



Activity **REPORT**



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(Covering, October 2005-October 2008)

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I. INTRODUCTION  The European Hospital and Healthcare Employers' Association (**HOSPEEM**) was established in September 2005. Through European sectoral Social Dialogue, HOSPEEM aims to ensure that the views of hospital and healthcare employers are properly taken into account by the EU institution when they launch policies in the European Union (EU) that have a direct impact on management and labour relations in the hospital and health care sector. HOSPEEM is recognised as a Social Partner (since 2006) in the hospital sector by the European Commission and takes part in the hospital sector Social Dialogue Committee alongside the European Federation of Public Service Unions (EPSU).


HOSPEEM was established following several years of work aimed at creating Social Dialogue in the European hospital sector which began after there was close contact between employers and trade unions in the late 1990's. The process began to gather pace in May 2000, when the Danish Social Partners, organised a conference under the auspices of the European Union's Leonardo Da Vinci programme.

In 2002, following a second conference of the European hospital sector Social Partners, a Joint Representative Taskforce was established with the aim of applying to the European Commission for a formal Social Dialogue Committee. Further momentum was added to the process in 2004, through a conference held by the Dutch Social Partners which helped to identify the work areas that the hospital sector Social Dialogue could focus on.

Up to this point, CEEP (European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest) had been working alongside EPSU to establish a Hospital Sector Social Dialogue. However, CEEP's remit which covers the entire public sector, led to serious issues in relation to the representation criteria set by the Commission for Social Dialogue. As a result, CEEP's hospital members established HOSPEEM as a new organisation. Since its creation HOSPEEM has maintained its close links with CEEP by becoming a member of CEEP.

The process of establishment was completed in July 2006, when HOSPEEM was officially recognised by the European Commission as a Social Partner in the Hospital Sector Social Dialogue. HOSPEEM then took its place alongside EPSU in the Hospital Sector Social Dialogue Committee.

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II. ORGANISATIONAL DEVELOPMENTS  HOSPEEM has two bodies which govern the organisation and set its future direction. These are the HOSPEEM General Assembly and the HOSPEEM Steering Committee. The HOSPEEM General Assembly has the power to modify the organisations statutes and approve members and observers. It also has the power to appoint and dismiss the HOSPEEM Secretary General, the two vice Secretary Generals and the HOSPEEM Steering Committee.

The HOSPEEM Steering Committee sets the strategic direction of the organisation. It also manages and administers the association and drafts the mandate on behalf of HOSPEEM, subject to final approval by the General Assembly, for negotiations on European collective agreements. The HOSPEEM Steering committee consists of the Secretary General, the two vice Secretary Generals, the Director, plus four other members elected from the HOSPEEM membership.

HOSPEEM also has a Board which consists of the Secretary General, the two vice Secretary Generals and the Director of HOSPEEM. **The Board** is involved in the day to day management of HOSPEEM.

At the first **HOSPEEM General Assembly** in September 2005, the General Assembly elected the HOSPEEM Secretary General, the two Vice Secretary Generals along with the HOSPEEM Steering committee. At the General Assembly, the following positions were elected.

- ✦ Secretary General – Godfrey Perera (NHS Employers)
- ✦ Vice Secretary General - Silvana Dragonetti (ARAN)
- ✦ Vice Secretary General – Christina Carlsen (Danish Regions)

The HOSPEEM Steering Committee

- ✧ The HOSPEEM Board members
- ✧ Brendan Mulligan (HSE – Employers Agency)
- ✧ Anette Dassau (Vereinigung der kommunalen Arbeitgeberverbände – VKA)
- ✧ Hélène Boyer (Fédération Hospitalière de France – FHF)

All the positions were elected for a period of two years up to 2007. During this time the Secretary General, Vice Secretary Generals and Steering Committee oversaw the creation of the organisation. In the 2006 General Assembly meeting, Valeria Ronzitti was appointed as Director of HOSPEEM and in this function she reinforced the role of the board in the recognition of HOSPEEM as a Social Partner and its establishment and major player in the European health arena.

The statutory positions came up for renewal at the 2007 HOSPEEM General Assembly and the following positions were elected.

- ✧ Secretary General – Godfrey Perera (NHS Employers)
- ✧ Vice Secretary General – Marta Branca (Agenzia per la rappresentanza negoziale delle pubbliche amministrazioni – ARAN)
- ✧ Vice Secretary General – Christina Carlsen (Danish Regions)

The HOSPEEM Steering Committee was also elected at the 2007 General Assembly and consisted of the following people.

- ✧ The HOSPEEM Board members
- ✧ Ludwig Kaspar (The Austrian Hospital and Health Services Platform in VÖWG)
- ✧ Brendan Mulligan (HSE – Employers Agency)
- ✧ Anette Dassau (Vereinigung der kommunalen Arbeitgeberverbände – VKA)
- ✧ Miroslav Jiránek (Association of Czech and Moravian Hospital)

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

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III. MEMBERSHIP

✧ One of HOSPEEM's key objectives over the coming years will be to increase its membership in order that the organisation can become more representative in the hospital sector Social Dialogue. The current members of HOSPEEM are:

- ✧ The Austrian Hospital and Health Services Platform in VÖWG– Austria
- ✧ Association of Czech and Moravian Hospitals – Czech Republic
- ✧ Danish Regions – Denmark
- ✧ Vereinigung der kommunalen Arbeitgeberverbände (VKA) – Germany
- ✧ HSE - Employers Agency – Ireland
- ✧ Agenzia per la rappresentanza negoziale delle pubbliche amministrazioni (ARAN) – Italy
- ✧ Latvian Hospital Association (LHA) – Latvia
- ✧ The Lithuanian National Association of Health care organizations - Lithuania
- ✧ Vereniging van Ziekenhuizen (NVZ) – The Netherlands
- ✧ The Employers' Association SPEKTER – Norway
- ✧ Polish Health Confederation – Poland
- ✧ Swedish Association of Local Authorities and Regions (SALAR) – Sweden
- ✧ NHS Employers – United Kingdom

The French Hospital Federation (FHF) withdrew his membership in January 2008.

The newest member of HOSPEEM is The Lithuanian Association of Healthcare Organisations who became a member in August 2008.

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

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IV. REPRESENTING MEMBERS VIEWS

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

As a recognised Social Partner in the hospital sector, the European Commission (in particular the Directorate General on Employment, Social Affairs and Equal Opportunities-EMPL) has an obligation, following Article 138 of the EC Treaty, to consult HOSPEEM on any draft proposals concerning social policies in the hospital sector. Moreover, HOSPEEM has the opportunity to give its views on open consultations relevant to the healthcare sector, such as those launched by the Directorate General on Health and Consumers-SANCO. As a result, in the past two years HOSPEEM has responded to several European Commission consultations on behalf of its members. The responses submitted have been formed from a consensus view of all the members. HOSPEEM has responded to the Commission on three issues that were relevant to the hospital and healthcare sector. The issues were:

- ✦ **DG SANCO** consultation regarding Community action on health services
- ✦ **DG EMPL** first stage consultation of the Social Partners on protecting European healthcare workers from blood-borne infections due to needlestick injuries
- ✦ **DG EMPL** questionnaire on the practical implementation of Directive 2003 / 88 / EC concerning certain aspects of the organisation of working time.

HOSPEEM was also consulted on a number of more transversal issues, such as new policies initiatives to better reconcile work, private and family life. In such cases, the organisation opted for feeding into the CEEP answers because of the cross-sectoral nature of the question. The CEEP answer has led to cross-sectoral negotiations on the issue and HOSPEEM being a member of CEEP it is also able to have a direct impact on those ongoing negotiations.

A summary of the views that HOSPEEM put forward on each issue can be found in annex A. The full versions of the responses submitted to the Commission are included in annexes B, C and D.

Multi sector initiative on third party violence

In April 2007, the cross sector Social Partners published a framework agreement on harassment and violence. This agreement did leave the way open to cover third party violence in national implementation, which is an important issue for several sectors. Some sectors have agreed at EU level to look at the possibility of a multi-sector agreement on this issue.

The hospital sector is one of the sectors and HOSPEEM is involved in the discussions. This agreement will help to prevent EU legislative action in this area. During the discussions and possible negotiations, HOSPEEM will represent member's views and seek an agreement that suits hospital and healthcare employers.

Networking activities

As a Social Partner, HOSPEEM has access to senior figures within the European Institutions. This means that HOSPEEM has the opportunity to put forward the views of employers on employment and industrial relation issues directly to key individuals at the EU Commission, the European Parliament and the Council.

As part of the process which saw HOSPEEM recognised as a Social Partner, Godfrey Perera (Secretary General of HOSPEEM) and Valeria Ronzitti (Director of HOSPEEM), together with Carola Fischbach-Pyttel (EPSU General Secretary) and Tamara Goosens (EPSU Officer – Health & Social Services), met with Vladimir Spidla, Commissioner for Employment, Social Affairs and Equal Opportunities at the European Commission. In a wide ranging discussion, Mr Perera was able to put forward the views of members on a number of issues including the Working Time Directive and patient mobility. Mr Spidla gave strong support to the hospital sector Social Dialogue. HOSPEEM also had meetings with key officials within DG Employment such as Jackie Morin. Access to Mr Spidla and key officials would have been much more difficult if HOSPEEM was not part of the Social Dialogue process and the meeting demonstrated the value of being a Social Partner.

Since the meeting with Commissioner Spidla, HOSPEEM has also met with other key officials at the European Commission. This included HOSPEEM and EPSU jointly meeting with Androulla Vassiliou, Commissioner of DG Health and Consumers, to raise member's views in relation to the Commission's proposals on cross-border healthcare.

Continuing to represent member's views

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

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V. INFLUENCING LEGISLATION AND POLICY

✚ HOSPEEM members felt it was very important that the organisation should become a Social Partner and take part in European Sectoral Social Dialogue. Being a Social Partner has many benefits for HOSPEEM and this stems from the key role accorded to European Social Partner organisations as legislators and influencers of European policy by the European Treaty (Articles 137-139).

Article 138 of the EC Treaty envisages the obligatory consultation of Social Partners on all matters of social policy laid down in **Article 137**. The consultation process has two stages:

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

After the second stage, the European Social Partners can inform the Commission that they wish to open negotiations and start the process laid down in Article 139.

