REGIONAL REPORT FOR SOUTHERN EUROPE:

Cyprus, Greece, Italy, Malta, Portugal and Spain

Approved by the Sectoral Social Dialogue Committee for the Hospital and Healthcare Sector on 6 March 2020.

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Authored by

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Abbreviations

CSRs	Country-Specific Recommendations within the European Semester framework
CY	Cyprus
EESC	European Economic and Social Committee
EL	Greece
EO	Employers' organisation
EPSU	European Federation of Public Service Union
ES	Spain
EU	European Union
EUR/I	EUR per inhabitant
GDP	Gross Domestic Product
HOSPEEM	European Hospital and Healthcare Employers' Association
IT	Italy
MS	Member States
MT	Malta
PPS/I	Purchasing power standard per inhabitant
PT	Portugal
SD	Social dialogue
SSD	Sectoral social dialogue
TU	Trade unions

Introduction

The **socio-economic relevance of the hospital and healthcare sector is growing and, in the same time, facing multiple challenges** to assure that "everyone has the right to timely access to affordable, preventive and curative health care of good quality".[1] According to the European Labour Force Survey, the human health activities sector employed more than 13 890 thousand people in 2018, encompassing 6,2% of the total employment in the European Union. In the Southern European countries, the share of people working in the human health sector accounts for 5% in Greece and Portugal and 6% in Spain and Italy. The healthcare sector is characterised by high segmentation of the healthcare providers, scaling from public sector bodies at different administrative levels to non-profit and private institutions.[2] The fragmentation of the providers influences also the social partners' structure; employees and employers organise themselves according to their occupational sector, subsectors and private/public sectors.

In light of these considerations, the social partners' **representation in the European Social Dialogue (SD) and their involvement into the European Semester became strategic relevant** to assure that the improvement of the employees' working conditions and the implementation of the market–related reforms (inevitable) across the EU are tackled at EU level.

To strengthen the role of the social partners at the EU level, the European Hospital and Healthcare Employers Association (HOSPEEM) and the European Federation of Public Service Unions (ESPU) commissioned a joint project with the following aims: (a) identify and address **capacity-building needs of the sectoral social partners**; (b) obtain quantitative and qualitative data on the **current involvement in the European Semester** and strengthen their role in this regard. Specifically, the project surveys the priorities of the social partners and how these priorities could be better articulated in the future activities of HOSPEEM and EPSU. The report provides relevant and comparable data and country-specific information from six targeted countries in Southern Europe: **Cyprus (CY), Greece (EL), Italy (IT), Malta (MT), Portugal (PT) and Spain (ES)**.

The findings in this report are the **results of the combined methodology** which includes:

- A tailored online survey dedicated to social dialogue in the hospital and healthcare sector conducted from July to November 2019;
- Desk research conducted from July to November 2019,
- Outcomes of the discussion with national social partner organisations and relevant organisations of the six targeted countries held at the second Regional Workshop in Rome on 15 November 2019.

The report is structured as follows:

- Chapter one outlines the leading **statistical indicators** based on comparative Eurostat data for the hospital and healthcare sector in the six Southern countries;
- Chapter two lists the **identified social partners** – trade unions and employers' organisations, or other types of social partners in the six targeted countries;
- Chapter three and four respectively analyse whether and what way are **social partners involved in the EU social dialogue structures and the European Semester;**
- Chapter fifth discloses the priorities and topics that the social partners wish to communicate to the EU level social dialogue, their satisfaction with the opportunities to address their problems at EU level and expectations from the EU.

The report is supplemented with a methodological and a statistical annex as well as further information on the Country-Specific Recommendations (CSRs) 2019 issued for the six countries in the European Semester process.

