively participate in the CPD of their personnel, not only by supporting them, but also by organising their own in-service education programmes. This is done because, by law, their personnel are legally bound to possess a valid license to practice. This practice is essential for the legal operation of both public and private hospitals and clinics.

[18] Dispositif français relatif à la formation professionnelle dans la fonction publique hospitalière: 1) Il y a un taux de cotisation que chaque établissement doit consacrer à la FPTLV; 2) Il y a un organisme paritaire collecteur agréé (Employeurs et les syndicats) appelé ANFH; 3) Le taux est de 2,1 % «plan de formation» le financement couvre le coût pédagogique, la rémunération des stagiaires en formation, leur déplacement et leur hébergement. Ventilation: 1) Plan de formation de l'établissement; 2) CFP/VAE/BC (Le Congé de formation professionnelle, le congé pour Validation des acquis de l'expérience et le congé pour Bilan de compétences); 3) FMEP (Fonds de mutualisation pour le financement des études promotionnelles): Actions de formation permettant aux agents d'évoluer professionnellement dans la fonction publique hospitalière; 4) ESAT: Formation continue des travailleurs handicapés des Établissements et services d'aide par le travail.

[19] a) Dispositif français relatif à la formation professionnelle dans le secteur privé: Droit pour tout le secteur privé. La loi n°2014-288 du 5 mars 2014 sur la formation professionnelle a mis en place une contribution de formation unique de 1 % pour toutes les entreprises à partir de 10 salariés. b) Dispositif français relatif à la branche associative sanitaire sociale et médico-social: Taux de cotisation est de 2,30% de la masse salariale brute dont 1,60% plan de formation, 0,50% au titre des périodes et contrats de professionnalisation, du tutorat et de l'observatoire des métiers et 0,20% au titre du CIF (Congés individuel formation)

agreement on individual holidays, leave built on skills assessment No. 2005-06 of 22 April 2005 - concerning individual training leave, leave skills assessment and accreditation of acquired experience (*F; legislation*)

- For the private sector several negotiations were concluded with agreements on the branch level. The CFDT acts in the related management bodies set up by these agreements (*F, trade union*)

- [2014] Creation of personal training account by the law of 5 May 2014 with the ambition to increase the skill level of each employee and to secure the career path of employees (*F; legislation*)

- [2014] Law of 10 July 2014 on trainees - Manages the use of interns, improves their remuneration, foresees in particular that they are entitled to the reimbursement of a part of their transport ticket and access to the company cafeteria ... The law also limits the duration of traineeships and the number of trainees that can be hired simultaneously in a company (*F; legislation*)

- Negotiations at the level of the branch which includes FEHAP on creating a statutory contribution aimed at financing professional trainings (ongoing negotiations) (*F, social partners*)

- The National Collective Agreement for the Health Sector [in Italian: *contratto collettivo nazionale di lavoro*, CCNL] defines provision for the improvement and for innovations in the organising and in the provision of continued professional development in order to better respond to changes in the organisation of the health system, in the work organisation or in the way how cure and care are being provided. Training programmes are directed towards the priority objectives of the National Health Plan, of Regional Health Plans and plans on the hospital/organisational level and are provided according to specifications of the National Commission for Continuing Education. Continuing professional development (CPD) is currently regulated in Italy by Article 16-bis of Legislative Decree no. 30 December 1992, No. 502 as amended by art. 14, Legislative Decree no. June 19, 1999, No. 229. CPD comprises activities aimed at improving the skills and clinical skills, technical and managerial and behaviour of health workers, their adaptation to scientific and technological progress in order to ensure effectiveness, appropriateness, safety and efficiency of health services provided in the context of the Service National Health. The National Collective Agreement for the Health Sector (applicable to the National Health System, not to the contracted private providers) regulates access to the various types of training, the costs of which are borne by health providers/companies. (*I; social partners*)

- The Working Environment Act grants employees the right to professional and personal development in their work. This includes both sufficient information and training for recent work and continuing education. A worker who has been employed for at least three years (and two years with recent employer) is granted the right to full-time or part-time leave up for three years, to participate in organised education. (*N; legislation*)