Article 139 addresses the negotiations through which the European Social Partners can conclude agreements on social policy. In this way, employers and workers have the opportunity to conclude agreements at EU level. Any agreements concluded by the European Social Partners will be legally binding once implemented.

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

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

Should the Social Partners fail to agree to negotiate on such employment relation issues then they the European Commission launch the intended legislative process. HOSPEEM can than still have the possibility to influence the latter towards lobbying activities vis à vis the EU Commission before the legislative proposal is finalised, or vis-à-vis the Council and the European Parliament all over the co-decision procedure.

Besides the process of consultation and negotiation provided for by the Treaty, there is also a process of autonomous social dialogue. This means the initiatives developed independently by the European Social Partners without first consulting with the Commission.

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

- The Hospital Sector Social Dialogue Committee provides a structured and regular platform for the exchange of information, the opportunity to learn from European solutions and experiences and to agree joint positions, not solely under the form of framework agreements.
- Full members of HOSPEEM have the right to take an active role in negotiations and discussions on issues that are important to the hospital sector.
- Full members of HOSPEEM are seen as major players (and as a source of expertise and information) in the hospital and health sector by the main European institutions.
- Both the European Commission and the European Parliament tend to be more sympathetic to the views of health employers than to governments.
- The ability to exercise political pressure and to have the right to participate in negotiations at European level increases the lobbying pressure and the influence of HOSPEEM members at national level.

HOSPEEM's lofty profile has enabled it to represent its member's views more effectively during its first two years. Being a Social Partner has meant that the European Commission has sought the views of HOSPEEM members and has listened to their opinions. The status of Social Partner has also given HOSPEEM, and its members, excellent access to the European Commission and the officials that work within it.

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VI. HOSPEEM SUCCESSSES

During its first two years as a Social Partner, HOSPEEM has jointly taken forward several strands of work with EPSU (The European Federation of Public Service Unions), its partner in the Hospital Sector Social Dialogue committee. As part of the first work programme of the Social Dialogue committee, HOSPEEM and EPSU established three working groups to examine issues that were of key concern to the hospital sector in Europe and worked on a project to strengthen Social Dialogue in the new Member States and candidate countries. HOSPEEM and EPSU have also issued a joint statement on health services in Europe and supported a conference in Poland which examined the role of Social Dialogue in the privatisation of healthcare and the migration of healthcare staff.

The working groups, project, joint statement and conference have all been a success and have demonstrated to the European Commission, the willingness and ability of employers and trade unions to work together in the hospital sector. As a new Social Dialogue committee, it has been vital for HOSPEEM and EPSU to demonstrate viable joint working.

Code of conduct on ethical recruitment

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

The guidelines were signed and shared across the European Union and will be implemented by HOSPEEM and EPSU members by April 2011. During this period the hospital sector Social Partners will have to report back to the social dialogue committee each year on the progress made. A full version of the code of conduct can be found in annex E.

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

During the first two years of the Social Dialogue committee, HOSPEEM and EPSU worked together on a project to strengthen Social Dialogue in the new Member States and candidate countries. The aim of the project was to help the Social Partners in these countries build up their domestic Social Dialogue systems. It was hoped that by strengthening national Social Dialogue in these countries, it would lead to an improved representation from these countries in European level Social Dialogue.

The project had two aspects. The first was background research on the organisation and financing of the hospital sector in Europe, the key labour market issues facing the sector and the Social Partners, and the processes involved in collective bargaining and Social Dialogue at the national level in the EU-27.

The second aspect of the project focussed on capacity building in Social Dialogue, which would help Social Partners to better influence the Social Dialogue process at both national and European level.

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

All parties agreed that the project was extremely successful in establishing links and strengthening Social Dialogue in both the Czech Republic and Slovakia. It also provided invaluable information on Social Dialogue across the whole of Europe. HOSPEEM will be able to use the information collected in the project to recruit new members and improve its representation at European level.

Joint declaration on health services

In response to the European Commission's plans to publish a directive on cross-border healthcare, HOSPEEM and EPSU published a joint declaration on health services in December 2007. The declaration set out the joint view of the Social Partners on the principles upon which the management, financing and delivery of healthcare in the European Union should be based. The importance of the joint declaration was that it highlighted the many areas in which HOSPEEM and EPSU agree and sent a powerful message to the European Commission.

The key messages included in the declaration were:

- ✧ It is not for the European Institutions to impose market and/or competition mechanisms in the health care sector, which could have the consequence of lowering the standards and increasing the costs of health care systems and thus diminishing the accessibility to care
- ✧ Healthcare should therefore be organised on the basis of common European social values including solidarity, social justice and social cohesion
- ✧ They should also follow the principles of general interest, like equality, accessibility and quality
- ✧ It is essential that EU-internal market or competition rules do not limit the EU Member States' autonomy in the implementation of these national responsibilities.

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

Conference on role of European and national Social dialogue in a changing hospital and health-care structure

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

The migration of healthcare professionals across borders is an issue that affects many HOSPEEM members. This is particularly an issue in some of the new Member States where they have lost many qualified health professionals to other countries. The conference was valuable as it gave a chance for the issue to be discussed and for solutions to be debated. It also emphasised the value of Social Dialogue in helping to achieve partnership solutions to some of these key issues.

VII. THE HOSPEEM - EPSU WORK PROGRAMMES 2006-07 & 2008-10

As part of the Hospital Sector Social Dialogue committee, HOSPEEM and EPSU have had two work programmes. The first work programme ran from 2006-07 and the second will run from 2008-10. The first work programme of the Hospital Sector Social Dialogue committee was the culmination of several years of planning. In March 2006, HOSPEEM and EPSU launched their work programme for 2006-07 and it was officially signed at the first meeting of the hospital sector Social Dialogue Committee in September 2006.

As part of the work programme, HOSPEEM and EPSU stated their aim to increase their influence over employment policies in hospital sector. In particular they agreed to:

- **promote quality** hospital services based on values of social responsibility and accountability.
- **actively contribute** to the shaping of the debate at European level on employment and industrial relations matters.
- **organise activities** to strengthen Social Dialogue between employer and trade unions organisations in the hospital sector in the new Member States.
- **complement the work** of the cross-sector Social Partners where appropriate.
- **address initiatives** by the European Commission in the field of employment policy and give a view on other policies having an impact on the hospital sector.

The work programme also focused on three issues that were of key concern to the hospital sector in Europe. Each issue had its own working group which consisted of fifteen members from both the employer and the trade union side. The three issues that the Social Partners agreed to work on were:

- **Recruitment and retention**
Identifying common positions for cross-border recruitment of hospital personnel
- **The ageing workforce in the hospital sector**
Identifying member state and regional initiatives to promote realistic active ageing policies
- **New skill needs in the hospital sector**
Identifying the new roles and skills, that will be needed in healthcare in the future.

Over the course of 2007 and the first half of 2008, the working groups identified solutions to some of the problems in these three areas. A full version of the 2006-07 work programme can be found in annex G.

The Hospital Sector Social Dialogue Committee working groups

Of the three working groups, the work of the recruitment and retention group progressed the fastest. The group was jointly chaired by Ulrike Neuhauser on behalf of HOSPEEM and Liza Di Paolo Sandberg on behalf of EPSU. Members of the group had several Social Dialogue tools available to them and agreed to produce a European Social Dialogue Charter on Ethical Cross-Border Recruitment and Retention in the hospital sector. This document has now been finalised. For further information on the code of conduct please see annex E.

The work of the new skill needs working group is still in progress. During its initial meetings, members of the working group discussed the possibility of producing guidance which will highlight examples of how new job roles and new skills are being developed around Europe. Employers and trade unions will work together at a national level in each Member State to highlight good practice which can be then shared across Europe. This guidance will provide both employers and trade unions with practical examples of what is happening in other Member States and will be an excellent way of sharing knowledge around Europe.

The third working group on the ageing workforce was unfortunately unable to complete its work. This was due to problems with the European Commission scheduling meetings for the group. As the group was unable to take forward work in this important area, HOSPEEM and EPSU agreed to submit to the European Commission a proposal for a project which would tackle issues around the ageing workforce. If HOSPEEM and EPSU are successful in getting funding for the project, then the work will be taken forward as part of their 2008-10 work programme.

Work programme 2008 -10

Following the success of the first work programme, HOSPEEM and EPSU agreed their second work programme in June 2008. The work programme will run from 2008-10 and will continue to strengthen Social Dialogue in the hospital sector at European, national and local level. In the work programme, HOSPEEM and EPSU commit themselves to:

- enhance the representativeness of their organisations in the hospital and health care sector throughout the European Union and its candidate-members.
- support the development and the strengthening of European, national and local social dialogue structures in the hospital sector.
- promote an interactive exchange of knowledge and experience in the fields of health sector and social policies between different national social partner organisations and their representatives.
- monitor, and where appropriate react, to European Commission social and health policy initiatives which will have an impact on the hospital sector work force and organisation.
- maintain an active working relationship with the relevant cross-sectoral partners and complement their work where suitable.
- develop policies and instruments to support a social and sustainable workforce management within the hospital sector in the European Union.
- promote quality hospital services based on the shared principles as agreed in the joint EPSU-HOSPEEM Declaration on Health services of December 2007.
- promote the application of equality principles and legislation.
- further explore how the organisation of healthcare systems influences work organisation in the hospital sector.

In order to achieve these goals, HOSPEEM and EPSU agreed to work together to strengthen Social Dialogue structures in order to build capacity in Social Dialogue. In particular they agreed to address the issue of how to retain healthcare staff as well as examine the issues relating to new skill needs and the phenomenon of third party violence. HOSPEEM and EPSU will also take forward a project on the ageing workforce in the European hospital sector if the project bid is successful with the Commission. A full version of the 2008-10 work programme can be found in annex H.

The 2008-10 work programme demonstrates the willingness of HOSPEEM and EPSU to continue to work together for the benefits of staff and ultimately patients. The success of the first work programme gives the Social Partners an excellent platform to build on, although more work remains to be done.

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VIII RELATIONSHIP WITH HOPE

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

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IX CONCLUSION

In the first three years of its existence, HOSPEEM has made giant strides in being accepted as an importance voice in European hospital and healthcare matters. HOSPEEM is now the first port of call when the European Commission wishes to discuss matters concerning hospital and healthcare workforce issues.