1. Facts and figures of the hospital and healthcare sector

To strengthen the social dialogue and increase its capacity, the broader context in which the social partners in the hospital and healthcare sector are operating needs to be highlighted. For compiling this report, statistical indicators on healthcare expenditure and the employment in hospital of the six countries have been provided. Standardised indicators based on the most recent and available data from Eurostat have been used. The comparative data are set in the context of the testimony of the social partners working and confronted with real-life conditions.[3]

The overall expenditure in the Southern European Member States ranges from 2 523 EUR/inhabitant (EUR/I) Italy to 1 528 EUR/I in Cyprus. The average PPS per inhabitant in these countries is 2 154 EUR and the percentage

[1] European Pillar of Social Rights
[2] Eurofound (2020) Representativeness of the European social partner organisations in hospitals and health care (forthcoming)
[3] Based on the discussions at the Regional workshop on 15 November 2019 in Rome

of health expenditure as part of the Gross Domestic Product (GDP) 8,45 but varying from 6,68% in Cyprus to 9,31 % in Malta.

Due to the underfunding and cuts of the expenditures in the public health sector, the sector is not meeting the demand causing long waiting lists and time for necessary procedures. In Greece, the waiting time for surgery is 4- 5 month, consequently increasing the use of private healthcare providers. The private providers (often non-profit), however, have fewer possibilities to offer high technological equipment during surgery and are also facing a lack of workforce. In Cyprus, due to the public healthcare sector cuts, a new private entity was established but was confronted with a shortage of professional staff. **Trade unions exert pressure to the government, but their messages are ignored.**[4] The shortage of professionals in Cyprus is also caused by cross-board mobility.

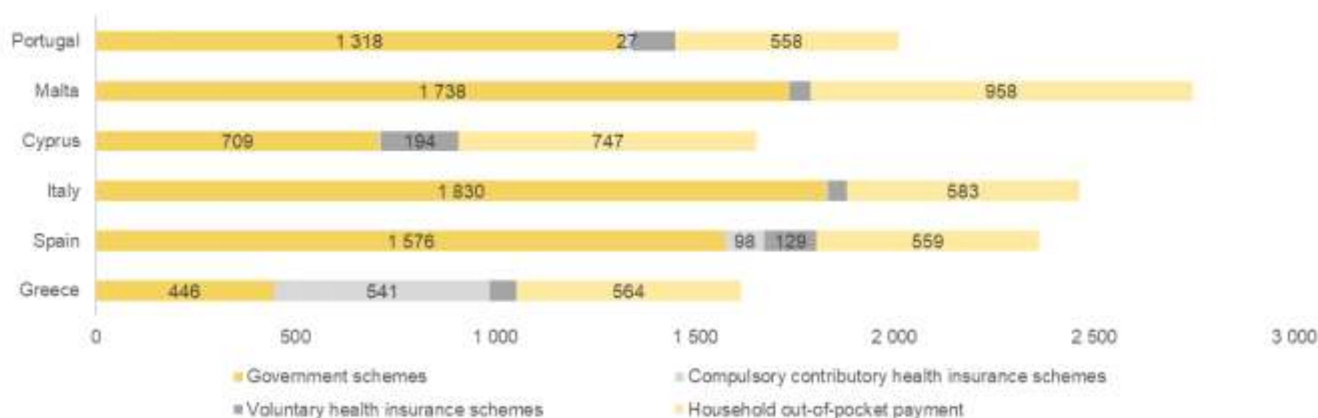
Table 1: Healthcare expenditure (all financial schemes, 2017)

Country	Cyprus	Greece	Italy	Malta	Portugal	Spain
Million EUR	1 313	14 492	152 705	1 053	17 456	103 489
EUR per inhabitant	1 528	1 347,53	2 523	2 250	1 695	2 221
PPS per inhabitant	1 674	1 623	2 483	2 747	2 028	2 371
% of GDP	6,68	8,04	8,84	9,31	8,97	8,87

Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]

Analysing the expenditure by financial schemes, in most of the Southern countries, **the highest PPS per inhabitant is paid from government schemes** ranging from 1830 PPS/I in Malta to 709 PPS/I in Cyprus. In Greece, the healthcare expenditures divide evenly between the government schemes, compulsory, and household out of pocket payments. **The house-of- pocket payments are high in all countries** scaling from 559 PPS/I in Spain to 958 PSS/I in Malta. In Cyprus, the PPS/I paid from the household out-of-pocket is even higher than the expenditures from the government shames.

