

Activity REPORT

2010



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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.

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. **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)
- Anette DASSAU (VKA)
- Helen BOYER (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, its recognition 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 (ARAN)
- Vice Secretary General – Christina Carlsen (Danish Regions) Miroslav Jiránek (Czech Moravian Hospital Association) is currently covering for Ms Carlsen while she is on maternity leave

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

- The HOSPEEM Board members
- Ludwig Kasper (VÖWG)
- Brendan Mulligan (HSE – Irish Employers Agency)
- Annette Dasau (VKA)
- Miroslav Jiránek (Czech Moravian Hospital Association)

> HOSPEEM steering committee renewed its composition in 2010:

- Godfrey Perera - Chairman
- Miroslav Jiranek – Vice-Chairman
- Tjitte Alkema
- Jevgenijs Kalejs
- Ulrike Neuhauser
- Eva Weinreich-Jensen

> A further vote on the make up of the positions of Secretary General and Vice Secretary General was in 2010:

- Secretary General – Godfrey Perera
- Vice Secretary General – Miroslav Jiranek

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

III. MEMBERSHIP

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

- The Austrian Hospital and Health Services Platform – Austria
- HIC “NADEJDA” JSC - Bulgaria
- Association of Czech and Moravian Hospitals – Czech Republic

- Danish Regions – Denmark
- FEHAP – France
- Vereinigung der kommunalen Arbeitgeberverbände – VKA - Germany
- HSE - Employers Agency – Ireland
- Agenzia per la Rappresentanza Nazionale delle Pubbliche Amministrazioni (ARAN) – Italy
- Latvian Hospital Association – Latvia
- Vereniging van Ziekenhuizen (NVZ) – The Netherlands
- SPEKTOR (Arbeidsgiverforeningene) – Norway
- Swedish Association of Local Authorities (SALAR) – Sweden
- NHS Employers – United Kingdom
- The Lithuanian Association of Healthcare Organisations
- CLAE - Finland

> 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.

IV. REPRESENTING MEMBERS VIEWS

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

> As 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 154 of the TFEU (Treaty on the Functioning of the European Union) to consult HOSPEEM on any draft proposals concerning social policies in the hospital sector. Moreover, HOSPEEM has the opportunity to give its views on open consultations relevant to the healthcare sector, such as those launched by the Directorate General on Health and Consumers-SANCO. As a result, HOSPEEM has responded to several European Commission consultations on behalf of its members. The responses submitted have been formed from a consensus view of all the members. HOSPEEM has responded to the

Commission on a number of issues that are relevant to the hospital and healthcare sector. The issues were:

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

> The full versions of the responses submitted to the Commission are included in annexes A, B, C, D, E and F.

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. In 2010:

> As part of the process which saw HOSPEEM recognised as a Social Partner, Godfrey Perera (Secretary General of HOSPEEM), together with Carola Fischbach-Pyttel (EPSU General Secretary), met with László Andor, Commissioner for Employment, Social Affairs and Equal Opportunities at the European Commission and Armindo Silva Director in the Directorate Social Dialogue of DG EMPL on 22nd June 2010. The topic of the discussion was the working time directive and the position of the European hospital sector on this issue. Access to Mr Andor 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.

> Mr Perera was invited, together with Mr. Frank Siebern-Thomas (European Commission) and Bernadette Segol (UNI-Europa) to the seminar "Regional social dialogue for growth, employment and sound

industrial relations in the services sector: Sharing experiences from ASEAN¹ and the EU”, that took place in Hanoi on March 31st to April 1st 2010. The seminar was organised by the Vietnamese Ministry of Labor and Friedrich-Ebert-Stiftung (FES). Mr Perera and Ms Segol were invited to the seminar to present how sectoral social dialogue is rooted and practically works in the European Union. In particular, Mr Perera was asked to give a presentation on the health sector agreement on sharps injuries.

> Mr Perera was invited by the European Association of Senior Hospital Physicians (AEMH) to speak at the conference “Doctors’ involvement in Hospital Management”. Mr Perera presented the employers’ point of view on doctors managing health services in the 21st century.

> Mr Perera and Ms Fischbach-Pyttel participated at the ILO Health and Safety Expert Meeting in Geneva to speak about the agreement on sharps injuries to a panel of international experts. This is a very important recognition by the International Labour Organisation (ILO) and the World Health Organisation (WHO) on HOSPEEM role in the European health sector.

> Mr Perera was also invited to the Ministerial Conference “Investing in Europe’s health workforce of tomorrow: scope for innovation and collaboration” that took place on 9 and 10 September 2010. Mr Perera presented in that occasion the work done in the Hospital Sector since its creation in 2006.

> On 30th September 2010, a Liaison Forum was organised by the European Commission on the development of the sectoral social dialogue committees. At this meeting the European Commission arranged an official signing ceremony of the agreement in front of the press. When the agreement was signed by the Secretary Generals of the organisations involved in the Multi-sectoral negotiations, Mr Perera, as Chairman of the negotiations team, gave a speech highlighting the importance of this agreement for both patients and staff.

> On 6th October 2010 Mr Perera was invited to a meeting with the Latvian Health Minister Mr Didzis Garvas. This meeting was also attended by Mr Jevgenijs Kalejs, Chairman of the Latvian Hospital association. Mr Perera discussed with the Minister the Healthcare Directive, the Directive on prevention from sharp injuries, the project “Strengthening social dialogue in the hospital sector in the Baltic countries” and the financial problems affecting the healthcare sector, in particular the financial problems affecting the healthcare sector in Latvia. During the discussion the Minister emphasised that should be taken further actions to improve the efficiency of the healthcare sector by the developing out-patients care. The Minister also commended and

¹ The Association of Southeast Asian Nations <http://www.aseansec.org/64.htm>

thanked HOSPEEM for the work they were doing to improve social dialogue in Latvia.

> On 7th December 2010 the WHO Regional Office for Europe organised a joint meeting of WHO Collaborating Centres (CCs) for Occupational Health and the National Focal Points on Workers' Health (NFPs) to launch the European Network for Workers' Health in Bonn. Mr Perera and Ms Fishbach-Pyttel were invited to this meeting to present the Framework Agreement on Prevention from Sharp Injuries in the Hospital and Healthcare Sector.

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.

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 TFEU (Articles 153-155).

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

- 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 155.

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

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

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

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

VI. HOSPEEM SUCCESSES

> As a Social Partner, HOSPEEM has jointly taken forward several strands of work with EPSU (The European Federation of Public Service Unions), its partner in the 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 G.

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

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

> HOSPEEM responded to this draft Directive in a position statement (annex K) which emphasised:

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

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

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

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

issues. It looked at the role of Social Dialogue in the privatisation of healthcare and at the migration of healthcare professionals in Europe.

> The migration of healthcare professionals across borders is an issue that affects many HOSPEEM members. This is particularly an issue in some of the new Member States 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.

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

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

> Godfrey Perera, Secretary General of HOSPEEM was also asked by the European Parliament, together with EPSU, to appear before them to answer questions on why the social partners wished to negotiate on a subject they had been working on for a number of years. The members of European parliament were displeased by the fact that the social partners had intervened and that the Commission had agreed with social partners, allowing them to negotiate an agreement. Part of the Parliament's concern was the fact that once the social partners had made an agreement, which was going to be transposed into a directive, they would have no say in the matter and would have to rubber stamp the agreement.

> HOSPEEM and the EPSU agreed a framework on the prevention of sharps injuries on 2 June 2009 (annex L). This agreement has now been approved by the European Commission and was signed by representatives from HOSPEEM and EPSU on the 17th July 2009 in the presence of Commissioner Spidla at the European Commission. The agreement now needs to be approved by the European Council of Ministers and passed to the European Parliament after which a Directive will be issued. This will set the legal standard across members

of the European Community. The Commission expect a directive towards the end of the year or early 2010.