As a recognised Social Partner, HOSPEEM has a key role accorded to European Social Partner organisations as legislators and influencers of European policy by the European Treaty (Articles 137-139). This allows, and will continue to allow, HOSPEEM members a voice at the European top table. It is important that HOSPEEM continues to grow at the current rate, and all HOSPEEM members will have to play important roles and give HOSPEEM their full support, if HOSPEEM is to thrive in representing its member's views.

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X. ANNEXES



ANNEX A. ❖ EUROPEAN COMMISSION CONSULTATION REGARDING COMMUNITY ACTION ON HEALTH SERVICES

SUMMARY OF THE CONSULTATION RESPONSES HOSPEEM HAS SUBMITTED TO THE EUROPEAN COMMISSION

The Commission's consultation regarding Community Action on health services was launched in September 2006 and asked a wide range of stakeholders for their views on cross-border healthcare within the European Union. Following a series of European Court of Justice (ECJ) Judgments which confirmed the rights of EU citizens to access healthcare in other Member States, the Commission's consultation invited views on where greater legal certainty was needed in relation to cross-border care and on what support and co-operation was needed to make it work in reality.

The consultation addressed four specific kinds of cross –border care. These were:

- ❖ Cross-border provision of services (e.g. telemedicine, remote diagnosis)
- ❖ Use of services abroad (what is referred to as 'patient mobility')
- ❖ Permanent presence of a service provider (the establishment of a healthcare provider in another Member State)
- ❖ Temporary presence of persons (e.g. mobility of health professionals)

As cross border healthcare has the potential to have an impact on the workforce of hospital and healthcare employers across Europe, it was important that the views of employers were represented in the consultation. The HOSPEEM response made some points about the general principles that members felt should be adopted in relation to cross-border healthcare, as well as highlighting specific issues in relation to the healthcare workforce.

HOSPEEM members felt that the following principles should be adopted by the European Commission when preparing any legislation:

- ❖ The principle of subsidiarity should be respected. The funding, organisation and delivery of health systems should remain the responsibility of individual Member States.
- ❖ Prior authorisation procedures are vital and if a patient goes abroad for treatment then they should go through existing gate keeping structures for referrals.
- ❖ If citizens of a Member State are not entitled to receive a particular treatment or intervention paid for by their home system, then they should not be entitled to receive it in another Member State.
- ❖ If a patient goes abroad for treatment then the standards of care, governance and the liability of the receiving country should apply. Patients should also not be able to seek redress from their 'home' healthcare system should something go wrong.
- ❖ If patient mobility is to be properly managed, it is imperative that the 'receiving' Member State is properly compensated for the treatment of foreign patients.

The specific workforce related issues which were raised in the response were:

- ❖ Cross border healthcare will raise significant issues around the training and resourcing of healthcare staff. Any significant increase or decrease in the numbers of patients in any Member State could cause serious problems in managing the workforce.
- ❖ An increase in the numbers of patients seeking treatment in other Member States will raise issues around communication skills and the training of staff. If staff cannot speak the language of the patients they are treating then this may lead to an increased need (and potential increased cost) for language and interpretation skills. Staff may also require increased training and new skills in order to better treat patients from different cultural backgrounds.

- ❖ Action is needed to ensure that dangerous professionals can not cross borders and that incidence of professional misconduct or criminal behaviour by healthcare professionals should be accessible across the European Union.

As a new Social Partner in the hospital sector, it was important that HOSPEEM responded to the consultation and that members views were heard. HOSPEEM also issued a joint declaration on health services with EPSU in December 2007 in response to the Commission's plans for cross-border healthcare (for further information please see the section on 'Joint work with the European Federation of Public Service Unions').

The Commission finally published its draft Directive in July 2008 and many of the points included in HOSPEEM's original consultation response were included in the draft Directive. This shows that, in conjunction with other stakeholders, HOSPEEM was able to influence the Commissions thinking and ensure that member's views were taken on board.

FIRST STAGE CONSULTATION OF THE SOCIAL PARTNERS ON PROTECTING EUROPEAN HEALTHCARE WORKERS FROM BLOOD- BORNE INFECTIONS DUE TO NEEDLESTICK INJURIES

- ❖ In December 2006 the Commission launched a first stage consultation of the Social Partners on protecting European healthcare workers from blood-borne infections due to needlestick injuries. The Commission asked the Social Partners whether they thought it would be useful to take an initiative in this area and whether a joint initiative by the Social Partners would be appropriate.

HOSPEEM responded to the consultation and was able to represent member's views successfully. Members also provided practical examples which were incorporated in to the HOSPEEM response and these strengthened the argument that was put forward to the Commission.

HOSPEEM members felt that although needlestick injuries are stressful and have the potential for transmission of blood-borne infections to staff, they are not a major cause of incidents in the healthcare sector in Europe. HOSPEEM argued that further legislation was not necessary on this issue but that action should be taken to raise the profile of needlestick injuries and to ensure that there is more effective implementation of the current legislation. The response said that HOSPEEM and EPSU were in a good position to tackle this issue and bring pressure to bear at a national level for better implementation of the current legislation. HOSPEEM members felt that awareness raising campaigns, a guide to prevention and good practice, along with effective monitoring of compliance with legislation at workplace level were some of the possible joint actions.

It was important that the views of employers were put forward on this issue as EPSU argued that new legislation should be introduced at European level which would make it compulsory for all EU Member States to provide safer needles for healthcare staff which could increase the costs for employers quite considerably.

In February 2008 the European Commission, in conjunction with HOSPEEM and EPSU, organised a technical seminar on needlestick injuries. HOSPEEM was able to get its members involved in the seminar which allowed them to put their views forward directly to Commission officials. This was an extremely good example of HOSPEEM allowing members to express their views and demonstrated the value of the organisation.

In June 2008, HOSPEEM wrote to the European Commission offering to negotiate, with EPSU, a Social Partner agreement on this issue. As this issue moves forward, HOSPEEM will continue to represent member's views and seek to influence the Commission on their behalf.

THE EUROPEAN COMMISSION QUESTIONNAIRE ON THE PRACTICAL IMPLEMENTATION OF DIRECTIVE 2003 / 88 / EC CONCERNING CERTAIN ASPECTS OF THE ORGANISATION OF WORKING TIME

- ❖ During the course of 2007 the European Commission issued a questionnaire to Social Partners on the practical implementation of Directive 2003 / 88 / EC concerning certain aspects of the organisation of working time. The questionnaire was a good opportunity for HOSPEEM members to make some key points to the Commission about how difficult the Directive has been to implement, particularly following the SiMAP and Jaeger court rulings.

HOSPEEM members again provided examples which were included in the response sent to the Commission. The key points that HOSPEEM made to the Commission included:

HOSPEEM members again provided examples which were included in the response sent to the Commission. The key points that HOSPEEM made to the Commission included:

- ✦ HOSPEEM members believe that patients should not be treated by tired staff and that staff are entitled to fair working conditions. While the Working Time Directive has been fully implemented by HOSPEEM members, the Directive and the subsequent rulings of the European Court of Justice (ECJ) have caused the hospital and healthcare sector problems and have imposed significant and unnecessary costs on hospital and healthcare employers
- ✦ The SiMAP and Jaeger rulings have caused serious problems in the operation of health systems and have led to Member States recruiting extra staff to prevent gaps in patient services without improved productivity. The recruitment of extra staff has come from outside Europe as well as from the new Member States. Losing staff in this way has had a large adverse impact on those health systems.
- ✦ The SiMAP and Jaeger rulings have made on-call working impractical and have led to inflexible applications of working practices. In some cases the judgements have resulted in increased shift working which has reduced the amount of (better quality) daytime training opportunities for junior doctors

Here again, HOSPEEM was able to represent its members views successfully and demonstrate the value of the organisation.



ANNEX B.

HOSPEEM RESPONSE TO THE CONSULTATION REGARDING COMMUNITY ACTION ON HEALTH SERVICES JANUARY 2007

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

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

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

THE CONSULTATION

✦ HOSPEEM is pleased that the Commission acknowledges the general interest nature of healthcare services. These irreplaceable services perform special missions and are provided directly or are controlled by the public authorities or entrusted to specific actors who are responsible for them. They are therefore subject to a process of public regulation under the general supervision of the Member State based on the objectives of the public policies assigned to them with respect to public health.

HOSPEEM would like to underline the important nature of health services and the requirement of access to quality health services for all citizens. It recalls that it is the responsibility of Member States to define and to organise the services in question as well as the scope of coverage of the health and social needs to be satisfied, in keeping with the principles of subsidiarity and of universal access to healthcare services in the Member States. Furthermore, healthcare services are characterised by asymmetric information between the principal (the patient) and the agent (the doctor). Therefore, we consider as main result that economic allocation of the usual market mechanisms do not apply in this area, but rather resources are planned / organised by the respective authorities.


In view of the diversity of the services concerned and the variety of approaches, organisational and funding methods in the Member States, HOSPEEM welcomes an in depth consultation on these matters.

At the end of this consultation process, the relationship between a possible general framework on services of general economic interest and potential legal initiatives on health services should be answered. Furthermore, any future Community action should include an assessment of the potential impact on national healthcare systems.

HOSPEEM is mainly concerned with workforce and industrial relations issues in the hospital and healthcare sector. HOSPEEM will therefore principally address aspects of the consultation that relate to workforce and industrial relation issues. As far as the provision of Healthcare Services of General Interest is concerned, HOSPEEM would like to refer to the CEEP framework on Services of General Economic Interest.


Moreover, before addressing the individual questions posed by the Commission there are some key principles that HOSPEEM members believe are important to state in relation to cross border healthcare in the European Union.

As stated in the Commissions consultation regarding Community action on health services, mechanisms already exist which enable European Union citizens to access emergency medical care whilst in another Member State in the shape of Regulations (EC) 1408/71 and 574/729. HOSPEEM's response will therefore aim to help clarify issues around cross-border healthcare treatment including impacts for patients, healthcare providers as well as healthcare funding organisations.

SUBSIDIARITY  According to Article 152 of the EC Treaty, the European Commission has always had limited competence in the field of health. The funding, organisation and delivery of health systems has been in the competence of individual Member States. Whilst acknowledging that there are issues to address in relation to cross border healthcare following a series of judgments by the European Court of Justice (ECJ), HOSPEEM supports the principle of subsidiarity. HOSPEEM believes that any action which appears to undermine the principle of subsidiarity could have long term serious unintended consequences for the health sector in the respective Member States.