Graph 1: Healthcare expenditure by financial schemes (PPS per inhabitant, 2017)



Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]
Note: out-of-pocket are estimates; not available for

Based on the health personnel employed in hospitals in 2017, the number of medical doctors per 100 000 inhabitants is the highest in Malta (260) and the lowest in Cyprus (93). The number of nursing professionals and midwives per 100 000 inhabitants varies tremendously, from 280 in Greece to 666 in Malta. **The migration of healthcare professionals, mostly to North and Western countries, is an economical and societal problem**.

Table 2: Health personnel employed in hospitals (2017)

Country	Cyprus	Greece	Italy	Malta	Portugal	Spain
Hospital employment (headcount)	N/A	98 342	625 107	9 650	130 539	563 835
Nursing professionals and midwives (headcount)	4 141	23 480	261 530	3 116	3 116	41 107

[4] Based on the discussions at the Regional workshop on 15 November 2019 in Rome

Country	Cyprus	Greece	Italy	Malta	Portugal	Spain
Nursing professionals and midwives/100 000 inhabitants	482	218	432	666	399	342
Medical doctors (headcount)	801	23 555	130 179	1 218	25 130	107 782
Medical doctors/100 000 inhabitants	93	219	215	260	244	231
Hospital beds/100 000 inhabitants	482	218	432	666	399	342

Source: Eurostat 2017, Health personnel employed in hospital [online code: hlth_rs_prshp1]

Similar problems occur in all targeted countries with **mutually reinforcing country-specific challenges**. For example, in Greece, the long-term trends in healthcare are influenced by the ageing of the population, mass immigration and downgrading of the public health sector. During the past ten years, the country underwent a deep crisis. This impacted all sectors. **The private and public healthcare sectors had difficulties in standing on their feet.** Forty-five clinics were shut down for lack of funds. Currently, there are 35 psychiatric clinics but used to be 70.

In the private sector, there are significant changes – those that are listed on the stock exchange were sold to foreigners. The private sector thus faces difficulties in delivering services similar to the public sector. The average percentage of 8% GDP for the expenditure has to be increased by the government and solve the problems in the medical insurance sector. The lack of medical staff was attempted to be addressed by the increase of the investment in the training of young people. Nevertheless, most of them left for Nordic but also Arabic countries, where they will earn 2 - 3 as much. Besides, they were highly specialised personnel, such as cardiologists or nephrologists.[5]

In Spain, the challenges faced in the healthcare sector are complex and are also related to failing modernisation. **The situation is common for both the private and public sector**. The sector needs to focus more on the prevention and universalisation of the care, to complement specific professions to stabilise the services. The Spanish healthcare workforce is characterised with a high level of temporary workers and low salaries.

In the Mediterranean countries in general, there is a **low rate of nursing staff for one patient, leading to endangering the safety of the people.** Trade unions are calling for an increase in the minimum rate for health care and staffing norms.

In general, the national systems face defunding in all targeted countries causing the decrease of the human recourses reflecting in the decline of the headcounts of the doctors and nurses. **The lack of workforce gives rise to the precarious labour** characterised with long working hours and a high number of nights' shifts and calling back the pensioners. The low wages force the employees to strive for additional income leading to difficulties to reconcile the work and family.[6]

2. Social partners in the hospital and healthcare sector

Based on the desk research and a shared database between HOSPEEM, EPSU and CELSI, the following social partners representing employees and employers in the hospital and healthcare sector in the Southern EU countries were identified. Due to the fragmentation and multiple social partners' diversion along the lines of the type of occupations and private/public health sectors, **not all the social partners are listed**. If available, the order of the named organisation complies with the number of members (a measure of representativeness) from the highest to the lowest number.[7] As the ministries of health employers in the public health sector in CY, MT, EL and EL and thus relevant actors in the national social dialogue and tripartism, these state bodies are listed as employers' organisations in the following table.

The trade unions tend to focus on particular subsectors and occupations such as doctors, nurses and specialisations (e.g. radiologist). Some of the employer´ organisations are cross-sectoral but other covers specific domain within the hospital and healthcare sector as is the case of trade unions. Most of the identified social partners are involved in social dialogue and bargaining at least at one level (national, sectoral or level of organisation).