- [2014-] In some agreements nurses have options to study further with salary paid (*N; social dialogue*):
  - Norwegian healthcare workers have a statutory duty to upgrade their professional skills. There is also an obligation for employers to facilitate such updating for the workers.
  - On the other hand Norway lacks a national unified system that specifies how these

obligations can be met.
  - [2014-] Example 1: Establish trainee positions or internships for new college graduates.
  - [2014-] Example 2: specialist training positions for nurses: During the spring negotiations between the social partners the parties reached agreement on specialist training positions for nurses. One result of the spring negotiations was to write into the tariff agreement to establish specialization positions for nurses while they are going through their specialty educational programs at the university or college.

- Until July 2014, hospitals were able to apply for funding for specific education for their employees. From 2014 until 2017 the government grants money to hospitals who would like to give an impulse to their employees' education (Quality Impuls Hospitals). Eligible activities are 1) the organization of internal and external education for personnel. 2) Tutoring employees who are on training. 3) The replacement of employees who are on training and 4) the use of specific educational facilities. (*NL; legislation and government policy*)
  Next to this, the ministry of Health has a fund that subsidizes the costs of internships for certain healthcare educations. By doing this, it creates more internships and it promotes the mobility of healthcare employees. (*NL; legislation and government policy*)

- In 2010 the social partners in the hospital sector introduced a Personal Life phase Budget (PLB) in the Collective Labour Agreement. In the current CLA this is still in place. The goal of the arrangement is to give the employee the possibility to use a saved budget when the moment in a career is asking for it. In 2011 the employee received 30 hours for that year. From 2012 onwards the employee received 57 hours. (*NL; collective labour agreement*)

  Several other arrangements on the education and professional training of employees are included in the collective labour agreement as well. Employees are stimulated to invest in their career and employability by for example career advise and arrangements on study costs and study leave. Next to this education is a standard topic during the annual performance appraisals. (*NL; collective labour agreement*)

- Tool '*Mijn PLB*' (*PLB = Persoonlijk levensfasebudget*): Hospital staff in the Netherlands has a couple of PLB hours each year that can be used to improve their employability. The hours can be used for education and professional development, but also for other ways of improving their employability. The tool 'Mijn PLB' gives inspiration on how to use the PLB hours. More info:
  http://www.staz.nl/versterken_arbeidsverhoudingen/instrumenten/mijn_plb.shtml (*NL; social dialogue*)
  [N.B.: This example is put here, but also under 4.2.2]

- [2011-] Vocational introduction employment (*S; social partners and public policy support*)
  - Basis: Collective agreements signed independently between the labour market actors
  - Target group: Young people who lack relevant vocational experience
  - The design of the agreements varies between different sectors, but a common factor is that work is combined with education (time in training is limited to a maximum of 25% of working hours). The education can either be on-the-job training or training provided by external providers. The time in training does not entitle for a salary.
  - Ex. 1: SALAR and Kommunal (BUI 13): Agreement on vocational introduction employment for young people with health care and care services upper secondary school education, who lack relevant vocational experience.
  - Ex. 2: SALAR and Kommunal (BAL 13): Agreement on vocational introduction

employment for unemployed young people aged 19 to 25 in the field of health care and cares services, to be able to enter into the labour market. The form of employment is temporary and the employee is employed for one year.
  - Government support structures for vocational introduction employment
    - Salary subsidy corresponding to ordinary employer contributions (31.42% in 2013)
    - Supervisor support amounting to SEK 2,500 [~270€]/month and employee (2013)
    - National support structure for educational content
    - Funding for the parties' promotion efforts

- Health Care and Care Services College/*Vård- och omsorgscollege (VOC) [VOC in SE is a protected trademark that is conferred to an institution only following a certification process once relevant quality criteria have been met; monitoring and audit process done by the "National Council"]* (*S; social partners and education providers)*
  - Operates at both regional and local level as part of a collaboration between education providers and social partners in the health and social care sector. A combination of greater cooperation, clarification of the respective responsibilities and a reliable system of quality assurance will ensure that the pooled resources of these parties can be used more efficiently.
  - VOCs are designed to give students a modern education of high standard that offers a good grounding in both theoretical and practical subjects. VOC provide education to students and education and LLL/CPD to those already in the labour market.
  - The demand for qualified staff in health care is rising. In order to meet this demand, qualitative and quantitative initiatives are necessary to address issues relating to the education and training of young people and adults. VOC aim at encouraging more people to train for or to take up a career within health and social care.
  - More information on VOC: www.vo-college.se