Member States should retain the right to plan services and manage resources (including workforce) in order to ensure the financial viability of their health systems. As HOSPEEM supports the principle of subsidiarity, it also supports Member States' public healthcare provision, i.e. the understanding of healthcare as a central part of Member States' services of general interest. In addition HOSPEEM supports common values of solidarity, social justice, social cohesion along with the requirements of universality, accessibility and quality of healthcare.


HOSPEEM is also of the view that healthcare is different to other 'services' that are offered throughout the European Union and that the free market principles should be counterbalanced. Therefore, developments in healthcare systems should not be the result of the expansion of internal market rules based on ECJ rulings but on political consensus based on the EC Treaty provisions on public health (Article 152 EC).

A REFERRAL SYSTEM  A key element of Member States being able to manage the finances of their healthcare systems is prior authorisation procedures. If a patient is going to another Member State for treatment then s / he should be obliged to go through a referral system in his / her own Member State. This will allow the 'sending' Member State to examine whether the care can be firstly delivered in their own state within a reasonable amount of time. 'Undue delay' should not be measured solely in terms of waiting time. Clinical need based on medical criteria's defined by the national Member States, should be an important consideration.

The referral process allows the financier of the care to monitor finances but is also an opportunity for patients and their healthcare funding organisation to assess the risks of treatment abroad, agree which parties will be responsible and liable, determine what the care package will involve, what it will cost and what the outcomes will be. It is also an opportunity to allow the patients a chance to understand their care pathway.

The referral process will also allow Member States to determine the benefits package that their citizens enjoy. Patients should not be able to access care abroad that isn't available in their own country.

SCOPE  In order to ensure the Member States ability to exercise control over the cost and to maintain the financial sustainability of the healthcare systems, it is essential that the patients who wishes to seek treatment abroad, only has the right to receive treatments that are offered in the national health care systems. The national healthcare systems should not get bypassed or extended, and the financial, medical etc. reasons there is not to offer certain treatments in the national healthcare systems should be respected.

ACCESS TO HEALTHCARE  HOSPEEM believes that any action at European level on health should aim to improve healthcare for all patients and should not have the unintended consequence of lowering standards of existing healthcare systems in Member States or of reducing access to healthcare and destabilising the health system. If large numbers of patients begin flowing out of an individual Member State there is the potential for this to happen. For example, if workforce numbers fall due to increasing numbers of patients going abroad for treatment it could lead to a situation where patients who remain in the country have their ability to access healthcare reduced. This may not happen immediately and will be difficult to track without monitoring.

HOSPEEM members also feel that access to healthcare in the ‘receiving’ country also needs to be clarified. Patients who travel abroad for treatment should not be able to gain access to healthcare quicker than patients already on waiting lists in the ‘receiving’ country who have greater clinical need. Member States should continue to have the freedom to manage their waiting lists and allocate resources as they see fit.

The principle of equal access to healthcare services must be ensured for both foreign and national patients who live in that country.

FINANCIAL SUSTAINABILITY

Healthcare is expensive and Member States with ageing populations will find it increasingly expensive. In general, any proposals by the European Commission should not increase the financial or human resource burden upon healthcare systems. In workforce terms this could include regulatory burdens that could prove expensive for employers.

If patient mobility is to be properly managed, it is imperative that the ‘receiving’ Member State is properly compensated for the treatment of foreign patients. The method by which providers of healthcare claim back the costs they have spent on treating a patient from another Member State (including the costs of employing their staff) need to be clarified to ensure payment is received. Some HOSPEEM members have previously experienced difficulties in claiming back costs from healthcare funding organisations in other Member States. If this issue is not satisfactorily resolved then cross-border healthcare will not operate successfully and the financial sustainability of health systems could be threatened.

CAVEAT EMPTOR (BUYER BEWARE)

HOSPEEM feels strongly that for treatment abroad, the standards of care, governance and liability of the receiving country should apply. Patients should also not be able seek redress from their ‘home’ healthcare system should something go wrong. This should be made clear to the patient at the referral stage. The responsibility for correcting mistakes made by the provider should remain with the provider and payment should be made by the provider to the country of origin, if the mistake was rectified in the patients’ home country.

The personal liability of healthcare staff also needs to be clarified. Staff should not be liable if something goes wrong during the treatment of a patient they have referred abroad. This should be made clear and agreed by both the provider and funding body.

WORKFORCE PLANNING

Cross-border healthcare will raise significant issues around the training and resourcing of healthcare staff. It is important to understand how long it takes to train doctors, nurses and other healthcare professionals and that any significant increase or decrease in the numbers of patients in any Member State is likely to create serious problems in managing the workforce. This is one of the reasons why it is important that healthcare systems have a prior authorisation system for referring their patients abroad so they are able to monitor the impact of cross-border healthcare.

One specific aspect of cross border healthcare referred to in the Commission’s communication is the movement of health professionals across borders. The movement of professionals between States will raise several issues for healthcare employers.

In Members States where staff are migrating to other European Union States it can create problems in meeting the healthcare needs of their population.

HOSPEEM and EPSU are working together in the Hospital Sector Social Dialogue Committee to provide solutions to the problems of recruitment and retention of staff that some countries (particularly the “new” member states and acceding countries) are experiencing. Any proposals by the Commission on cross-border healthcare should not exacerbate these problems. Furthermore, patient mobility is likely to be unevenly distributed, both in terms of the “receiving” and “sending” countries. Some Member States will experience a larger pressure than others. The pressure can also differ in relation to some specialised treatments, which could create problems in terms of shortage of healthcare professionals within some medical specialities.

HOSPEEM believes that patient safety is paramount. In countries that are receiving healthcare staff, there are issues for employers around the protection of patients and action to prevent dangerous healthcare professionals moving from country to country. HOSPEEM would support a system put in place where incidents of professional misconduct or criminal behaviour by healthcare professionals are made available to the relevant regulatory bodies or where one does not exist, to all healthcare employers across the European Union. This would help employers ensure the suitability of the staff they employ and help increase patient safety. Passing on information should be a simple process without additional financial burdens for employers.

An increase in cross-border healthcare treatment will raise issues about the communication and the training of staff. Increased patient mobility will result in increased demands on the healthcare professionals. If staff do not speak the language of the patients they are treating this could lead to an increased need (and therefore increased cost) for language and interpretation skills. Staff may also require increased training and new skills in order to better treat patients from different cultural backgrounds. HOSPEEM and EPSU are considering these issues in two social dialogue sub-committees on recruitment and retention and new skill needs.

QUESTION RESPONSES

1. What is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

Currently there seems to be a lack of solid information regarding cross border healthcare. Available data is insufficient but there is a feeling that figures could rise significantly in the future.

As discussed in greater depth above, any increase in cross-border healthcare will raise significant issues in the management of healthcare systems. These issues include:

- ▶ The systematic exchange of information
- ▶ A common definition of 'healthcare services' (hospital and non-hospital)
- ▶ The health and safety standards in each Member State
- ▶ The potential to lower healthcare standards in some Member States
- ▶ The potential to restrict access to healthcare
- ▶ The potential that 'mobile' patients could jump waiting lists in 'receiving' States thereby reducing access to healthcare of the resident population
- ▶ The financial sustainability of healthcare systems
- ▶ The need for increased training for healthcare staff
- ▶ Accelerated migration of healthcare professionals from the accession states
- ▶ The need for action to prevent dangerous healthcare professionals crossing borders.

2. What specific legal clarification and what practical information is required by whom (for instance, authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

HOSPEEM believes that the issue of funding the treatment of cross-border care and issue of liabilities need to be clarified. HOSPEEM would support passing on of information about professional misconduct or criminal behaviour by healthcare professionals and this being accessible across the European Union.

In general there will be a greater need for Member States to exchange information between them and to increase information to patients. The different legislation in the Member States in this area could create problems of ensuring equal patient rights. Practical and sufficient information between the Member States regarding treatment must be ensured with respect to the data protection regulations. Moreover it is essential that the patients receive proper and sufficient information prior to treatment in another Member State. This information should contain information about their rights, the treatment, the risk for complications, the liability rules, waiting time, etc.

3. Which issues (such as clinical oversight, financial responsibility) should the responsibility of the authorities of which country? Are these different for the different types of cross-border healthcare?

HOSPEEM feels strongly that with regard to cross-border healthcare the standards of care, governance and liability of the receiving country should apply.

4. Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

It should be the responsibility of Member States to regulate the types of treatment available to their citizens. HOSPEEM believes that the rule 'caveat emptor' (buyer beware) should apply. The safety regulations, quality standards, data protection regulation, patient rights, liability systems etc, of the country that provides the treatment/healthcare services should apply. Patients should not be able to seek redress from their 'home' healthcare system should something go wrong. This should be made clear to the patient at the referral stage. However depending on the legislation in the different European Member States, there is a risk that the patients will not have equal legal rights. Therefore it is crucial that patients receive proper and sufficient information about their rights prior to seeking treatment in another Member State.

Cooperation agreements and bilateral agreements between Member States concerning cross-border healthcare service could have other settlements and the possibility to enter into bilateral agreements, should not be affected by any European initiative concerning healthcare services.

The personal liability of healthcare staff who refer patients abroad needs to be clarified. Staff should not be liable if something goes wrong during the treatment of a patient they have referred abroad. This should be made clear and agreed by both the provider and funding body. In terms of permanent and contemporary presence of healthcare providers, the healthcare providers should apply to the rules of the country where they provide the service.

EQUAL ACCESS

✚ HOSPEEM members also feel that access to healthcare in the 'receiving' country also needs to be clarified. Patients who travel abroad for treatment should not be able to gain access to healthcare quicker than patients already on waiting lists in the 'receiving' country who have greater clinical need. Member States must retain the ability to manage their waiting lists and allocate resources.

5. What action is needed to ensure that treating patients from other Member States is compatible with the provision of balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in 'receiving' countries)?

An important and underlying principle of European health policy must remain the fulfilment of public provision of healthcare in the respective Member States. Thus intervention by the responsible public authorities is made with regard to the planning and commissioning of healthcare services. Ultimately, it must be ensured that whatever entity pays for healthcare services rendered is the principal.