Despite common features in the structure of social partners, country specificities are worth to notion. In Spain, multiple trade unions and one merged employers' organisations in the private sector were identified. In Portugal, nurses appear to be the most organised group of healthcare employees but fragmented into several organisations; employers' organisations cover both private and public healthcare sector. Several active and mutually interconnected trade unions and two core employers' agencies have been listed for Italy. Multiple trade unions and employers' associations representing diverse healthcare professions in Greece reflect the high rate of fragmentation of the social partners' structure. The state is a significant public sector employer in all six countries.

[5] Based on the discussion at the Regional workshop in Rome, November 2019
[6] Based on the discussion at the Regional workshop in Rome, November 2019
[7] Eurofound (2020) Representativeness of the European social partner organisations in hospitals and health care (forthcoming)

	Cyprus[8]	Greece	Italy	Malta	Portugal	Spain
Trade Unions						
	Pancyprian Public Servants Trade Union (PASYDY)	Pan-Hellenic Federation of Public Hospital Workers (POEDIN)	Public Service Union (FP-CGIL)	Voices of the Workers (UHM)	Union of Portuguese Nurses (SEP)	Federation of Health Sectors and Socio-Sanitary Sectors of the Trade Union Federation of Workers´ Commission and Sectoral Health Sectors (FSSS – COO)
	Pancyprian Union of Government Nurses (PASYNO)	Confederation of Civil Servants (ADEDY)	Local Authorities Federation (FPL UIL)	General Workers Union (GWU)	Union of Nurses of the Autonomous Region of Madeira (SERAM)	General Union of Workers (UGT)
	Pancyprian Union of Government Doctors (PASIKI)		Federation of Public Workers and Services (FPS-CISL)	Malta Union for Midwives and Nurses (MUMN)	Union of Nurses (SE)	Federation of Public Services of the General Workers Union (FSP – UGT)
	Cyprus Trade Union of Workers-Employees in Governmental. Military and Social Institutions (PASYEK – PEO)		Federation of Autonomous Health Workers (FIALS)	General Workers Union - Government and Public Entities Section	Independent Union of Nursing Professionals (SIPE)	Spanish Trade Unions of Nursing Professionals (SATSE)
	Cyprus Federation of Private Employees (OIYK-SEK)		Federation of Independent Unions - Health Care (FSI)		Independent union of Doctors (SIM)	Spanish Central Independent and Public Employees´ Trade Unions (CSIF)
			Association of medical and executive staff of the NHS (ANAAD ASSOMED)		Union of Portuguese Nurses (SEP)	
Employers' organisations						
	Cyprus Employers & Industrialists Federation (OEB) – Private sector (cross-sectoral)	Ministry of Health: Public sector	Agency for the contractual representation of the Public Administration (ARAN)	Malta Employers' Association (MEA)	Portuguese Association of Private Hospitals (APHP)	Spanish Private Health Alliance (ASPE)
	Ministry of Health: Main employer for public healthcare	Panhellenic Union of Private Hospitals (PEIK)	Italian Federation of Hospitals and Health Agencies (FIASO)	Ministry of Health: Public sector	Employers Confederation of Commerce and Services (CCP)	Ministry of Health: Public sector
	State health services organisation: Public sector				National Confederation of Institutions of Solidarity (CNIS)	

[8] The order of the trade unions stands for the number of active members in the sector (based on the Eurofound (2020) Representativeness of the European social partner organisations in hospitals and health care (forthcoming))