> The purpose of this framework agreement is:

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

> The benefits of this agreement are:

- there will not be a directive on the use of the new safety needles for all treatments. According to the agreement the risk assessment will decide when and if the new safety needles should be used. As the new needles can cost as much as up to ten times the cost of the current needles and if the directive proposed by the Commission had gone through it would have had significant cost implications for our health budget.
- this agreement stresses the importance of risk assessment and requires employers to put in place procedures to avoid injuries with medical sharps including needlesticks.

Multi sectoral initiative and Guidelines 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. A meeting between a number of sectoral employers (HOSPEEM, CEMR, CoESS, EuroCommerce) was organised and this was followed by a joint meeting with the trade unions (EPSU and UNIEuropa). At this meeting the employers elected Mr Perera to be the chair of the employers group. At the joint meeting with the trade unions it was agreed by all the parties involved that further research was necessary.

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

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

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

> On 30th September 2010, at the Liaison Forum on the development of the sectoral social dialogue committees, the European Commission arranged an official signing ceremony of the agreement in front of the press. When the agreement was signed by the Secretary Generals of the organisations involved in the Multi-sectoral negotiations, Mr Perera as Chairman gave a speech highlighting the importance of this agreement for both patients and staff.

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

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

> Dissemination will specifically focus on the framework agreement reached at sectoral level in 2009 on sharps injuries. Good practice sharing will relate to a priority of the work programme agreed by EPSU and HOSPEEM for 2010 and the activities of one of its working groups on skills development in the sector. Finally, the project will focus on involving employer and trade union organisations in the sector in Latvia,

Lithuania and Estonia to help them develop their national sectoral dialogue in order to allow them to feed their own priorities, concerns and good practices to the European level.

- **Specific objectives**

- I. To build on the activities and findings of a previous project completed in 2008 which focussed on strengthening social dialogue in the hospital sector in all new Member States. This project involved the identification of relevant social partner organisations and social dialogue processes in all EU countries, as well as providing capacity building to social partner organisations in the Czech Republic and Slovakia. This new projects hopes to draw on the organisations and priorities identified in this report for the Baltic countries and provide similar capacity building measures in Latvia and Lithuania (where HOSPEEM currently has members) and to follow up contacts with relevant employers organisations in Estonia to establish if similar activities can be envisaged between the social partners in this country, which could ultimately boost the representativity of HOSPEEM in this country and to add value to the European social dialogue process.
- II. To contribute to the dissemination of the framework agreement on *sharps by assessing its potential impact and implementation* and organising a dissemination event in Latvia.
- III. To contribute to the proceedings of the working group on retention and skills development by gathering good practice examples to be discussed at two seminars in Lithuania and Estonia and shared at the final dissemination event.

Steering Committee Meeting – Riga, 5th October 2010

> On 5th October 2010 the first meeting between the organisations (HOSPEEM, EPSU, Latvian Hospitals Association, Trade Union of Health and Social Care Employees of Latvia, Estonian Hospitals Association, Lithuanian National Association of Health care organizations, SALAR and Kommunal) that support the project took place in Riga. The scope of this first meeting was to discuss the objective and the development of the research, carried out by the external expert from GHK, Ms Tina Weber and her team. The meeting was very positive, and was considered a success by all involved. The participation of Latvian

Hospital stakeholders was large. The meeting was attended by the Chief Executives of most of the biggest hospitals in Latvia, as well as the former Minister of Health and the ex Mayor of Riga. All the representatives expressed their interest in the project and their willingness to contribute to the achievement of a successful result with it.

> The representatives from Latvia, Lithuania and Estonia, gave a short presentation of the situation in their country. They all mentioned the severe financial situation in the Baltic countries, in particular stressing the difficult situation of the healthcare sector, which has experienced huge cuts, especially in Latvia and Lithuania. Mr Perera asked the participants to provide HOSPEEM with some figures in order to help in discussion with the Commission and other actors in the European arena.

> HOSPEEM is now organising the next seminar that will be held in Vilnius on 15th February 2011. After that, there will be a seminar hosted by the Estonian Hospitals association in March 2011. A final conference will be held in Riga in May 2011.

> During the final conference we will present the results of the project. The intent is to provide successful good practices between Estonian, Lithuania and Latvia and other Nordic countries.

The Meeting between the Latvian Minister for Health and Godfrey Perera - 6th October 2010

> Mr Perera was invited to a meeting with the Latvian Health Minister Mr Didzis Garvas. This meeting was also attended by Mr Jevgenijs Kalejs, Chairman of the Latvian Hospital association.

> Mr Perera discussed with the Minister the following issues:

- The Healthcare Directive;
- The Directive on prevention from sharp injuries;
- The project "Strengthening social dialogue in the hospital sector in the Baltic countries";
- The financial problems affecting the healthcare sector, in particular the financial problems affecting the healthcare sector in Latvia.

> During the discussion the Minister emphasised that should be taken further actions to improve the efficiency of the healthcare sector by the developing out-patients care. The Minister also commended and thanked HOSPEEM for the work they were doing to improve social

dialogue in Latvia. The Minister then invited Mr Perera for a further meeting in Latvia after the conference in May.

> Following this meeting, the Latvian health Ministry issued this press release:

“The involvement of health care sector NGO’s in the decision making of high importance issues gives an opportunity for eventually best problem solutions. Therefore the proposals and warnings from professionals should be taken into account in the development process of next year’s budget. In my opinion, the health care budget should not be subject for further decrease and taking into account all the financial possibilities in future the health care budget should make 4% of the GDP in order to stabilize the health care sector”, said the Minister for Health of the Republic of Latvia Didzis Gavars in the meeting with Godfrey Perera, Secretary General of the European hospital and healthcare employers' association and Jevgenijs Kalejs, the Chair of Latvian Hospital Association.

VII. THE HOSPEEM - EPSU WORK PROGRAMMES **2006 - 2007 | 2008 – 2010**

> 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.

> 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 I.

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 paragraph 6.3.

> 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 J.
- > 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.

Work programme 2011 -13

In the Sectoral Social Dialogue Committee for the Hospital Sector on both 18 December 2010 (Plenary Meeting) and 31 January 2011 (Working Group) EPSU and HOSPEEM reaffirmed their **commitment to continue their work and partnership approach** as developed in the context of their first two joint work programmes 2006-2007 and 2008-2010.

The main general tasks for HOSPEEM and EPSU will remain in the coming three years to **strengthen the social dialogue** in the hospital sector at European, national, regional and local level and to **take up our responsibilities as the recognised social partner European organisations** for employers and workers in the hospital sector.

The **third joint work programme** covers the period from **2011 to 2013**. There is ample evidence from the second period 2008-2010 that a three years work programme is instrumental for the Sectoral Social Dialogue Committee to discuss, plan, implement, complete and follow up on agreed priorities. Halfway through this period, in autumn 2012, the Committee will take stock of the work accomplished by then and assess its outcomes in order to – where appropriate – adapt planned activities and/or update priorities. The EPSU-HOSPEEM Work Programme 2011-2013 sketches out **planned activities and projects** under the European Sectoral Social Dialogue in the Hospital Sector.

It reflects the intention of both European social partners in the field of health and social service to pursue their work under **three reference frames**, by concretely

- Making active use of the HOSPEEM-EPSU Framework of Actions “Recruitment and Retention”, adopted on 17 December 2010 by developing targeted activities and joint projects in view of improving the quality of services, their effectiveness and efficiency as well as working and employment conditions
- Taking up and contribute to the implementation of the European Action Plan on the Health Care Workforce (to be adopted during 2011) to address challenges in particular related to qualification, ageing, the cross-border mobility of patients, workers and service providers and the use of eHealth
- Implementing and further developing on all levels – enterprise, sector, member state, EU, as appropriate – documents adopted and agreements concluded until the end of 2010 in the context of the European Sectoral Social Dialogue.

The **three main priorities** at least until mid 2012 as identified at the 31 January 2011 Working Group of the Sectoral Social Dialogue Committee were

- Qualifications and skills
- Ageing workforce and balanced workforce development and planning
- Cross-border mobility of workforce within the EU and migration from third countries

The planned activities and projects are being complemented in a continuous manner by a **three transversal tasks** HOSPEEM and EPSU.