MIGRATION

✚ In the long term the movement of health professionals could cause problems of people accessing health services. If there are significant movements in the numbers of health professionals leaving a Member State then the subsequent reduction in the number of professionals could leave patients unable to access treatment or have a lower quality of healthcare available. The migration of staff is already an issue within some Member States (particularly the "new" member states and acceding countries) and any proposals by the Commission should not exacerbate these problems. HOSPEEM and EPSU are currently working together in the Hospital Sector Social Dialogue Committee to find solutions to the problems of recruitment and retention of healthcare professionals.

**FINANCIAL
COMPENSATION**

✚ Furthermore as stated earlier, it is essential that the "receiving" Member State is ensured payment for the treatment of foreign patients. There are significant differences in how the European Member States organise and finance their healthcare systems, also in terms of reimbursement etc. In order to ensure the financial sustainability of the national healthcare systems, it must be ensured that the financial compensation is in accordance with the expenses and that the compensation are canalised back to the national healthcare systems.

6. Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers not already addressed by Community legislation?

In addition to the answer given against question 5 (please see above) there are several issues raised by the mobility of professionals. In countries that are receiving healthcare staff there are issues for employers around the protection of patients and action to prevent dangerous healthcare professionals moving from country to country within the European Union.

HOSPEEM would strongly support the passing on of information on professional misconduct or criminal behaviour by healthcare professionals. This would help employers ensure the suitability of the staff they employ and help increase patient safety.

The national law and the regulations in the collective agreements in the country where the healthcare service is provided, should apply to health professionals and healthcare providers, who permanently or temporarily are delivering healthcare services in another Member State.

An increase in cross-border healthcare treatments will raise issues about the communication and the training of staff. If staff does not speak the language of the patients they are treating then this could lead to an increased need (and therefore increased cost) for language and interpretation skills. Staff may also require increased training and new skills in order to better treat patients from different cultural backgrounds. Some consideration needs to be given to these potential costs as employers can not meet these costs alone.

Mobility changes will have an impact on training and education budgets, with greater potential movement of the workforce to areas where working conditions are at a higher level. This could have significant implications for the workforce and how we educate them.

Following the 1999 Bologna Declaration, a number of local universities have been participating in the “Tuning Educational Structures in Europe” project. This work has relevance to the issue of patient mobility, particularly in relation to workforce mobility and assuring safe practice.

Common competencies for Nursing and Occupational Therapy have already been completed, with on-going work on competences for medicine, radiography and social work. Whilst being focussed on education, the ultimate goal is to enhance workforce mobility throughout Europe.

7. Are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

8. In what ways should European Action help support the health systems of Member States and the different actors within them? Are there areas not identified above?

HOSPEEM believes that in order to assess the impact of any Community action on cross-border healthcare on respective national health systems, a clear methodology is required. In this respect European action could be taken to improve the availability and compatibility of Europe-wide indicators for both the health and social care sector.

9. What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

HOSPEEM believes that it could be an advantage to create common, legal guidelines concerning patient's rights and patient mobility in order to stop the European Court of Justice making policy in the healthcare arena through decisions in individual cases. It is essential that the European basic goal of free movement does not limit the European Member States' national competence in relations to the health care area.

HOSPEEM also believes that the issue around the sharing of information on health professionals by regulatory bodies, information to patients and financial compensation to receiving countries for the treatment of patients will require some form of legal certainty. Furthermore it should be clear, that the legal system (liability rules, safety regulations, collective agreements, quality standard etc) of the country where patients are treated and where health professionals and healthcare providers are delivering healthcare services should apply.

In closing, HOSPEEM states firmly that any action on European level that affects health systems across Europe as a whole, whether directly or indirectly should be based on the EC Treaty articles on public health rather than the internal market rules. Thus it would be ensured that any European action regarding health services respects the principle of subsidiarity.

ANNEX C. THE ISSUE

HOSPEEM RESPONSE TO THE FIRST STAGE OF CONSULTATION OF THE SOCIAL PARTNERS ON PROTECTING EUROPEAN HEALTHCARE WORKERS FROM BLOOD-BORNE INFECTIONS DUE TO NEEDLESTICK INJURIES

The European Commission has launched a first stage consultation of the European Social Partners (according to article 138 of the EC Treaty) on protecting European healthcare workers from blood-borne infections due to needlestick injuries. The consultation follows the adoption on 6th of July by the European Parliament of a resolution (hereby “the EP Resolution”) that calls the Commission to bring forward a legislative proposal for a Directive amending Directive 2005/54/EC. The questions that the Commission is asking are:

1. Do you consider it useful to take an initiative to strengthen the protection of European healthcare workers from blood-borne infections due to needlestick injuries?
2. Do you think that a joint initiative by the European Social Partners under Article 139 of the Treaty establishing the European Community would be appropriate?

POSITION STATEMENT

Needlestick injuries, whilst stressful and with the potential for transmission of a blood-borne infections to staff, are not a major cause of incidents in the healthcare sector in Europe. HOSPEEM members believe that there is sufficient legislation, at European and, consequently, national level, to manage and control the incidence of needlestick injuries, provided that legislation is followed. Effective management of needlestick injuries requires proper risk assessment, effective and regular training and updates and the provision, in those areas identified by risk assessment as being the most at risk, of safer devices that, if properly used, will reduce the transmission of blood-borne infections. It is not necessary, in areas identified as having little or no risk of transmitting bloodborne infection, to introduce more expensive safer devices.

HOSPEEM supports the principle of subsidiarity in this field. It is the responsibility of Member States to determine the details of regulations the framework of which has been set at European level. This is the approach, for instance, taken by Directive 200/54/EC. HOSPEEM would like this approach to be respected.

BACKGROUND

The EP Resolution on which the Commission consultation paper is based states that:

“A needlestick injury occurs when the skin is accidentally punctured with a needle that is potentially contaminated with a patient’s blood. Contaminated needles can transmit more than 20 dangerous blood borne pathogens, including hepatitis B, hepatitis C and HIV. The majority of these injuries are suffered by nurses and doctors, but other medical staff are also at significant risk, as are auxiliary staff such as cleaners and laundry staff and other downstream workers. Approximately 10% of workers in the EU are employed in the health and welfare sector with a significant proportion employed in hospitals. This makes healthcare one of the biggest employment sectors in Europe. Work related accident rates in the healthcare and social services sectors are 30% higher than the EU average. High on the list of hazards are exposures to biological agents especially HIV and the hepatitis B and C viruses”.

From HOSPEEM’s point of view it would not be possible to argue with any of these figures but the final assertion that exposure to biological agents is high on the list of hazards is, at best, misleading. For example, in the UK the four highest rated causes of sickness absence and reports to the Health and Safety Executive under current reporting arrangements are Stress, Musculo Skeletal issues, Slips and Trips, Violence by patients and visitors. These four causes account for some 90% of absence and reporting and are all in double figures (e.g. stress 30%plus, MSD’s 30%plus) whilst needlestick incidents are in the lower single figures by comparison. In Denmark the pattern is the same where most accidents are related to lifts, slips and trips, violence or the handling of machines / equipment.

In Germany, the most common causes for sickness absence are Psychological disorders, Respiratory Diseases, Diseases of the Muscular and Skeleton System, Cardiovascular Diseases and Digestive Tract Diseases.

“Percutaneous injury from hollow-bore blood-filled sharp objects is the primary route through which healthcare workers occupationally acquire blood borne and potentially fatal diseases. It is estimated that there are 1 million needlestick injuries in Europe each year.”

There is no argument about the primary route of transmission of blood-borne infections. The figures given for the possible number of needlestick injuries each year are, to the best of our knowledge, correct. However, to see this issue in perspective, they need to be seen in relation to the number of staff working in the healthcare sector across the European Union and the number of patients seen by healthcare professionals each year with the potential for use of a needle.

“High risk procedures include blood collection, IV cannulation and percutaneously placed syringes. Small amounts of blood can result in potentially life threatening infection. The risk of infection is dependent on various factors, such as the infection status of the patient, the virus load of the patient, the immune status of the staff member, the depth of the wound, the volume of blood transferred, the time between receiving and disinfecting the wound and the availability and use of post-exposure prophylaxis.”

“The prevalence of these infections is considerably higher in the healthcare setting than in the general population.”

“The risk of hepatitis B can be reduced by vaccination and, if administered rapidly post exposure prophylaxis can lower the risk of HIV transmission. For hepatitis C, however, such measures are not helpful.”

These are inarguable facts. However, it should be noted that for example in the UK all National Health Service (NHS) staff are vaccinated for Hepatitis B when they start work in the service. In Austria, Hepatitis B immunisation by the employer has been made compulsory for all healthcare workers attending to patients.

The Salzburg Clinic Holding (SALK) employs 4,900 staff and provides health services for 650,000 people in the Salzburg region and neighbouring regions. Five hundred thousand IV cannulations are used per year in the hospitals of SALK. In 2006, 300 occupational injuries (needlestick and stitch/sting) were reported of which 30% occurred in the operation theatre and 70% in inpatient and outpatient clinics. The number of these injuries has been consistent for many years with an annual variation of $\pm 10\%$. Seventy three injuries are demonstrably caused by needlesticks out of which 12 are related to patients with infectious diseases (HIV, Hepatitis B and C).

Since 1994 there has been an internal regulation in place which gives strict guidance to the procedure following needlestick injuries and related injuries caused by stitches and stings. In the 13 years since the introduction of monitoring of these injuries not one single case of secondary illness has occurred.

“Studies have shown that the use of safer instruments can significantly reduce the number of needlestick injuries. Independently of this measure, regular training and organisational measures can also significantly lessen the number of needlestick injuries. Therefore, as well as the use of appliances with safety features, emphasis should be placed on organisational measures such as established working procedures, training and instruction of workers and raising awareness of risky activities.”

The use of safer instruments can significantly reduce the number of needlestick incidents, if the safer devices are used properly. There is also some evidence that the reduction in incidents due to safer devices is partly due to the need to retrain staff before they use the device. The likelihood is that any device would prove safer if training had been given just before its use. It is interesting that there is also an insistence here on the use of improved and regular training, better risk awareness and improved working procedures. Failure to train and retrain staff, coupled with a lack of risk assessments and slack working practices can contribute significantly to needlestick injuries.