- [2013-] Life-long learning for nurses (*S; social partners: trade unions)*
  - The Swedish Association of Health Professionals (*Vårdförbundet*) has since 2013 promoted a model where education to become a specialist nurse takes place within the framework of employment. They are regulated in some local collective agreements and based on local circumstances. They have now been introduced in some county councils and municipalities across Sweden and also with some private providers of healthcare.
  - The education programme is given by universities on advanced level, with academic progress in nursing throughout the programme. Education goals are regulated by the state and entitle to a protected specialist designation. A large part of the education takes place on the job ('activity-integrated learning').
  - The education to become specialist nurses is beneficial to employers, nurses and patients as well as to society as it contributes to high quality care, new research and to the development of the nurse's principal field of knowledge – nursing.

4.6. Achievement of the safest possible working environment [=> FoA R&R 3.6]

- Collectively agreement covering work-life-learning balance arrangements and age-adapted health promotion initiatives (*D; social partners*)
  In Germany a collective agreement for the employees in the university hospitals in the state of Baden-Württemberg was agreed in 2013 between ver.di and the University hospitals Freiburg, Heidelberg, Tübingen, Ulm to ensure flexible arrangements for employees' long-term disposal on working time, smooth transition into retirement and professional

qualifications ("*Tarifvertrag Langzeitkonten und Demografie für die ArbeitnehmerInnen der Universitätsklinika, Baden-Württemberg*", valid from 1 January 2014).
  - Employees receive the possibility to save parts of their wages (e.g. max 25% of the annual average regular wage, anniversary bonus money, special incentives and to some extent additional working time - including the related employer´s contribution.)
  - This money will be stored in an insurance fund with a long-term guarantee that its value will be preserved. The employees receive an annual review of the fund's development.
  - Before signing a savings agreement the employee has the right to consult with an independent institution and is mentored by the works councils' representative.
  - The money – and the working time – can be used for
    - (Part-time) child care and care for relatives (min. 1 month)
    - (Part-time) qualification and education
    - Sabbatical (3-6 month, employer must agree)
    - (Partial) leave of absence before retirement
  - The individual agreement on leave shall be signed by both parties 6 months prior to using the savings. Reasons for refusing their approval must be seriously justified by the employer. During the period of leave the employee receives her/his regular average monthly wage (min. 70%, max 130%, but no bonus)
  - Full text of collective agreement of 1 October 2013: https://www.klinikum.uni-heidelberg.de/fileadmin/personalrat/Dateien/pdf_und_hmtl_Seiten/Tarifvertraege/TVUK/2013/2013-09-24_TV-UK_LZK-D_UF.pdf

- Programme with preventive actions to secure the ability to stay in the health workforce, as part of the health promotion management and of professional rehabilitation measures at organisational level (*D; social insurance*)
  - Pilot programme "Beschäftigungsfähigkeit teilhabeorientiert sichern" (Betsi)
  - More info: https://www.deutsche-rentenversicherung.de/BadenWuerttemberg/de/Inhalt/Allgemeines/Downloads/Reha-Projekte/Betsi-Rahmenkonzept.pdf?__blob=publicationFile
  - Webpage: http://www.deutsche-rentenversicherung.de/BadenWuerttemberg/de/Inhalt/2_Rente_Reha/02_Reha/01_Modellprojekte/Betsi.html

- Programmes for the reintegration of workers after long-term sickness leave in the context of packages of measures at the organisational level (*D; social insurance*)
  - Programme: Betriebliches Eingliederungsmanagement
  - More info: http://www.bgm-report.de/category/betriebliches-eingliederungsmanagement http://www.reha-servicestellen.de/