3. Social partners' involvement in the EU social dialogue structures

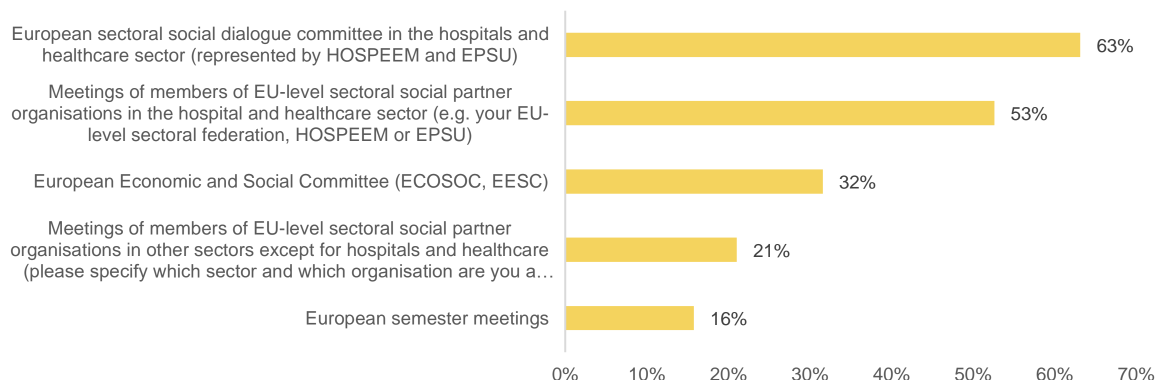
The importance of the European social dialogue is anchored in the Treaty on the Functioning of the European Union (TFEU) by several articles. Mainly by Art. 152: The European Union recognises and promotes the role of social partners at Union level respecting their autonomy; Art. 154: Consultation of EU level social partners by the Commission; Art. 155: Agreements concluded by social partners.[9] There are plenty of instances, where the **social partners played an active role in the EU-wide agreements**. For example, the telework agreement (2002) and the agreement on the work-related stress (2004) was co-created by the social partners. European social dialogue was relevant also with regards to the agreements implemented as Council Directives, for example, the parental leave directive (1995/2009), the directive of part-time work (1997) or Maritime Labour Convention (1999/2006/2018).[10]

> **To strengthen the European social dialogue is a priority for the new European Commission.**
> *Kristine Krivmane DG EMPL Unit A2 Social Dialogue*

The findings related to the involvement of the social partners in the EU social dialogue presented below are based on the online survey circulated to relevant social partners/organisations in the six targeted countries between July and November 2019. It has to be noted that the data relate predominantly to trade unions in general, due to the lower participation of the employers' organisations in the survey[11]. From each of the six countries, at least one response from trade unions or employers' organisation were received except for Spanish employers. The lack of information from the survey was completed by the findings of the desk research.

Most of the organisations of the six Southern EU countries are involved in EU level SD structures either represented by EPSU and HOSPEEM or another sectoral or cross-sectoral European organisation. Out of those involved, 63 % participate directly in the EU sectoral social Dialogue Committee in the Hospital and Healthcare Sector (SSDC HS) via EPSU or HOSPEEM, 53% in meetings of members of the two EU level SSD partner organisations and 32% in European Economic and Social Committee (EESC) over the past three years.

Graph 2: Direct participation at the committee meetings of EU level social dialogue structures since 2015 (%, N = 19)



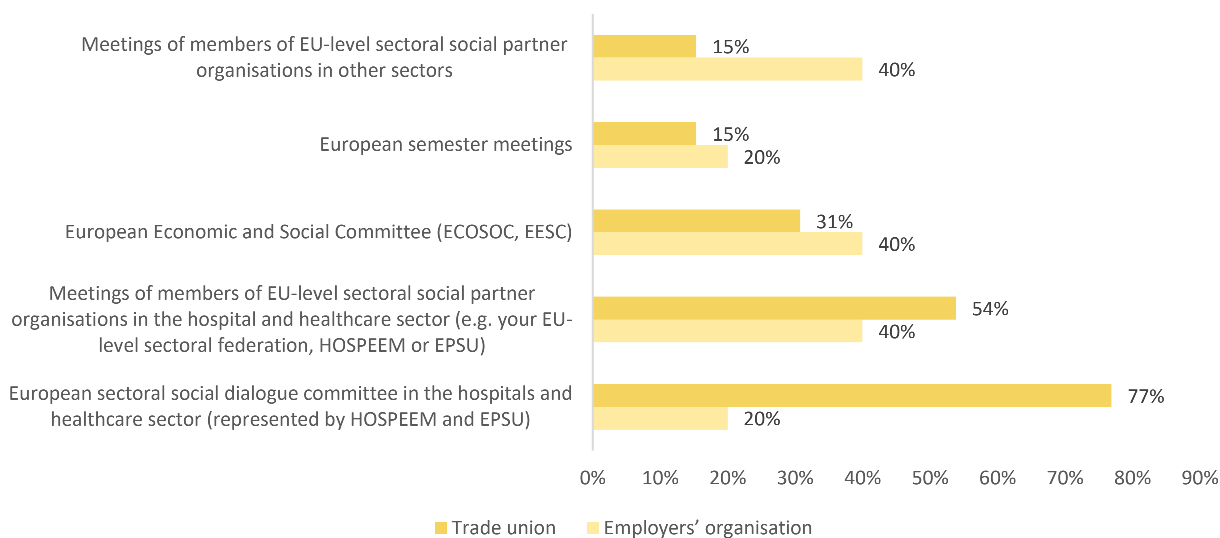
Source: Survey on social dialogue in the hospital and healthcare sectors
Note: the possibility of multiple answers