The first consists in building up and strengthening the capacity of social partners in the sector across all Member States to engage in collective bargaining and cooperation on different levels and in different contexts (social dialogue; decision making processes; tripartite arrangements). A particular focus will be on Central and Eastern Europe.

- HOSPEEM-EPSU project on social dialogue in the Baltic countries (2010-2011)

- Organising three events (workshops; conference) in 2011, in Vilnius, Tallinn and Riga
- HOSPEEM and EPSU members to fill in questionnaire
- Presentation of analysis of questionnaires dealing with three topics: retention and recruitment; skills development; transposition of Directive 2010/32/EU on the prevention from sharp injuries in the hospital and health care sector
- Discussing GHK project report, its insights and conclusions in view of improving the functioning and effectiveness of social dialogue in the Baltic countries and beyond
- Exploring further steps for the Baltic countries and/or similar projects for other countries to address specific needs and weaknesses identified in view of capacity building of social partners
- HOSPEEM and EPSU will encourage and support to the extent possible national affiliates to make use of available resources for social partnership funding under the European Social Fund and PROGRESS

Secondly EPSU and HOSPEEM also endeavour doing joint efforts and activities

- to enhance the representativeness of their organisations in the hospital and health care sector throughout the European Union and its candidate countries;
- to support the development and the strengthening of European, national, regional and local social dialogue structures in relation to the hospital sector;
- to promote an exchange of knowledge and experience in the fields of health care, social and employment policy between social partner organisations and their representatives;
- to maintain an active working relationship with the relevant cross-sectoral partners and complement their work where suitable, also building on their Joint Declaration on Health Services, signed 7 December 2007.

Thirdly, EPSU and HOSPEEM intend to influence policy developments at EU level on the basis of the Lisbon Treaty. This includes policy monitoring and an involvement in European consultation procedures or legislative initiatives in those cases where the initiatives would have an impact on the hospital sector, its financing, organisation, regulation and workforce. HOSPEEM and EPSU reaffirm their ambition to develop as social partners own initiatives using the available bipartite and autonomous social dialogue instruments. They will promote the application of equality principles and legislation – where appropriate and agreed.

Looking at European consultation procedures or legislative initiatives (as known at the time of setting up this work programme and therefore

subject to later changes), EPSU and HOSPEEM intent to put particular emphasis on

- Evaluation, consultation and revision of the Directive on the Recognition of Professional Qualifications 2005/36/EC of 30 September 2005
- Directive on Patient Rights in Cross-border Healthcare (expected to be adopted by the European Parliament and the European Council during 1st half of 2011)
 - Monitor implementation, building on joint HOSPEEM-EPSU statement.
 - Explore idea of producing a joint HOSPEEM-EPSU assessment paper of the process of transposition in national legislation and administrative practice; including recommendations as to appropriate possible further adaptations
- European Voluntary Quality Framework on Social Services of General Interest (SSGI), adopted by the Social Protection Committee (SPC) on 12 October 2010, endorsed by the EPSCO Council on 6 December 2010

HOSPEEM and EPSU do not consider this work programme to be exhaustive. The parties may thus jointly decide to up-date it, e.g. in the light of relevant developments in the EU.

VIII. RELATIONSHIP WITH CEEP

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.

HOSPEEM is, since its creation, an individual member of CEEP. Between the two organisations there is a close link and they collaborate closely in the European arena on all issues that concern employment and health of the European workforce.

IX. 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.

X. CONCLUSION

> 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. The recent invitation by the World Health Organisation to discuss the Sharps Directive at their conference in Bonn in December 2010, shows that HOSPEEM is recognised by the world health community as one of the important voices on health issues in Europe.

> 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 TFEU (Articles 153-155). This allows, and will continue to allow, HOSPEEM members a voice at the European top table. It is important that HOSPEEM continues to grow 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.

XI. ANNEXES



ANNEX A. HOSPEEM response to the Consultation regarding Community action on health services JANUARY2007

> 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 THE 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 EMPORTOR (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 B. *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 ISSUE

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 +/- 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.

CONSULTATION PAPER ASSUMPTION

The EP resolution that lead 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 needlesticks 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 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.

FINANNCIAL 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.

ANNEX C. HOSPEEM response to Commission questionnaire on the practical implementation of Directive 2003 / 88 / EC concerning certain aspects of the organisation of the working time

INTRODUCTORY COMMENTS

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 D. HOSPEEM response to the first consultation of the European social partners on the protection of workers from the risks related to exposure to electromagnetic fields at work

This paper summarises the responses received from HOSPEEM members to the Commission's consultation on the protection of workers from the risks related to exposure to electromagnetic fields at work.

Summary

The protection of the health workforce from workplace risks is a key priority for hospital and healthcare employers across Europe and HOSPEEM fully supports the risk assessment-based approach which underpins the legislative framework for health and safety at work. There is a strong safety culture in the hospital and healthcare sector, focussing on minimising risks to both workers and the patients they care for.

In this context, given the lack of evidence for any long-term adverse health effects and the exceptional rarity of even short term effects associated with the use of magnetic resonance imaging (MRI) in the hospital and healthcare sector, HOSPEEM's view is that the directive 2004/40/EC, in its current form, is not fit for purpose. In fact, if implemented it could expose healthcare workers to greater risks as it would be likely to lead to the increased use of other imaging techniques that rely on ionising radiation, the potential negative health effects of which are well known. HOSPEEM would therefore support a revision of the existing directive so that it is based upon the principle of risk assessment, excluding restrictive compliance with exposure limit values for the hospital and healthcare sector which already has alternative adequate safeguards in place.

Consultation questions

Do you consider the current Directive 2004/40/EC sufficient for the health and safety protection of workers exposed to electromagnetic fields during their work?

HOSPEEM's view is that, if implemented as it stands, Directive 2004/40/EC would not provide an overall enhancement of the health and safety of workers in the hospital and healthcare sector. The healthcare sector has a strong safety culture and there are already safeguards that protect healthcare workers whose activities involve exposure to electromagnetic fields. For example, the magnetic resonance security standard IEC/EN 60601-2-33² (as amended), defines thresholds for time-varying magnetic fields that completely rule out any sort of danger for workers or patients. Adverse incidents and effects in the hospital and healthcare sector are routinely monitored and recorded. To date, there are no known long-term adverse health effects to patients or workers arising from exposure to electromagnetic fields at the

² <http://webstore.iec.ch/Webstore/webstore.nsf/mysearchajax?Openform&key=IEC%2060601-2-33%20&sorting=&start=1&onglet=1>

frequencies used in MRI. As regards short-term effects, MRI equipment used in healthcare settings is designed to avoid such effects being induced in patients and, as such, incidences are exceptionally rare. For example, data from the UK's Medicines and Healthcare products Regulatory Agency (MHRA) records only two incidences of physiological effects arising from MRI in the period 1995-2005, during which time in excess of 6 million scans were carried out.³ We are not aware of any reports of such effects being induced in workers in the hospital and healthcare sector.

In view of this, HOSPEEM concludes that practices in place in the hospital and healthcare sector already provide adequate safeguards to protect workers from any risks related to exposure to electromagnetic fields at work.

In addition, we are concerned that, if implemented in its current form, Directive 2004/40/EC has the potential to negatively impact upon the health and safety of workers in the hospital and healthcare sector. Since it would be difficult or impossible to undertake certain MRI procedures whilst complying with the directive, clinicians would be placed in the position of having to use alternative imaging techniques, which in most cases would mean relying on the use of ionising radiation. Unlike in the case of EMFs, the serious long term negative health effects of exposure to ionising radiation are well known.

Whilst hospital and healthcare employers take all reasonable steps to prevent and minimise exposure of workers to ionising radiation, greater reliance on imaging techniques based on ionising radiation implies a greater risk of exposure to workers, in addition to the exposure of patients to ionising radiation which might be unnecessary if the full range of MRI techniques remain as options.