- In Denmark an amendment in the Law on the Working Environment was endorsed in April 2013. This amendment means that the psychological work environment now enjoys the same status as the physical work environment with regard to possibilities for interventions from the Danish Working Environment Authorities. Hopefully, the amendment will support the goal of achieving the safest possible working environment. With regard to measures the Danish government's strategy on the working environment towards 2020 states that the aim, among other things, is to decrease the number of workers who have been mental overtaxed with 20 percent. (*DK; legislation*)

- In collaboration with the Danish Working Environment Authority and the National Research Centre for the Working Environment the social partners in Denmark have drawn up a booklet with recommendations concerning retention and inclusion of workers. The below

mentioned categories are embedded in the 20 recommendations on
  - Improving the place of work towards inclusion
  - Inclusion of workers with reduced working capacity
  - Continuously matching of expectations and evaluation
  - More information: http://forandringoginklusion.amr.dk/Files/Sagsmapper/Initiativ%205/Psykisk%20arbejdsmiljø%20-%20inklusion.pdf (*DK; social partners*)

- [2010] Obligation for some institutions to negotiate agreements on arduous work to prevent arduous/demanding working conditions - Law of 9 November 2010 (*F, legislation*)

- [2013] Publication in OJ of 9 July 2013 of the decree on the protection against biological risks to which are subjected some workers likely to be in contact with medical sharps and amending the measures on the protection of workers exposed to hyperbaric conditions. This decree transposes into French law the Directive 2010/32/EU (*F; government policy*)

- [2013] The law of financial security dated 14 July 2013 foresees that all employees should have a complementary health insurance (partially financed by the employers) at the latest as of 1 January 2016 (*F, legislation*)

- [2014] Branch Agreement of 17 April 2014 related to health and quality of life at work (deemed unwritten agreement because of the opposition majority of the trade unions of the branch) (*F, social partners*)

- [2015] Creation of personal account for arduous working conditions: employees exposed to arduous working conditions will accumulate points on their account that they will then be able to use for taking a training course (allowing them to access to a less arduous job), to reduce their working time or to anticipate their retirement. This system came into effect on 1 January 2015 (*F, legislation*)

- FEHAP is currently a partner of a project led by Chorum (mutuality of social complementary protection for institutions of the social and solidarity economy) on the "Prevention of musculoskeletal disorders (MSD) in the social economy." This project aims to identify the tools that could provide the best support to structures of the social economy in their MSD prevention approach (*F; social partners: employers*)

- Negotiation at the level of FEHAP on the complementary health insurance and draft agreement slightly more favourable than initially foreseen by the legislator (*F; social partners: employers*)

- The purpose of the Working Environment Act of Norway is to secure a health-promoting and meaningful employment, granting full safety from both physical and mental harm, and with a standard of welfare that at any time is in accordance with society's technological and social development. The working environment requirements are elaborated in several regulations. The Working Environment Act states in its general requirements to working conditions, that the prevention of injuries and illness is to be emphasised in planning for and executing work. The purpose of the regulations on organisation, management and participation is that work is organised and facilitated so that workers are granted a fully justified working environment, protected against physical and mental harm through:
  - mapping, risk assessment and implementation of measures being done ahead of activities,

- securing participation of the workers and their representatives,
- the workers and their representatives are given the information and training needed. (*N; legislation*)

- In 2012 three ministries together with the social partners launched the action "Working safely in the health care sector" (*Veilig Werken in de Zorg*). This action plan is aimed at the whole healthcare sector. Its goal is creating a safer working climate by i.a. financially stimulating training for employees, sharing good examples and stimulating the report of assaults (*NL; legislation and government policy*)

- In 2014 the government reserved an extra of 3.4 million € for a programme on reducing and preventing aggression towards employees in the health sector. This amount was spent on top of the 7 million € that had been reserved already for the period 2012-2015. (*NL; legislation and government policy*)

- Guide on Occupational Safety and Health. This guide contains the agreements on safe and healthy working conditions. See the website for more information (*NL; collective labour agreement*)

- Project "Safe healthcare" (*Veiligezorg*): Supports hospitals and employees in preventing and dealing with aggression at the workplace. (*NL; social dialogue*)

- Handbook and project "Good night". This project contains a research and handbook on the risks of night work and provides insights on how to reduce the negative impact of night work. (*NL; social dialogue*)