Based on the survey findings the involvement of the trade unions in the European social dialogue structures is higher than the one of the employers. However, these results might be biased by the low number of employers' organisations' participation in the survey. Taken this aspect into account, the employers' organisations participate evenly per 40% in EU level social dialogue of other sectors, EESC committees and meetings of their EU level sectoral federations.

[9] Kristīne Krivmane DG EMPL Unit A2 Social Dialogue, Social dialogue at EU level, presentation given at the Regional Workshop in Rome, November 2020 within the joint project HOSPEEM/EPSU

[11] For more details on the methodology see Annex A.

Graph 3: Direct participation at the committee meetings of EU level social dialogue structures since 2015 by type of organ4sation (%, N = 18)



Source: Survey on social dialogue in the hospital and healthcare sectors
Note: the possibility of multiple answers

The most frequent reasons for non-participation in any EU level social dialogue structures are the lack of financial recourses (60%). The difficulties in understanding the role, barriers of entry, and the perceived low importance of EU level social dialogue for the organisation' activities (per 40%) are other reasons for non-involvement in any EU level social dialogue structure.

The non-involvement of the social partners from the Southern EU countries into the EU level social dialogue might be **hampered by their fragmentation at the national level and/or the currently limited presence of independent employers' organisations**.

Table 3: Reasons for non-participation in EU level social dialogue structures (%, N= 5)

Reasons for non-participation	Per cent
Lack of financial resources (high travel costs, high membership fees)	60%
Difficulties in understanding the role and functioning of EU-level social dialogue	40%
Barriers of the entry (not meeting representativeness criteria)	40%
Low importance of EU-level social dialogue to the activities of our organisation	40%
Other (please specify):	40%
Language barrier	20%
Lack of personal capacities, lack of time to participate in meetings	0%
Barriers of the entry (another organisation from our country is a member and is not supporting our participation)	0%

Source: Survey on social dialogue in the hospital and healthcare sectors
Note: the possibility of multiple answers

Trade unions are represented at the European level mostly by EPSU. However, there are also other European organisations operating in the healthcare and hospital sector, to which some of the trade unions might be affiliated. However, it has to be noted that these organisations are mostly professional organisations, not recognised EU level social partners as it is the case for EPSU.

The same relates to HOSPEEM as the only European social partner representing employers in line with the Treaty of the Functioning of the European Union and with a legal right to be involved in the European Semester. In this sense, employer's organisations affiliated to HOSPEEM have thus unparalleled opportunity to influence the legislation and mandate to create directives that are then applied to the national legislations. The affiliation to the European Union of Private Hospitals (UEHP) or the European Hospital and Health Care Federation (HOPE), as

is the case of several employers' organisations, does not provide the opportunity of real and legally binding measures-taking.[12]

4. Social partners' participation in the European Semester

The European Semester (ES) is an annual governance cycle to monitor and enforce compliance with stringent budgetary and structural reforms. **The focus on social aspects in the ES recently intensified by linking the mechanisms to the European Pillar of Social Rights**, which was proclaimed by the European institutions in 2017. Principles which are directly linked are among other principles 16, which states that "*Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality."*