Furthermore, if the directive was implemented as it stands it would place scientific research and the provision of healthcare in the European Union at a major disadvantage compared to other countries which do not have such stringent requirements. This could put innovation and jobs within the European Union at risk, as well as jeopardising European citizens' access to advances in healthcare.

HOSPEEM considers, therefore, that the best solution would be to amend Directive 2004/40/EC so that it is based on risk assessment but without strict enforceable exposure limit values.

Do you think that a Community initiative is the best way to ensure a high standard of protection of workers exposed to electromagnetic fields?

Do you think that certain categories of workers should be excluded from the scope of any future Community initiative because of reported implementation problems (e.g.

³ See Appendix 14 to House of Commons Science and Technology Committee (2005) *Watching the Directives: Scientific Advice on the EU Physical Agents (Electromagnetic Fields) Directive: Fourth Report of Session 2005-06*. London: The Stationary Office, pp Ev 61-62.

medical procedures involving MRI) with some provisions (exposure limit values) of Directive 2004/40/EC?

If so, how would you provide for the protection of such workers?

If not, do you think that there should be some flexibility for workers exposed under special circumstances in their sector (e.g. MRI personnel during certain MRI procedures when normal protection measures cannot provide adequate protection by

- a) Introducing higher/other exposure limit values?*
- b) Introducing different methods for evaluating exposure?*
- c) Introducing the possibility of occasional or conditional derogations?*

Given that a Community initiative is already in place, HOSPEEM considers that the optimum solution is to amend the present directive so that it is based on risk assessment but does not have specific, enforceable exposure limit values.

Would you find non-binding measures such as the production of good practices guides, launching of regular information campaigns, setting up of appropriate training programmes, and drawing up of voluntary agreements between the social partners at EU or sector level useful, and for what purpose?

HOSPEEM is fully supportive of initiatives aimed at increasing workers' awareness of, and compliance with, measures to avoid, mitigate or minimise risks in the workplace, including risks associated with exposure to EMF. As regards EMFs, informed use can both help to ensure the responsible, competent, handling of risks and avoid the emergence of unfounded fears. However, given the very great variation between sectors in the circumstances which may result in exposure to EMFs, we believe that, in order to be effective, any such initiative would need to be sector-specific. A good example for the healthcare sector exists in the Dutch Guidelines *Using MR Safely – Practical Rules for Employers*⁴.

It is important that any EU-wide initiatives are effectively coordinated with relevant national initiatives to ensure they are complimentary and take account of different contexts. HOSPEEM also considers that all parties, including national governments, employers organisations and trade unions, and all other interested organisations at local and regional levels, must work together to ensure that workers fully understand the meaning and implications of any legislation or guidance.

Should a possible future EU Community initiative cover the long-term effects of workers' occupational exposure to electromagnetic fields?

Since, to date, there is no evidence of any long term effects associated with exposure to EMFs, there would not appear to be a need for a Community initiative to cover this area at present. Nevertheless, HOSPEEM members feel that long-term effects of work-related exposure to electromagnetic fields should be the subject of

⁴ http://www.alliance-for-mri.org/html/img/pool/20081210_Dutch_Guidelines_on_MR_Safety.pdf

further research, with the main focus on areas that have the clearest insufficiency of data. It would be useful to involve international organisations such as the WHO in such research, as their expertise would be of value in the unlikely event any incidences of long term effects arising from EMF exposure were found to occur.

ANNEX E. HOSPEEM (European hospital and healthcare employers' association) response to the Commission first phase consultation “Reviewing the Working Time Directive”

Introductory comments

The European Commission, following the provision of article 154 of the Treaty has launched the Consultation “Reviewing the Working Time Directive”. The aim of this document is to seek the social partners’ views on possible action that could be undertaken at Community level regarding any revision of Directive 2003/88/EC⁵ “Working time Directive”.

HOSPEEM contributed to the earlier consultation focusing on the working time organisation of the healthcare systems in the Member States. This is an issue of great importance to the health sector that delivers a 24 hour service, 365 days a year. Patient safety and the safety of health workers are of paramount importance to HOSPEEM. As the health sector is a 24 hour service, it needs flexibility to deliver high quality care. Therefore HOSPEEM believes that in order to run efficient health services in the European Union, it is important that any future changes to the directive should have real flexibility to ensure well functioning health services, able to match European citizens needs in the 21st century, as well as proper protection measure to ensure the health and safety of all those who work in the health services.

As a general premise, HOSPEEM members believes that fair working conditions have to be ensured for all the workers and the patients should not be treated by over-tired staff. This responsibility is shared with the workers themselves, who have to ensure they are sufficiently rested to enable them to look after the well-being of their patients. In recent years, healthcare employers have faced increasing costs, due to SIMAP (C-303/98), Jaeger (C-151/02) and Dellas (C-14/04) cases, which interprets on-call as 100% of working time and required workers to be given immediate compensatory rest. This has led to a shortage of skill medical staff across Europe. This is detrimental to the quality of the service and it has also increased cost. These increasing costs, during a financial crisis, have caused many problems in the health services, including the shutting down of some hospitals. Many health services also have had their health budget greatly reduced because of the financial crisis, leading to poorer services to its citizens.

The Communication requests the social partner to play a proactive role, as indicated in the article 154 of the TFUE (Treaty on the Functioning of the European Union). HOSPEEM members replied to the six questions proposed by the European Commission. This paper summarises the responses received from our members to the Commission’s consultation.

Response to the Consultation

⁵ DIRECTIVE 2003/88/EC of the European Parliament and of the Council, 4 November 2003, concerning certain aspects of the organisation of working time.

(a) How could we develop balanced and innovative proposals regarding the organisation of working time that move beyond the unsuccessful debates of the last conciliation process? What is your long-term vision for the organisation of working time in a modern setting?

HOSPEEM members consider that the hospital sector is particularly sensitive to the changes in the provisions of the working time. Indeed, in the hospital sector flexibility is required to:

- ensure an essential 24/7 service;
- provide a work life balance (e.g. more flexibility in the working time patterns and self rostering); and
- organise an effective and efficient workplace, overcoming the shortage of the healthcare staff;

Furthermore, the changes that our society is experiencing affect directly our sector. In particular the demographic changes, with a longer life expectation and an ageing population, will have decisive implications on the healthcare sector. Moreover, as underlined in the Consultation, the European labour market is in evolution, there are an increasing number of part-time workers. There are increasing expectations by the European population for high quality health services. This is difficult to deliver, because of the reduction in health budget and the shortage of staff caused by the SIMAP, Jaeger and Dellas cases. For all these reasons, the Working Time Directive plays a fundamental role in the framework of the healthcare service organisation.

(b) What impact do you think that changes in working patterns and practices have had on the application of the Directive? Have any particular provisions become obsolete, or more difficult to apply?

HOSPEEM members worked on several solutions to make the healthcare sector an attractive employer; for example the NHS in England implemented the “Improving Working Lives” (IWL) standards, an instrument that sets out a series of performance standards for NHS employers. The standards are designed to improve the working lives of NHS employees and are an integral element of the NHS Plan.

As already stated in the previous response on the practical implementation of the Directive 2003/88/EC, the Working Time Directive has been fully implemented by HOSPEEM members. It is the HOSPEEM members view that greater flexibility is required regarding the compensatory rest and to ensure that the resident on-call time is not counted as working time. In order to operate efficient health services in the EU, HOSPEEM members think that it is important to retain the opt-out subject to reasonable safeguards. HOSPEEM members believe that as a free European citizen, it is an individual right to make the decision whether or not they want to work over 48 hours. HOSPEEM members do not accept it is helpful to have rigid rules, and believes it is imperative to retain the opt-out in order to maintain efficient health services in the European Union. The ECJ rulings in the SIMAP and Jaeger cases have caused serious problems to the operational health systems and have led the Member States to recruit extra staff at extra cost without improving productivity. In order to solve the problems of shortage of staff caused by the SIMAP, Jaeger and Dellas judgments, some HOSPEEM members were obliged to recruit staff from outside Europe (including Sub-Saharan Africa which can ill-afford to lose their trained staff)

as well as healthcare staff from the new Member States. HOSPEEM members do not believe it right that some of the poorest country on earth have lost their experienced staff as result of European legislation and case law. The flow of healthcare professionals from new to the old Member States has also created serious problems to the organization of the healthcare systems in countries like Latvia, Lithuania and Poland.