For some injuries, e.g. those caused by scalpel, lancet etc., risk minimising measures are hardly feasible. In those cases, a lot depends on the skilfulness and attention of the healthcare worker. It is, however, not necessary to introduce devices with protective mechanisms – e.g. for syringes/hypodermic needles – for which the effectiveness and the actual benefit cannot be proven, and which, increase the costs.

✚ The EP resolution that led to the present first stage consultation by the Commission makes the following statements as fact. “whereas needlestick injuries may lead to the transmission of more than 20 life-threatening viruses, including hepatitis B, hepatitis C, and HIV/Aids, and thus presents a serious public health problem” It is true that “life-threatening” viruses may be transmitted through a needlestick incident and this is probably not the place to enter into a debate about what constitutes “life threatening” and the timescales involved. It is, at best, disingenuous to portray it as a serious public health problem for the EU.

“whereas the prevalence of hepatitis B, hepatitis C, and HIV is increasing, and the United Nations programme to combat AIDS (UNAIDS) has reported that there are over 40 million cases of HIV and over five million cases of hepatitis C worldwide”

It has to be assumed that this paragraph is intended to show that the risk to healthcare workers of coming in contact with infected patients is increasing.

“whereas independent studies have shown that the majority of needlestick injuries can be prevented by better training, better working conditions, and the use of safer medical instruments”.

The references to training and better working conditions here should be noted. Increasing training and repeating it at regular intervals can have a great impact on reducing needlestick injuries. Ensuring that used needles can be disposed of at the bedside rather than having to carry them to a central sharps box also reduces the risk of accidents. In Denmark for example, different initiatives concerning the training of staff and information to them in relation to the safe use of needles have been introduced in several regional hospitals. These initiatives range from analysing the causes of needlestick accidents and changing the procedures accordingly to launching information campaigns for staff (thereby reducing the needlestick injuries by 37% in that specific hospital) and educating and training all new employees specifically to prevent needlestick injuries.

“whereas the existing European legislation protecting health workers from needlestick injuries has proved ineffective in practice,”

It is HOSPEEM’s view that the current legislation is perfectly adequate to protect health workers if it is implemented correctly. This is why HOSPEEM would like here to recall, as the consultation paper does itself, the number of directives that altogether certainly constitute an already appropriate legislative framework:

1. *Directive 89/391/EEC lays down general preventive measures to protect the health and safety of workers. The Directive contains minimum requirements concerning, among other things, risk assessment and the information, training and consultation of workers. In particular, Article 6 of this “framework” Directive contains general principles for prevention which the employer is obliged to implement, namely “avoiding risks”, “combating risks at source” and “replacing what is dangerous with what is not dangerous or with what is less dangerous”.*

2. *Directive 2000/54/EC contains provisions designed to protect workers from risks related to exposure to biological agents at work. The following provisions are particularly relevant in this context:*

- ▶ Biological agents are classified into four groups according to their level of risk infection (Article 2).
- ▶ In the case of any activity likely to involve a risk of exposure to biological agents the employer must carry out a risk assessment (Article 3).
- ▶ Where it is not technically practicable to prevent exposure to risk, the risk must be reduced to as low a level as necessary to protect adequately the health and safety of the workers concerned. This includes individual protection measures, drawing up plans to deal with accidents and safe collection, storage and disposal of waste (Article 6).
- ▶ Procedures for taking, handling and processing samples of human or animal origin must be established (Article 8).
- ▶ Appropriate measures must be taken in health and veterinary care facilities in order to protect the health and safety of workers concerned (Article 5).

3. Directive 89/655/EEC concerning the minimum safety and health requirements for the use of work equipment by workers at work is also relevant. Article 3 imposes an obligation on the employer:

- ▶ to ensure that work equipment is suitable for the work to be carried out and may be used by workers without impairment to their health and safety;
- ▶ to pay attention to the specific working conditions and hazards posed by the use of the equipment in question;
- ▶ to take measures to minimise the risks.
- ▶ In addition, Workers should receive information and training on the use of work equipment and any risks which such use may entail (Article 6 and 7).

4. Directive 89/656/EEC lays down that the use of personal protective equipment is required where risks cannot be avoided or limited by technical means or work organisation methods or procedures. All personal protective equipment must be adapted to the risks encountered, without increasing the level of risk. It must correspond to prevailing conditions at the workplace and be adapted to the person wearing it.

5. Directive 93/42/EC stipulates that “devices and manufacturing processes must be designed in such a way as to eliminate or reduce as far as possible the risk of infection to the patient, user and third parties. The design must allow easy handling and, where necessary, minimise contamination of the device by the patient or vice versa during use”.

Adding further paragraphs to current legislation or issuing a new Directive will not ensure the safety of healthcare workers. Effective monitoring of compliance with legislation at a national level is likely to have more effect. Additionally, the European Commission may want to consider an awareness raising campaign on the issue to raise its profile, for instance with the support of the European Agency for Safety and Health at Work (OSHA). HOSPEEM would be of course ready, after consultation with its counterpart in the hospital sector social dialogue, EPSU (European Public Services Unions), to give a proactive input to such a campaign.

The same availability, if not a call for direct involvement, relates to the guide to prevention and good practice in the hospital sector, which should include risks from biological agents that the Commission is currently planning. As Social Partners in the hospital sector we do feel that such a guide would be better issued by representative of employers and workers in the sector than by an external contractor as mentioned in the consultation paper.

The direct involvement of the hospital sector Social Partners in issuing such guidelines would very likely also have the effect of addressing the real concerns and sensitivity of potential healthcare workers. The EP resolution states that one of the main reasons why the care profession is unattractive is because of the daily risks involved. It is interesting to note that this assumption is not even referenced, contrary to most of the other assumptions of the text.

Having said that, HOSPEEM as representative of the employers in the hospital and healthcare sector all over Europe is fully committed to make healthcare profession more attractive and is aware that risk prevention is a key element. Instruments such as the guidelines quoted above can however be much more effective than adding to an already important set of legislation. Agreed guidelines would be compulsory for the signatory parties and their respective members at national, local and workplace level. This would therefore allow a much more effective monitoring of the implementation of the instrument on the ground.

FINANCIAL IMPLICATIONS

✦ HOSPEEM would also like to comment on the assumption made by the EP resolution as far as financial implications are concerned. The text says indeed, in relation to the financial implications of introducing safer devices:

“Numerous independent studies have examined the short and long-term benefits of investment in safer working practices and medical devices to prevent needlestick injury and each of these has concluded that, overall, economic savings will be achieved.”

Whilst this statement is true, it should be noted that there are higher costs involved in purchasing safer devices and that these only produce an economic saving when set against the future costs of needlestick incidents resulting in transmission of a blood-borne virus which may ultimately be life threatening.

These higher initial costs are what managers in healthcare settings will see. There would need to be an educational programme to point out the benefits and long term cost savings. With the aim to prevent needlestick injuries, more emphasis should be placed on training and re-training of staff, and possibly using best-practise examples, which also will help to reducing costs in the end.

CONCLUSION HOSPEEM answers to the commission consultation document are as follows:

1. HOSPEEM members (who cover both the Public and Private sector across the European Union) are not convinced that further legislation is necessary on this issue. **With regards to question one** about strengthening the protection of European healthcare workers from blood-borne infections due to needlestick injuries, HOSPEEM's view is that an initiative in this field should be taken, but not in the sense of strengthening an already ineffective (taking the Commission and EP assumption into account) Directive. The action should be to raise the profile of needlestick injuries and their effect on healthcare workers, across the European Union and to ensure a more effective implementation of current legislation.

2. **With regards to question two** about the appropriateness for the European Social Partners to take any initiative forward, HOSPEEM believes that the Social Partners are in a good position to tackle this issue and to bring pressure to bear at national level for better implementation of the current legislation. As the representatives of both employers and employees, joint action by the Social Partners in the hospital sector is more likely to bear fruit. Awareness raising campaigns, guide to prevention and good practice and effective monitoring of compliance with legislation at workplace level, as stated above, are some of those possible joint actions.

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ANNEX D. Introductory comments

HOSPEEM RESPONSE TO THE COMMISSION QUESTIONNAIRE ON THE PRACTICAL IMPLEMENTATION OF DIRECTIVE 2003/88/EC CONCERNING CERTAIN ASPECTS OF THE ORGANISATION OF WORKING TIME

This paper summarises the responses received from HOSPEEM members to the Commission's questionnaire. As a general remark, HOSPEEM members believe that patients should not be treated by tired staff and that staff are entitled to fair working conditions. While the Working Time Directive has been fully implemented by HOSPEEM members, the Directive and the subsequent rulings of the European Court of Justice (ECJ) have caused the hospital and healthcare sector problems and have imposed significant and unnecessary costs on hospital and healthcare employers.

The main problems emerging from the SiMAP and Jaeger judgments are around the interpretation of the term working time for on-call duties and the requirement for immediate compensatory rest. These rulings have caused serious problems in the operation of health systems and have led to Member States recruiting extra staff to prevent gaps in patient services at a large cost without improving productivity. HOSPEEM members have been both gainers and losers. In order to resolve the problems caused by the SiMAP and Jaeger judgments, some HOSPEEM members recruited staff from outside Europe as well as healthcare staff from the new Member States. Losing staff in this way has had a large adverse impact on those health systems.

1. TRANSPOSITION

- *Do you consider that the Working Time Directive has been transposed in a satisfactory way in the EU Member States?*

The Working Time Directive has been fully transposed in the Member States. However, the SiMAP and Jaeger rulings caused significant difficulties by defining all residential on-call time as work and stating that compensatory rest has to be taken immediately after a period of work finishes. These rulings have caused serious problems in the operation of health systems and led to Member States recruiting extra staff to prevent gaps in patient services at a large cost without improving productivity. HOSPEEM members believe that the interpretation by the ECJ of the definition of working time is incorrect and that revision of the Directive based on the compromise text proposed by the Finnish presidency should be taken forward.

- *If you consider that there is room for concern about transposition in specific sectors or concerning specific provisions, please give details.*

See above.

- *If you consider that transposition of the Directive has been particularly satisfactory in any respect, please give details.*

No comments received in relation this question.

- *Do you consider that any particular issues arise regarding implementation as concerns the previously excluded sectors (implementation of Directive 2000/34/EC)? If so, please give details.*

HOSPEEM members have been able to implement the Directive successfully in relation to previously excluded sectors although in some Member States it has led to large changes in working patterns. For example, in the National Health Service (NHS) in the UK there has been a significant change in working patterns for junior doctors. There has been a shift from predominantly on-call working to predominantly shift working.