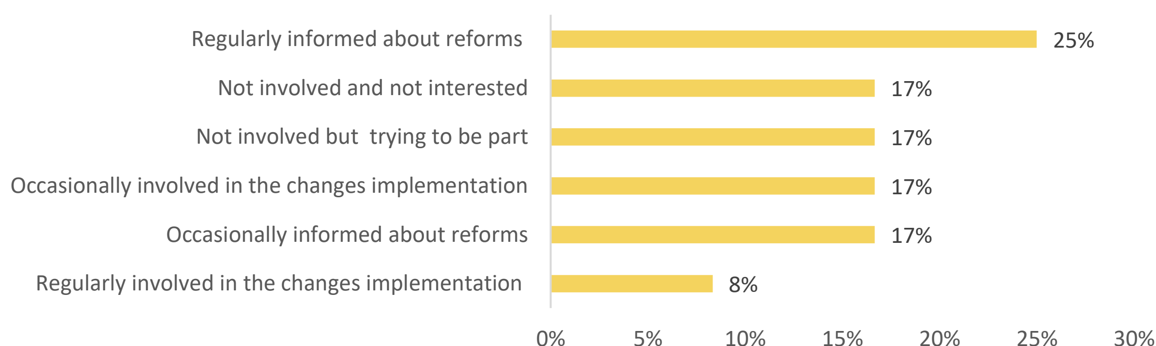
The relevance of the healthcare sector and social dialogue for fiscal consolidation, social cohesion, to fight poverty and increase of the health system is reflected in the European Semester's Country-Specific Recommendations (CSRs). **The number of EU Member States (MS) receiving CSRs related to healthcare is increasing**: 10 MS in 2017, 15 MS in 2019.

Out of the targeted countries of Southern Europe, Cyprus ad Portugal received CSRs both in 2017 and 2019. In 2019, also Greece, Italy and Malta added up to the countries which obtained tailored recommendations on how to improve the health care (for the particular CSRs see **annexe C**)

The survey revealed that most of the social partners (42%) are **informed about the reforms proposed within the European Semester** (25% regularly and 17% occasionally). Out of the 24 organisations responding to the questionnaire, 26 % are involved in the implementation of the changes resulted from the procedure. Further 17% are not involved but are trying to be part and the other 17% are not interested to be involved at all.

Regarding direct participation in the European Semester meetings, 16% of social partners attended the meeting of this mechanism in the last 3 years (out of with 20% were employers´ organisations and 15% of trade unions).

Graph 4: The ways the social partners are involved in the European Semester procedure (%, N = 24)



Source: Survey on social dialogue in the hospital and healthcare sectors

The discussion at the Regional Workshop in Rome revealed that: (a) more active involvement in the European Semester process is needed, reaching out to social partners, possibly via delegations in the Member States and ad hoc consultations; and (b) reconsider a shift from 'information' to 'consultation' as social partners are of the opinion that they are not listened to and not consulted, and the fact that receiving information is not sufficient for them.

The precondition to be more involved and contribute to the European Semester is to know what the mechanism is about and to understand how it is working. Currently, the European Semester is not very well understood. This limits the opportunities to take the problem to the EU level and receive support.

The Italian representative from the public administration presented that, despite that, there is a practice to consult the trade unions federations, many contradictions occurred in the procedures; the EC recommendations often focus on the public sector, requiring, for example, the extension of the public healthcare. However, this is not compatible with the stringent expenditure and fiscal coordination criteria set by the European Semester itself.

A presentation on the involvement of the Swedish social partners in the European Semester process showed a long history of close involvement of social partners in the national implementation of EU growth and employment policies. Swedish government have been organising over the years consultation with the Swedish social partners

[12] Based on the discussion at the Regional workshop in Rome, November 2019.

both at a technical and political level to assure the participative approach. The Swedish approach could be seen as a good practice, when the process of consultation throughout the semester is institutionalised, involving the local and regional social partners Swedish Association of Local Authorities and Regions (SALAR) and The Swedish Confederation of Professional Employees.