(c) What is your experience to date on the overall functioning of the Working Time Directive? What has been your experience regarding the key issues identified in section 5 of this paper?

As stated above, in point (b), the European healthcare employers have experienced difficulties with the issues identified in the section 5 of the consultation. In particular:

- With regard to the on-call time, the application of SIMAP and Jaeger ruling imposes on healthcare providers unnecessary financial burdens because to the need to recruit additional staff to make the 24 hour services work effectively. HOSPEEM express its concern about the interpretation of the Working Time Directive in the SIMAP, Jaeger and Dellas cases. The ECJ has ruled that on-call time must be regarded as working time, even the inactive on-call time. HOSPEEM looks positively to the introduction of the concept of inactive on-call time, it would avoid unreasonable costs for healthcare employers.
- Severe difficulties could be created by a restriction of the opt-out. For example in Germany, there is already a shortage of 5.000 doctors. A restriction to the use of the opt-out would require approximately 10.000 doctors more and the quality of the service would be compromised. Moreover, in England, although of NHS managed to implement the 48-hour working week for the vast majority of the services, they experienced significant difficulties with maternity and paediatric services as they are staffed by specially trained doctors who need to be in the hospital on-call to respond to emergencies.

(d) Do you agree with the analysis contained in this paper as regards the organisation and the regulation of working time in the EU? Are there any further issues which you consider should be added?

HOSPEEM members do agree with a broader approach to the regulation and organisation of the working time. It is important to avoid having over-tired workers for the safety of the patients and the staff. However HOSPEEM wants also to underline that the consultation does not provide a clear assessment on the connections between the impact of a flexible working arrangement and the health and safety of the staff. Furthermore HOSPEEM members do not agree with the analysis which indicate that the flexibility represent a threat for the workers. In our view it needs to be taken into consideration the benefit of a flexible working time arrangement for the workers; it might represent a fruitful opportunity for workers to realise a better work-life-balance. HOSPEEM's view is that flexibility, when combined with health and safety protection for workers will make hospitals safer places, give a

better work-life-balance and help to save jobs during a period of financial turmoil. HOSPEEM's position is that job losses and reduced staff in health services represent a real threat to workers because there will be greater pressure for workers to deliver results with fewer staff. HOSPEEM does not believe that it will be good for either patients or workers. The rights of workers must be balanced with the protection of patients and the ability of health services in the EU to deliver efficient and safe healthcare for all its citizens.

(e) Do you consider that the Commission should launch an initiative to amend the Directive? If so, do you agree with the objectives of a review as set out in this paper? What do you consider should be its scope?

HOSPEEM members are concerned about the detrimental consequences that would occur maintaining the *status quo*. In particular, as already stated above, with regard to the application of ECJ ruling, the functioning and the financial situation of the European healthcare are jeopardized.

HOSPEEM considers that the unsuccessful outcome of the previous process of revision needs to be taken into account before undertake further steps. HOSPEEM members consider the Social Partners could have an important role in the process. An agreement between the social partners would allow to achieve a balanced and successful solution for all the parties involved in the process.

(f) Do you think that, apart from legislative measures, other action at European Union level would merit consideration? If so, what form of action should be taken, and on which issues?

HOSPEEM members believe that any actions that increase the exchange of experiences between the EU countries would be useful. Further work is also required to ensure that all Member States have an adequate supply medical staff.

(g) Do you wish to consider initiating a dialogue under Article 155 TFEU on any of the issues identified in this consultation? If so, on which ones?

HOSPEEM believes that Social Partners negotiations at cross-sectoral level might be the way forward and supports CEEP position on this issue. If this is not possible, other ways involving the social partners might need to be explored.

Conclusion

HOSPEEM members believe that in order to operate safe and efficient European health systems it is important to resolve the problems caused by the SIMAP and Jaeger cases. If more hospitals in the European Union are not to be shut down, in order to provide a proper health service to the population, it is important to retain the flexibility given in the opt-out.

Any attempt to remove the opt-out will led to serious consequences in the operation of health services in the EU. HOSPEEM also takes the view that it is important not to have tired staff treating patients. Therefore sensible rules are necessary to ensure the health safety of both patients and staff. HOSPEEM considers that the retain of the opt-out, accompanied with sensible rules on its operation, together with the

introduction of the “inactive on-call time” and an extended reference period, it would better satisfy the need of flexibility that our sector requires and it would be the best way forward to resolve this impasse.

ANNEX F. HOSPEEM (European Hospital and Healthcare Employers' Association) response to the second-stage of consultation on the protection of workers from the risk related to exposure to electromagnetic fields at work under Article 154 of the TFUE

Introductory comments

The European Commission, following the provisions of article 154 of the Treaty, has launched a second stage social partner consultation on the protection of workers from the risk related to exposure to electromagnetic fields at work. HOSPEEM responded to the first stage consultation underling its support for an approach to the issue based on risk assessment and emphasising the strong health and safety culture which characterises the healthcare sector, stressing that the safeguard of workers and patients is guaranteed through several practices already in place in the sector.

Moreover, HOSPEEM expressed deep concern with regard to the exposure limit values established in Directive 2004/40/EC that would have ruled out certain Magnetic Resonance Imaging (MRI) practices, leading to the unwelcome consequence of requiring the use of different medical imaging techniques, based on ionising radiation, which has serious potential long term effects on health.

HOSPEEM welcomes the European Commission's second stage consultation document and in particular the proposed approach it sets out in relation to the use of MRI in the healthcare sector.

Questions to the social partners

Opinion or, where appropriate, a recommendation on the content of the envisaged legislative and non-legislative initiatives pursuant to Article 154(3) of the TFEU, giving particular attention to the topics identified in section 4 above

HOSPEEM is of the opinion that the approach proposed by the European Commission goes in the right direction. In particular, we welcome the European Commission's intention to exempt *the medical MR sector and activities related to the use and development of MR techniques from the binding exposure limit values*. HOSPEEM considers the Commission's proposal as set out in section 4 of the document represents a good starting point for a legislative proposal to revise Directive 2004/40/EC.

As already stated in its response to the first stage consultation, HOSPEEM emphasises there is no scientific evidence of adverse health effects for workers and

patients regarding the clinical use of magnetic resonance imaging. Moreover, the existing safeguards that are already in place and the strong safety culture in the healthcare sector are sufficient to protect healthcare workers whose activities involve exposure to electromagnetic fields. For example, the magnetic resonance security standard IEC/EN 60601-2-331 (as amended), defines thresholds for time-varying magnetic fields that completely rule out any sort of danger for workers or patients.

HOSPEEM fully supports the qualitative approach proposed in the consultation document rather than an approach based on quantitative exposure limits that would threaten the use of this fundamental method of medical examination. In view of this, HOSPEEM could support an approach based on the EU-wide implementation in medical MR facilities of appropriate and commonly agreed qualitative prevention and protection measures, with these measures applying in place of the requirement to comply with binding exposure limit values.

Finally, HOSPEEM takes the view that the consultation document over-estimates the impact of measures for “slightly adjusting working practices”, indicated in section 4.8. Consequently, we disagree with the assertion that by implementing these measures, compliance with the provision of the Directive would be assured in more than 90% of MRI procedures. For example, the recommendation “*walking normally in the MRI room (~ 4km/h)*” is not sufficient to respect the quantitative exposure limits indicated in the directive. This because a much lower walking speed (approximately 0.6-1.0 km/h) would in fact be required and this obviously would lead to inefficient working practices. The derogation proposed by the European Commission for the medical MR sector is therefore fundamental in order to allow a well functioning system.