These changes have not come directly from the Directive but have been driven by the SiMAP and Jaeger Rulings made by the European Court of Justice (ECJ) which have made on-call working impractical. The rulings have led to inflexible applications of working practices. For example, under the Jaeger Ruling, compensatory rest has to be taken immediately if the daily or weekly rest requirements can not be met. Danish Regions were amongst the HOSPEEM members who felt there should be sufficient flexibility in the approach to the timing of compensatory rest. Increased flexibility in relation to compensatory rest would create greater flexibility in the implementation of the Directive.

In order to make the changes necessary to comply with legislation and ECJ Rulings, European Health systems have needed considerable financial resources, which could have been used in a better way to help patients.

2. FORMERLY EXCLUDED SECTORS CONCERNING THE SCOPE OF FORMER DIRECTIVE 2000/34/EC (THE ‘EXCLUDED SECTORS DIRECTIVE’), PLEASE REPLY AS FOLLOWS:

- ▶ *Do you consider the transposition and application of Directives 2000/34/EC and 2003/88/EC satisfactory, as regards doctors in training?*

The implementation of the Directive in relation to doctors in training is considered satisfactory by HOSPEEM members. While the “direct” provisions of the Directive as implemented in the Member States is generally perceived to have been helpful (if difficult and in many cases costly), the implications of the SiMAP and Jaeger rulings have not. As stated above these rulings have led to inflexible applications of working practices.

- ▶ *Has this aspect been transposed in any Member States by way of collective agreement? Please give details.*

The responses received from HOSPEEM members indicate that this varies between countries depending on national industrial relations structure and traditions.

- ▶ *Please refer to any particular effects of transposition in this area, and to any positive or negative effects you perceive.*

The positive effects of transposition have included the reduction of the hours worked by junior doctors. This had been good for the health and safety of healthcare staff and for patient safety. No patient should be treated by tired staff and doctors are entitled to fair working hours.

Parts of European healthcare systems have clearly benefited from Working Time Directive compliance but there have also been significant costs which have resulted from the SiMAP / Jaeger judgments. In some cases the judgments have resulted in increased shift working which has reduced the amount of (better quality) daytime training opportunities for junior doctors. SiMAP / Jaeger has been particularly challenging for small and isolated hospitals.

3. SOCIAL PARTNERSHIP

- ▶ *Do you consider that the social partners have been sufficiently consulted and involved by the national authorities, regarding the transposition and practical implementation of the Directive?*

Yes. Responses received from HOSPEEM members indicate that the Social Partners have been sufficiently consulted and involved by the national authorities.

- ▶ *The Directive provides at Articles 17 and 18 for derogations by means of collective agreements or agreements concluded between the two sides of industry. Please indicate how you evaluate the experience in this regard. Are there any examples which you consider as providing models of good practice?*

4. MONITORING OF IMPLEMENTATION

- ▶ *Please indicate whether you consider that the enforcement and monitoring of the Directive at national level is satisfactory.*

HOSPEEM members are satisfied with the enforcement and monitoring of the Directive.

- ▶ *If you see any problems, please indicate their overall impact and make recommendations for improvement.*
- ▶ *Can you identify any examples of good practice as concerning monitoring and enforcement?*

5. EVALUATION

► *Please list any positive and negative aspects of the practical implementation of the Directive.*

Several HOSPEEM members have implemented the 2004 Working Time Directive requirements for doctors in training by recruiting thousands of extra doctors from abroad and adopting new and innovative working practices. However, the recruitment of extra medical staff from outside Europe and from some of the newer EU states has had an adverse effect on those health systems as many have experienced staff shortages.

A great deal of innovative work continues by HOSPEEM members to find new ways of working which comply with the Working Time Directive 2009 provisions and to improve services. For example, in the NHS in the UK many hospitals have implemented a project called Hospital at Night which uses multidisciplinary teams to provide the range of care patients need at night and replace demarcated teams.

Maintaining good quality medical education, quality of patient care and delivering on key priorities for improving patient services is made more difficult for HOSPEEM members by the restrictions on working patterns from the SiMAP/Jaeger Judgments. The SiMAP and Jaeger rulings have caused the HOSPEEM members difficulties by defining all residential on-call time as work and stating that compensatory rest has to be taken immediately after a period of work finishes. In the Netherlands, employers see a revision of the directive in relation to the ECJ judgment in respect to 'on-call' time as urgent.

The judgments have also resulted led to increased shift working in some health systems which has reduced the amount of (better quality) daytime training opportunities for doctors. They have also created difficulties in scheduling services. The nature of patient care means that staff sometimes need to work into rest breaks. The immediate compensatory rest requirement can occasionally result in some Member States in patient care being withdrawn because it is not always possible to arrange cover to replace staff taking immediate compensatory rest.

HOSPEEM members consider the Working Time Directive to be a useful addition to the health and safety of workers. However, because the subsequent Court rulings it has been expensive to put into operation and has been costly to health employers. HOSPEEM also believes that retaining the right for individuals to choose whether to voluntarily opt out is also essential to maintaining twenty four hour, seven day a week services to patients. In Germany the rulings of the ECJ have caused significant organizational and financial burdens and VKA particularly supports the introduction of a third time category (inactive time during on-call duty) as well as the retention of the opt-out.

Does the practical application of the Directive in the Member States, in your view, meet its objectives (to protect and improve the health and safety of workers, while providing flexibility in the application of certain provisions and avoiding imposing unnecessary constraints on SMEs)?

The practical application of the Directive has led to an improvement in the health and safety of healthcare workers and also to increased patient safety. However, as mentioned above, due to subsequent ECJ Rulings, the Directive lost some of its flexibility.

6. OUTLOOK

Please indicate:

- *any priorities for your organisation, within this subject area.*
- *any proposal for additions or changes to the Directive, stating the reasons.*
- *any flanking measures at EU level which you consider could be useful.*

HOSPEEM members generally support the proposals by the Finnish presidency to amend the European Working Time Directive to give greater flexibility over the timing of compensatory rest; to ensure that resident on-call time is not counted as work and to maintain the right for individuals to opt-out subject to reasonable safeguards. The amendment of the Directive should take precedence over any other flanking measures.

ANNEX E. INTRODUCTION

EPSU- HOSPEEM CODE OF CONDUCT AND FOLLOW UP ON ETHICAL CROSS-BORDER RECRUITMENT AND RETENTION IN THE HOSPITAL SECTOR

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

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

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

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

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

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

KEY PRINCIPLES AND COMMITMENTS

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

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

2. REGISTRATION AND DATA COLLECTION

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

3. WORKFORCE PLANNING

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

4. EQUAL ACCESS TO TRAINING AND CAREER DEVELOPMENT

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

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

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

6. FAIR AND TRANSPARENT CONTRACTING

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

7. REGISTRATION, PERMITS AND RECOGNITION OF QUALIFICATIONS

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

8. PROPER INDUCTION, HOUSING AND STANDARDS OF LIVING

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

9. EQUAL RIGHTS AND NON-DISCRIMINATION

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

10. PROMOTING ETHICAL RECRUITMENT PRACTICES

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

11. FREEDOM OF ASSOCIATION

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

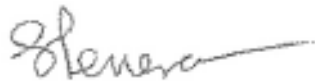
12. IMPLEMENTATION, MONITORING AND FOLLOW-UP

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

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

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

Brussels, 07 April 2008



Godfrey Perera
Secretary General of HOSPEEM



Carola Fischbach-Pyttel
Secretary General of EPSU

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ANNEX F.

EPSU HOSPEEM

JOINT DECLARATION ON

HEALTH SERVICES

14 NOVEMBER 2007

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

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

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

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

1. HOSPEEM and EPSU fully support the principles as set out in the articles 152 and 153 of the Treaty, and consider these articles to be the starting point and basis for any Community action on health. The European Community should thus fully respect the subsidiarity principle in any EU initiative on the field of health and/or health services. We are of the opinion that the funding, organization and delivery of health services should fall under the competence of individual Member States. We also emphasize that it is the role of the European Community to promote public health, and that it should aim to improve health care for all patients. It is not for the European Institutions to impose market and/or competition mechanisms in the health care sector, which could have as consequence the lowering of standards and increasing costs of health care systems and thus diminishing the accessibility to care.

2. Health services, including hospital services, are essential in guaranteeing human rights. It is part of the Member States' public responsibilities to promote the general interest including a high level of public health. Health care should therefore be organised on the basis of common European social values including solidarity, social justice and social cohesion. They should also follow the principles of general interest, like universality, accessibility and quality. It is essential that EU-internal market or competition rules do not limit the EU Member states' autonomy in the implementation of these national responsibilities.

3. To maintain and improve the level of services, Member states should maintain their autonomy to plan services and organize resources at a local, regional and national level. This includes the possibility to manage the concrete delivery of services to patients by effective planning and organizing. Without proper coordination, a high rate of cross-border patient mobility can seriously harm the possibilities for governments and authorities to organize the care in a financially sustainable way. It could also endanger equal access to health care. Authorities therefore should be encouraged to coordinate both the incoming and outgoing patient movements by setting up transparent and fair procedures for cross-border care including referral systems, authorization procedures and financial compensation schemes.

4. It is important that local and regional health care facilities meet the health care needs of the population and ensure patient safety. Patient care is paramount and this will be difficult to guarantee without a well-trained and motivated workforce. Health care authorities and providers should take all actions necessary to promote high quality health care staff, be it in the recruitment, the training or the employment of health workers. In cases of cross-border mobility of health workers, adequate monitoring and registration systems should be established in order to enable work force planning, assist a quick exchange of information and facilitate the mutual recognition of qualifications. Cross-border health workers should have the rights and responsibilities according to the legislation and the collective agreements of the country in which they do their work.