To inform the Commission about alternative solutions in particular for the expression of exposure limit values in the range of 0 to 100 kHz and for ways to foster and concretise the aspects linked to the implementation of sound and efficient protection of workers exposed to electromagnetic fields during their work. Alternative solutions for the range from 100 kHz to 300 GHZ are also welcome

Whilst the approach to exposure limit values (discussed in section 4.3 of the consultation paper) would not be relevant to the medical MR sector if the proposal to exempt these activities from ELVs is adopted, this is of course, not guaranteed. In addition, the revised ELVs could have an impact on the healthcare sector in relation to other activities where there may be a significant exposure to EMFs, such as the use of diathermy.

HOSPEEM agrees with the proposed “zoning” system introduced in section 4.2 but has concerns with regard to the limits indicated and how they would be defined. The exposure limits indicated for zone 1 and 2 are referred to the levels proposed by ICNIRP in 2009; these limits should be replaced in 2010 with a new communication. Therefore, we would expect different data to be made available shortly.

Moreover, the definition of zone 3 it is not clear; it contains two contradictory assertions “no access should be allowed or even possible” and “if access is required it must take place under strictly controlled conditions, never in routine work”.

Finally, taking into consideration once again the absence of evidences of long-terms effects, and the infrequency of short-term effects, a complete prohibition on activities where exposure would fall within zone 3 seems disproportionate.

More generally, it should be noted that, in the hospital and healthcare sector workers’ exposure to EMFs generally occurs as a side effect of a medical intervention, where a patient is exposed to the same or greater effects. As explained above, the design of medical devices is such as to minimise risks to patients. It might, therefore, be argued that the Commission’s proposed definition for ‘Zone 0’: “where the situation is deemed similar to what is acceptable for the public”, would almost always apply to workers’ exposure to EMFs in the hospital and healthcare sector.

Where applicable, to indicate their willingness to enter into negotiations on the basis of the proposals described in this document under the terms of Article 154(4) and Article 155 of the TFEU

HOSPEEM is willing to contribute to the development of guidelines or other initiatives that would help, for example, to increase workers awareness of incompliance with measures to avoid, mitigate or minimise any risk associated with workplace exposure to EMF.

With regard to the possibility of starting a social dialogue process, HOSPEEM does not envisage a negotiation under the terms of article 154(4) and article 155 of the TFEU on this highly technical matter. Therefore, in this instance, HOSPEEM would prefer a legislative proposal from the European Commission on the revision of Directive 2004/40/EC.

ANNEX G. *ESPU-HOSPEEM code of conduct and follow-up on Ethical cross-border recruitment and retention in the hospital sector*

INTRODUCTION

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

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

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

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

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

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

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

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

2. REGISTRATION AND DATA COLLECTION

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

3. WORKFORCE PLANNING

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

4. EQUAL ACCESS TO TRAINING AND CAREER DEVELOPMENT

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

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

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

6. FAIR AND TRANSPARENT CONTRACTING

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

7. REGISTRATION, PERMITS AND RECOGNITION OF QUALIFICATIONS

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

8. PROPER INDUCTION, HOUSING AND STANDARDS OF LIVING

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

9. EQUAL RIGHTS AND NON-DISCRIMINATION

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

10. PROMOTING ETHICAL RECRUITMENT PRACTICES

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

11. FREEDOM OF ASSOCIATION

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

12. IMPLEMENTATION, MONITORING AND FOLLOW-UP

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

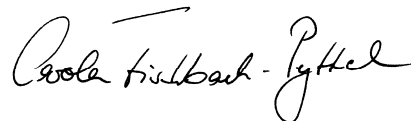
Therefore HOSPEEM and EPSU agree to effectively implement, through their respective members: the Code within a period of 3 years after adoption. In this period, social partners in the hospital sector will monitor the situation and report at least once a year back to the Social Dialogue Committee about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

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

Brussels, 07 April 2008



Godfrey Perera
Secretary General of HOSPEEM



Carola Fischbach-Pyttel
Secretary General of EPSU

ANNEX H. *ESPU-HOSPEEM joint declaration on health services* ***14 NOVEMBRE 2007***

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

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

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

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

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

follow the principles of general interest, like universality, accessibility and quality. It is essential that EU-internal market or competition rules do not limit the EU Member states' autonomy in the implementation of these national responsibilities.

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

to ensure that they continue to serve the public interests, while able to respond to the challenges generated by globalisation. For those reasons, HOSPEEM and EPSU strongly believe that:

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

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



Godfrey PERERA
Secretary General of HOSPEEM



Karen JENNINGS
President of EPSU Standing
Committee Health and Social Services

ANNEX I. WORK PROGRAMME OF THE EUROPEAN SOCIAL DIALOGUE COMMITTEE IN THE HOSPITAL SECTOR IN THE EUROPEAN UNION (2006 – 2007)

1. INTRODUCTION

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 J. WORK PROGRAMME OF THE EUROPEAN SOCIAL DIALOGUE COMMITTEE IN THE HOSPITAL SECTOR IN THE EUROPEAN UNION (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:
 - a towards the launch of joint social dialogue projects at regional, national and/or cross-border level
 - a 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:
 - a 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 workforce 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



Godfrey PERERA
Secretary General of HOSPEEM



Karen JENNINGS
President of EPSU Standing
Committee Health and Social Services

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

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

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

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

THE DIRECTIVE

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

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

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

SUBSIDIARITY

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

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

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

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

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

HOSPEEM is pleased that the draft Directive states that for cross border hospital care, Member States will be able to impose the same conditions that apply domestically (for example, consulting a general practitioner) before receiving

hospital care. We do however feel that there is work to be done on the definition of what constitutes hospital care.

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

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

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

PRIOR AUTHORISATION PROCEDURES

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

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

As healthcare employers, HOSPEEM members know the importance of workforce planning. It is important to understand how long it takes to train doctors, nurses and

other healthcare professionals and that any significant increase or decrease in the numbers of patients in any Member State is likely to create serious problems in managing the workforce. If, due to the affects of the Directive, the workforce of health systems can not be managed properly, then it could mean that patients have to wait longer for certain treatments or that certain treatments will not be delivered at all. This will certainly not benefit the patients in that country.

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

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

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

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

HEALTH INEQUALITIES

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

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

Although all patients have the right to access healthcare in other Member States, only the mobile and well informed patients will be able to use this right. For many patients treatment abroad is not a real option, either because they are too sick to travel, they can not afford it, language problems, or they prefer to stay close to home and family etc. As a result, HOSPEEM fears that these benefits will not be

available to all patients and will create inequality in healthcare. On current figures, that means over 90% of EU patients will not make use of the new rights. HOSPEEM's view is that only strong patients, who have the financial and social capacity to move between States, will benefit as a result of this directive.

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

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

OVERARCHING VALUES

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

NATIONAL CONTACT POINTS AND THE COLLECTION OF DATA

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

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

PATIENT SAFETY AND ADDITIONAL COST ISSUES

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

HOSPEEM takes the view that cross border healthcare could raise issues around patient safety which may not necessarily 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.

ANNEX L. FRAMEWORK AGREEMENT ON PREVENTION FROM SHARP INJURIES IN THE HOSPITAL AND HEALTHCARE SECTOR

Preamble:

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

General Considerations:

1. Having regard to the Treaty establishing the European Community and in particular Articles 138 and 139 (2) thereof;
2. Having regard to Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work⁶;
3. Having regard to Council Directive 89/655/EEC of 30 November 1989 concerning the minimum safety and health requirements for the use of work equipment by workers at work⁷;
4. Having regard to Directive 2000/54/EC of the European Parliament and of the Council of 18 September 2000 on the protection of workers from risks related to exposure to biological agents at work⁸;
5. Having regard to the Community strategy 2007-2012 on health and safety at work⁹;

⁶ OJ L 183, 29.6.1989. p.1.

⁷ OJ L 393, 30.12.1990. p.13.

⁸ OJ L 262, 17.10.2000. p.21.

⁹ COM(2007) 62 final, 21.2.2007.