5. *Cross-border health care should only take place if that is in the best interest of the patient. As the care provision should in principle be liable to the rules and regulations of the country in which the care is provided, information about health care standards, the delivery of services and its regulatory framework should be made available to patients, so that patients are fully aware of potential problems and complications of receiving treatment in another country. In cases of crossborder cooperation between health care authorities and facilities, other settlements, such as bilateral agreements, could prevail in order to meet national requirements and obligations towards patients and workers.*

6. *Health services are a key element of the European Social Model, especially in relation to social and territorial cohesion. They have a critical role to play in the economic and social development of Europe, including in the achievement of the Lisbon objectives. At the same time, a common European approach is needed to safeguard, support and nourish healthcare services so to ensure that they continue to serve the public interests, while able to respond to the challenges generated by globalisation. For those reasons, HOSPEEM and EPSU strongly believe that*

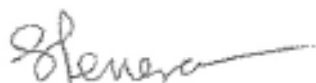
► *Sufficient legal clarity for authorities and providers is needed to guarantee an appropriate delivery of services at national, regional and local level, and to avoid further interventions by the European Court of Justice;*

► *The principle of subsidiarity should be fully respected in the financing, planning and operation of healthcare services at national, regional and local level;*

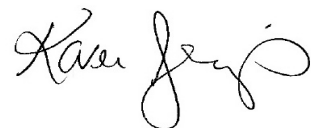
► *A common evaluation needs to be carried out about the interface between the private sector and public services, ensuring, for instance, that public/private partnerships would not be detrimental to high quality, effective and solidaritybased healthcare services*

► *Healthcare systems should be governed by the awareness that forward-looking and long-term investments in the service-provision would result in considerable improvements in the population's health status and consequently lead to (financial) benefits and savings that are favourable to the community as a whole. Health should be considered as a growth factor.*

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



Godfrey PERERA
Secretary General of HOSPEEM



Karen JENNINGS
President of EPSU Standing
Committee Health and Social Services

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ANNEX G. 1. INTRODUCTION

WORK PROGRAMME OF THE EUROPEAN SOCIAL DIALOGUE COMMITTEE IN THE HOSPITAL SECTOR IN THE EUROPEAN UNION

(2006-2007)

The Committee's work programme is multi-annual (initially for two years) and sets out the strategy and goals we want to achieve and the themes to jointly react on.

The programme deals with a limited number of topics / issues in order to ensure qualitative results.

2. OBJECTIVES

HOSPEEM and EPSU shall aim to strengthen the possibilities of the social partners to shape the future developments regarding employment in the hospital sector and to articulate European, national, regional and local levels of social dialogue. The Social Partners shall in particular:

- ▶ Promote quality hospital services based on values of social responsibility and accountability.
- ▶ Actively contributing to the shaping of the debate at European level on the delivery and organisation of hospital services.
- ▶ Organise activities to strengthen social dialogue between employer and trade unions organisations in the hospital sector in the new Member States;
- ▶ Complement the work of the cross-sectoral social partners where appropriate;
- ▶ Address initiatives by the European Commission in the field of employment policy and other policies having an impact on the hospital sector.
- ▶ Participation in the Commission's policy-making and activities on the European sectoral social dialogue, including the Liaison Forum for the Adaptation and Promotion of Social Dialogue.



3. THEMES

Suggested themes are:

- ▶ Statement supporting the establishment of working groups in the agreed subject areas of;
 - ▶ **RECRUITMENT AND RETENTION**
 - ▶ One working group.
 - ▶ Identifying common positions for cross-border recruitment of hospital personnel
 - ▶ **THE AGEING WORKFORCE IN THE HOSPITAL SECTOR**
 - ▶ One working group;
 - ▶ Identifying member state and regional initiatives to promote realistic active ageing policies.
 - ▶ **NEW SKILL NEEDS IN THE HOSPITAL SECTOR**
 - ▶ One working group;
 - ▶ Defining existing categories of hospital professionals and workers. Identifying successful training initiatives and weak-points.
- ▶ Organisation of a seminar and workshops on industrial relations to support the development of social dialogue in the hospital sector in the new Member States;

4. IMPLEMENTATION

Following agreement on these broad lines of the work programme, a more precise programme will be drawn up with the European Commission to fix the timetable and detailed arrangements for implementation of the work programme.

ANNEX H.

WORK PROGRAMME OF THE EUROPEAN SOCIAL DIALOGUE IN THE HOSPITAL

SECTOR (2008-2010)



✚ **EPSU** and **HOSPEEM** agreed in the Social Dialogue Committee for the Hospital Sector on 7 December 2007 to continue their work and their joint partnership approach as developed during the period of their first work programme in 2006-2007. This work will serve as basis for further activities in the Hospital Sector Social Dialogue as presented in this work programme. The work programme will cover a period starting from the date of the signature until 31 December 2010. This timing gives the Social Dialogue Committee better opportunities for planning, complete and follow up on the priorities for the period. Halfway in the period the Committee will take stock on the work in order to make eventual changes in the planned activities and priorities where appropriate.

The main priority for HOSPEEM and EPSU in the coming years is to strengthen the social dialogue in the hospital sector at European, national and local level and take up our responsibilities as the recognized social partner European organizations for employers and workers in the hospital sector.

EPSU and HOSPEEM therefore want to make, where appropriate, active use of the opportunities and possibilities to influence EU policy development as offered by the European Treaty to the social partners. This includes an active involvement in the European consultation procedures in those cases where the initiatives would have an impact on the hospital sector and its workforce, but also to develop as social partners own initiatives using the available bipartite and autonomous social dialogue instruments.



✚ **HOSPEEM AND EPSU COMMIT THEMSELVES:**

- ▶ to enhance the representativeness of their organizations in the hospital and health care sector throughout the European Union and its candidate-members.
- ▶ to support the development and the strengthening of European, national and local social dialogue structures in relation to the hospital sector
- ▶ to promote an interactive exchange of knowledge and experience in the fields of health sector and social policies between different national social partner organizations and their representatives
- ▶ to monitor and where appropriate react on European Commission social and health policy initiatives, which will have an impact on the hospital sector work force and organization.
- ▶ to maintain an active working relationship with the relevant cross-sectoral partners and complement their work where suitable.
- ▶ to develop policies and instruments to support a social and sustainable workforce management within the hospital sector in the EU.
- ▶ to promote quality hospital services based on the shared principles as agreed in the joint EPSU-HOSPEEM Declaration on Health services of December 2007.
- ▶ to promote application of equality principles and legislation.
- ▶ to further explore how the organization of healthcare systems influence work organization in the hospital sector In order to reach all the above mentioned goals, EPSU and HOSPEEM commit to focus in particular on the following actions:
 - ▶ Strengthening hospital and healthcare social dialogue structures, using a social partnership approach in capacity building and cooperation:
 - towards the launch of joint social dialogue projects at regional, national and/or cross-border level

- towards encouraging and supporting national affiliates to make use of available resources for social partnership funding under the European Social Fund programme 2007-2013

- ▶ Retention: Developing a sectoral initiative, building on ongoing cross-sectoral work on reconciliation of work and family life with a specific focus on work organization

- ▶ Creating specific instruments to face the challenges of an ageing work force through an ad hoc project

- ▶ Addressing the challenges related to new skill needs by:

- collecting and exchanging practices and experiences in the field of education and training, management of health care, and interaction between technology, ICT, skill needs and/or work-force planning and assessing the consequences of the different developments for work organization and workers, with a specific focus on education and training, skills mix and healthcare management

- on that basis, working towards a joint initiative on the basis of the Cross-Sectoral Framework of Actions for the lifelong development of competences and qualifications) in order to meet the sectoral needs

- ▶ Developing an adequate response to the phenomenon of 3rd party violence. HOSPEEM and EPSU do not consider this work programme to be exhaustive. The parties may thus jointly decide to up-date it in the light of relevant developments in the EU. Brussels, 23 June 2008

KAREN JENNINGS
President Health and Social Services Committee
EPSU

GODFREY PERERA
Secretary General
HOSPEEM



ANNEX I.

HOSPEEM POSITION

STATEMENT ON THE

PROPOSAL FOR A

DIRECTIVE OF THE

EUROPEAN

PARLIAMENT AND

OF THE COUNCIL

ON THE

APPLICATION OF

PATIENTS' RIGHTS

IN CROSS-BORDER

HEALTHCARE

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

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

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

✦ THE DIRECTIVE

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

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

HOSPEEM questions that Article 95 of the EC Treaty, relating to internal market harmonisation, is the proper legal basis for a Directive on the application of patients' rights in cross-border healthcare. In contrast to the view of the European Commission, HOSPEEM sees a fundamental conflict between Article 95 and the principles enshrined in Article 152 of the EC Treaty which outline the responsibilities of the Member States to fund, organise and deliver health services.

✦ SUBSIDIARITY

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

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

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

Member States should be able to retain the right to plan services and manage resources in order to ensure the financial viability of their health systems. HOSPEEM members believe it is important that when patients go abroad for treatment then their home health system, as the financer of the care, is able to decide what treatment is most appropriate. HOSPEEM members believe that if European health systems are not able to plan the provision of services and the workforce that is needed to deliver this healthcare, then patients may suffer. On that basis HOSPEEM finds, that it should be left for the individual Member States to define what can be regarded as hospital care and therefore subject to prior authorisation procedures.


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

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

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

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

PRIOR AUTHORISATION PROCEDURES

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

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

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


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

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

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

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

HEALTH INEQUALITIES

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

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

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

HOSPEEM takes the view that serious consideration should be given to the fact that an increasing number of the patients currently not moving across borders (over 90% of EU patients) is made up of older people, meaning not strong patients. Demographic change and the ageing population in Europe means there will be a growing number of older people in the years to come. This seems to contradict the effort deployed by the Commission and strongly supported by HOSPEEM, to invest in solutions to the problem of the ageing EU population. Moreover, being the provider and employer in healthcare services, HOSPEEM members increasingly experience the need to create a proper infrastructure for long term and elderly care and would see a political effort in that sense at EU level, much more effective than in the field of patients' mobility.

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

❖ OVERARCHING VALUES

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

❖ NATIONAL CONTACT POINTS AND THE COLLECTION OF DATA

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

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

❖ PATIENT SAFETY AND ADDITIONAL COST ISSUES

❖ HOSPEEM believes that the safety of patients is paramount. It is therefore concerned about the situation a patient might find themselves in when things go wrong with their treatment. We have concerns about after care services, for example homecare, physiotherapy, further hospital care where the patients have returned to their home state, after treatment in another Member State. HOSPEEM asks for further clarity on the issue of aftercare services, continuing care, malpractice etc., including the issue of how the home state will be reimbursed for the potential additional costs.

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

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


❖ CONCLUSION


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


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


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