6. Having regard to the Directive 2002/14/EC of the European Parliament and of the Council of 11 March 2002 establishing a general framework for informing and consulting employees in the European Community;
7. Having regard to the resolution of the European Parliament of 6 July 2006 on protecting European healthcare workers from blood-borne infections due to needlestick injuries (2006/2015(INI));
8. Having regard to the first and second stage consultation of the European Commission on protecting European healthcare workers from blood-borne infections due to needlestick injuries;
9. Having regard to the outcomes of the EPSU-HOSPEEM technical seminar on needlestick injuries of 7 February 2008¹⁰;
10. Having regard to the hierarchy of general principles of prevention laid down in Article 6 of Council Directive 89/391/EEC as well as to the preventative measures defined in articles 3, 5 and 6 of Directive 2000/54/EC;
11. Having regard to the joint ILO/WHO guidelines on health services and HIV/AIDS and to the joint ILO/WHO guidelines on post-exposure prophylaxis to prevent HIV infection;
12. With full respect to existing national legislation and collective agreements;
13. Whereas action needs to be taken to assess the extent of the incidence of sharp injuries in the hospital and healthcare sector, scientific evidence shows that preventive and protection measures can significantly reduce the occurrence of accidents and infections;
14. Whereas a full risk assessment process is a precondition to take appropriate action to prevent injuries and infections;
15. Whereas the employers, and workers' health and safety representatives need to cooperate to prevent and protect workers against injuries and infections from medical sharps;
16. Whereas healthcare workers are primarily but not exclusively concerned by sharp injuries;
17. Whereas students undertaking clinical training, as part of their education, are not considered as workers under this agreement, they should be covered by the prevention and protection measures outlined in this agreement, with liabilities being regulated according to national legislation and practice;

¹⁰ OJ L OJ L 80, 23.3.2002, p. 29–34.

Clause 1: Purpose

The purpose of this framework agreement is:

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

Clause 2: Scope

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

Clause 3: Definitions

Within the meaning of this agreement:

1. **Workers:** any persons employed by an employer including trainees and apprentices in the hospital and healthcare sector-directly related services and activities. Workers who are employed by temporary employment business within the meaning of Council Directive 91/383/EC supplementing the measures to encourage improvements in the safety and health at work of workers with fixed-duration employment relationship or a temporary employment relationship¹¹ fall within the scope of the agreement.
2. **Workplaces covered:** healthcare organisations/services in public and private sectors, and every other place where health services/activities are undertaken and delivered, under the managerial authority and supervision of the employer.
3. **Employers:** natural/legal persons/organisations having an employment relationship with workers. They are responsible for managing, organising and providing healthcare and directly related services/activities delivered by workers.

¹¹ OJ L 183, 29.6.1989, p.1.

4. **Sharps:** objects or instruments necessary for the exercise of specific healthcare activities, which are able to cut, prick, cause injury and/or infection. Sharps are considered as work equipment within the meaning of Directive 89/655//EEC on work equipment.
5. **Hierarchy of measures:** is defined in order of effectiveness to avoid, eliminate and reduce risks as defined in article 6 of Directive 89/391/EEC and articles 3, 5 and 6 of Directive 2000/54/EC.
6. **Specific preventative measures:** measures taken to prevent injury and/or transmission of infection in the provision of hospital and healthcare directly related services and activities, including the use of the safest equipment needed, based on the risk assessment and safe methods of handling the disposal of medical sharps.
7. **Workers' representatives:** any person elected, chosen or designated in accordance with national law and/or practice to represent workers.
8. **Worker's health and safety representatives** are defined in accordance with Article 3(c) of Directive 89/391/EEC as any person elected, chosen or designated in accordance with national law and/or practices to represent workers where problems arise relating to the safety and health protection of workers at work.
9. **Subcontractor:** any person who takes action in hospital and healthcare directly related services and activities within the framework of working contractual relations established with the employer.

Clause 4: Principles

1. A well trained, adequately resourced and secure health service workforce is essential to prevent the risk of injuries and infections from medical sharps. Exposure prevention is the key strategy for eliminating and minimizing the risk of occupationally acquired injuries or infections.
2. The role of health and safety representatives is key in risk prevention and protection.
3. The employer has a duty to ensure the safety and health of workers in every aspect related to the work, including psycho-social factors and work organisation.
4. It shall be the responsibility of each worker to take care - as far as possible - of their own safety and health and that of other persons affected by their actions at work, in accordance with their training and the instructions given by their employer.
5. The employer shall develop an environment where workers and their representatives are participating in the development of health and safety policies and practices.

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

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

8. Action needs to be taken through a process of information and consultation, in accordance with national laws and/or collective agreements.

9. The effectiveness of awareness-raising measures entails shared obligations of the employers, the workers and their representatives.

10. In achieving the safest possible workplace a combination of planning, awareness raising, information, training, prevention and monitoring measures is essential.

11. Promote a "no blame" culture. Incident reporting procedure should focus on systemic factors rather than individual mistakes. Systematic reporting must be considered as accepted procedure.

Clause 5: Risk Assessment

1. Risk assessment procedures shall be conducted in compliance with articles 3 and 6 of Directive 2000/54/EC, and Articles 6 and 9 of Directive /89/391/EEC.

2. Risk assessment shall include an exposure determination, understanding the importance of a well resourced and organised working environment and shall cover all situations where there is injury, blood or other potentially infectious material.

3. Risk assessments shall take into account technology, organisation of work, working conditions, level of qualifications, work related psycho-social factors and the influence of factors related to the working environment. This will:

- Identify how exposure could be eliminated;
- Consider possible alternative systems;

Clause 6: Elimination, prevention and protection

1. Where the results of the risk assessment reveal a risk of injuries with a sharp and/or infection, workers' exposure must be eliminated by taking the following measures, without prejudice to their order:

- Specifying and implementing safe procedures for using and disposing of sharp medical instruments and contaminated waste. These procedures shall be regularly reassessed and shall form an integral part of the measures for the information and training of workers referred in clause 8;
- Eliminating the unnecessary use of sharps by implementing changes in practice and on the basis of the results of the risk assessment, providing medical devices incorporating safety-engineered protection mechanisms;
- The practice of recapping shall be banned with immediate effect;

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

- Place effective disposal procedures and clearly marked and technically safe containers for the handling of disposable sharps and injection equipment as close as possible to the assessed areas where sharps are being used or to be found;
- Prevent the risk of infections by implementing safe systems of work, by:
 - a. Developing a coherent overall prevention policy, which covers technology, organisation of work, working conditions, work related psycho-social factors and the influence of factors related to the working environment;
 - b. Training;
 - c. Conducting health surveillance procedures, in compliance with article 14 of Directive 2000/54/EC;
- Use of personal protective equipment;

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

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

- Workers shall be informed of the benefits and drawbacks of both vaccination and non-vaccination;
- Vaccination must be offered free of charge to all workers and students delivering healthcare and related activities at the workplace;

Clause 7: Information and awareness-raising

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

- To highlight the different risks;
- To give guidance on existing legislation;
- To promote good practices regarding the prevention and recording of incidents/accidents;
- To raise awareness by developing activities and promotional materials in partnership with representative trade unions and/or workers' representatives;
- To provide information on support programmes available;

Clause 8: Training

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

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

Employers must organise and provide training which is mandatory for workers. Employers must release workers who are required to attend training. This training

shall be made available on a regular basis taking into account results of monitoring, modernisation and improvements.

Clause 9: Reporting

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

Clause 10: Response and Follow-up

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

In particular the following action shall be taken:

- The employer takes the immediate steps for the care of the injured worker, including the provision of post-exposure prophylaxis and the necessary medical tests where indicated for medical reasons, and appropriate health surveillance in accordance with clause 6 §2,c
- The employer investigates the causes and circumstances and records the accident/incident, taking -where appropriate- the necessary action. The worker must provide the relevant information at the appropriate time to complete the details of the accident or incident;
- The employer shall, in cases of injury, consider the following steps including counselling of workers where appropriate and guaranteed medical treatment. Rehabilitation, continued employment and access to compensation shall be in accordance with national and/or sectoral agreements or legislation;
Confidentiality of injury, diagnosis and treatment is paramount and must be respected;

Clause 11: Implementation

This agreement will be without prejudice to existing, future national and Community provisions which are more favourable to workers' protection from medical sharps' injuries.

The signatory parties request the Commission to submit this framework agreement to the Council for a decision in order to make this agreement binding in the member states of the European Union.

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

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

Brussels, 17 July 2009



Godfrey PERERA
Secretary General of HOSPEEM



Karen JENNINGS
President of EPSU Standing
Committee Health and Social Services



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

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

(I) INTRODUCTION

1. The aim of the Guidelines is to ensure that each workplace has a results-oriented policy which addresses the issue of third-party violence. The Guidelines set out the practical steps that can be taken by employers, workers and their representatives /trade unions to reduce, prevent and mitigate problems. The steps reflect the best practices developed in our sectors and they can be complemented by more specific and/or additional measures.
2. According to EU and national law, both employers and workers have obligations in the field of health and safety. Although, the duty to ensure the health and safety of workers in every aspect related to the work lies with the employer¹², the employee also has a responsibility to take care, as far as possible, of their

¹²EU law includes the following Directives:

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

own health and safety and that of other persons affected by their actions at work, in accordance with their training and the instructions given by their employer. Employers also have an obligation to consult workers and/or their representatives and allow them to take part on all questions relating to health and safety at work. This reflects awareness that, in practice, a joint approach to health and safety is the most successful.

3. The signatory social partners from the local and regional government, healthcare, commerce, private security, education sectors¹³ are increasingly concerned about the impact of third-party violence on employees because it not only undermines an individual's health and dignity, but also has a very real economic impact in terms of absences from the workplace, morale and staff turnover. Third party-violence can also create an environment that is unsafe and even frightening to the public and service users and therefore has a wide negative social impact.
4. Work-related third-party violence and harassment can take many forms. It could:
 - a) Be physical, psychological, verbal and/or sexual
 - b) Be one-off incidents or more systematic patterns of behaviour, by an individual or group
 - c) Originate from the actions or behaviour of clients, customers, patients, service users, pupils or parents, members of the public, or of the service provider
 - d) Range from cases of disrespect to more serious threats and physical assault;
 - e) Be caused by mental health problems and/or motivated by emotional reasons, personal dislike, prejudices on grounds of gender, racial/ethnic origin, religion and belief, disability, age, sexual orientation or body image.
 - f) Constitute criminal offences aimed at the employee and his/her reputation or the property of the employer or client which may be organised or opportunistic and which require the intervention of public authorities
 - g) Deeply affect the personality, dignity and integrity of the victims
 - h) Occur at the work place, in the public space or in a private environment and is work related.
 - i) Occur as cyber-bullying/cyber-harassment through a wide range of information and communication technologies (ICT).
5. The issue of third party violence is sufficiently distinct from the question of violence and harassment (among colleagues) in the workplace, and sufficiently significant in terms of its impact on the health and safety of workers and its economic impact to warrant a distinctive approach.
6. Although there are sectoral and organisational differences with regard to third-party violence faced by workers in different occupations and workplaces, the key

¹³ See annex for details

elements of good practice and steps to tackle it are common to all working environments. These elements are: a partnership approach; clear definitions; prevention through risk assessment, awareness raising, training; clear reporting and follow-up; and appropriate evaluation.

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

(II) AIM

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

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

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

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

(IV) IMPLEMENTATION AND NEXT STEPS

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

Stage 1 – Commitment and dissemination

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

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

Stage 2 – Awareness Raising

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

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

Stage 3 - Monitoring and follow-up

The signatory social partners will:

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

ANNEX N. RECRUITMENT AND RETENTION, A FRAMEWORK OF ACTION

1. PREAMBLE

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

2. GENERAL CONSIDERATIONS

- 2.1 Member States are responsible for the organisation and delivery of healthcare systems and, as part of this, play a crucial role in the organisation and provision of professional training for healthcare workers in consultation with social partners and other stakeholders where appropriate. Member States also play a role in setting terms and conditions for healthcare workers through legislation on health and safety, working time, equal treatment and other measures. Social partners should work with national, regional and local authorities when developing policies relating to the healthcare workforce,¹⁴ for example, to

¹⁴ To take due account of the “Report on the open consultation on the Green Paper on the European Workforce for Health” http://ec.europa.eu/health/ph_systems/docs/workforce_report.pdf and the Green paper on the European Workforce for Health (COM (2008) 725 Final)

support lifelong learning training, internal job mobility, and provision of management and organisation skills.

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

3. PURPOSE

- 3.1. **Support the recruitment and retention of workers in the hospital sector**
EPSU and HOSPEEM recognize the need to meet existing and future staff needs. To deliver the highest level of care to the patients and society, healthcare services need to be well-equipped, in particular in terms of a well-trained and motivated workforce. Investments in training and working conditions are therefore a necessity. This means that health care staff needs to be valued and receive recognition in their terms and conditions of work to be competitive with other sectors. Social partners in cooperation with the relevant member states’ authorities will take action to promote the health care sector and attract young people into employment in health services. Valuing and retaining the skills and experiences of older workers is equally crucial in transferring experience and the retention of knowledge. Social partners at all levels, in cooperation with member states’ authorities, should

develop supporting infrastructures to facilitate work in a 24/7 service delivery context.

3.2. **Improve work organization**

Hospital organizations have to respond to the requirements of a 24 / 7 service delivery. This will always remain a feature in the hospital sector and has to be based on a workforce that is able to render the necessary range of services in a variety of shifts. Work organization needs to take account of workers' and employers' needs and preferences. Workers and their representatives should have the opportunity to be involved in determining work organization, aiming at achieving a balance in accordance with employers' and workers' interests. Better work-life balance will lead to improved quality of work and job motivation. HOSPEEM and EPSU acknowledge the benefits¹⁵¹⁶ that can be gained from staff having planned and agreed hours of work and rest periods. Social partners will cooperate to promote the best way of delivering efficient health care, which will safeguard staff and patient health and safety.

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

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

Workforce planning mechanisms¹⁷ need to take account of present and future needs, to ensure that a sufficient number of staff with the requisite skills are available in the right place at the right time. Such measures need to adhere to ethical recruitment principles and respond to the changing demographic profile. Amongst other things, workforce planning may involve examining: the existing and future skill needs of the sector / organization, the availability of workers with regard to their competences / qualifications and the prospects to fill existing and potential skills gaps.

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

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

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

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

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

The majority of health care staff are women, a significant number of whom also currently have caring responsibilities. In order to facilitate the full

¹⁵ Danish Nurses Organization study 2010

¹⁶ UK Boorman report on health and well-being – 2010

¹⁷ WHO International recruitment of Health Personnel: Global Code of Practice

participation of men and women in the healthcare labour market, health employers and social partners should take measures and develop policies which will improve the work-life balance of workers.

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

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

A well-trained and motivated workforce will produce better health outcomes and services. In order to facilitate a combination of work and learning, social partners have to take account of a range of options including secondments, on-the-job training, e-learning and other innovative career policies and training methods¹⁸.

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

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

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

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

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

Sharps Directive¹⁹

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

¹⁸ European funding mechanisms may play a role in supporting training and development opportunities for healthcare workers through instruments such as provided by the European Social Fund (ESF), the European Regional Development Fund (ERDF) and the European Globalisation Adjustment Fund (EGF)

¹⁹ Council Directive 2010/32/EU

Multi Sector Guidelines to tackle third party violence and harassment related to work²⁰

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

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

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

4. IMPLEMENTATION

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

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

Signed in Brussels on 17 December 2010

For
EPSU



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

Carola Fischbach-Pyttel
General Secretary

For
HOSPEEM



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

Godfrey Perera
General Secretary

²⁰ European social Dialogue Multi-Sectoral Guidelines to tackle third-party violence and harassment related to work

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