The primary responsibility for a good involvement at the national level remains with the Member State. HOSPEEM and EPSU provide a space for good practices sharing and strengthen thus the national and EU level social dialogue.

5. Social partners' priorities to be communicated to the EU level

The social partners listed their priorities to be communicated at the EU level, for example, through their membership in the respective EU level social partner organisation in the hospital and healthcare sector.

Collective bargaining was identified as a common priority by Trade Unions in Italy, Malta and Portugal. Enhancement of skills and recognition of qualifications were addressed in Spain and Portugal.

Employers Confederation of Commerce and Services in Portugal prioritise EU convergence and employment Greek employers´ organisation - Panhellenic Union of Private Hospitals needs to address the equalisation of the treatment from the side of the state between the public and private healthcare providers as well as staff shortages that are impacting the capacity of the healthcare system capacity to ensure efficiency and accessibility. All the targeted countries wish to discuss the lack of staff and budgetary issues and calling for sustainable healthcare reform, involving setting the standards and meeting the working rights.

In general, **the priorities relate mostly to working conditions interconnected to health and safety issues and labour rights, but also improvement of social bargaining.**

Not all social partners consider the EU level as the most appropriate to communicate their priorities. The most appropriate social dialogue committee to address the priorities is, according to the organisations participating in the survey, the national social dialogue committee (41%). The EU level social dialogue committee is on the second place (23%) together with the national social dialogue committee. The establishment-level collective bargaining with the individual employers is considered as the most appropriate level to communicate their priorities by 9% of social partners.

The social partners from the Southern EU countries, predominantly trade unions, marked staff shortages, safety and health at work and the working conditions together with the reconciliation of work and family as their highest-rated priorities.

Despite common priorities for all, some countries rated another topic as urgent. Portuguese social partners rated several items higher than other countries, indicating the acute need to address multiple challenges: safety and health, working conditions, recognition of skills at national and cross - border level, professional development, reconciliation of work and family. Italy rated the topic of recruitment and retention policies very strongly.

Table 4: Priorities to be communicated to the EU level

Country	Priorities	
	Trade unions	**Employers' organisations**
Cyprus	• Lack of nursing staff and resources (especially in private hospitals); • Health sector reform (general health system & autonomy of public hospitals); • The reduced state budget for the health section in relation to the EU28; • Professional Development and Life-long learning.	• Sustainability of the national health system; • Functional and financial autonomy of public hospitals; • Implementation of a common legal and regulatory framework for the public and private health sector.
Greece	• Lack of staff and labour issues; • Interference of primary structures with appropriate equipment; • Specialist doctors for the central; structure-medical technological equipment; • Interconnection with similar structures abroad; • Healthcare in risk occupations.	• Increasing the financing of the health system from 5% to 8% of GDP; • Equal treatment from the state of the private sector with the public; • Minimising bureaucracy • Costing method (DRG'S, ICD 10), financing of investment in existing private hospitals; • Minimum operating standards for providing safe health services.
Italy	• Collective bargaining; • Employment in the healthcare sector; • Dialogue with sectoral trade unions; • Working conditions; • Safety and health at work; • Reconciliation of work and family; • Recruitment and retention policies for all health workers.	• Lifelong learning and continuing professional development; • Work organisation; • The digitalisation of workplace / digital skills; • Vocational education and training; • Recruitment and retention policies for all health workers.
Malta	• Collective bargaining; • Private partnership; • Employee rights in a healthcare setting; • Burn out at work; • Reconciliation of work and family.	• Posting of workers; • The attractiveness of the sector for young workers.
Portugal	• Collective bargaining; • Enhancement of nurses' skills; • Career progression; • Cross-border recognition of professional qualifications.	• EU Convergence; • Safety and health at work; • Working conditions; • Ageing workforce; • Vocational education and training; • Recognition of skills at the national level; • Continuing Professional Development and Life-long learning.
Spain	• Working and employment conditions, especially the working day and salaries; • Health and safety at work with a gender perspective; • Ratios of healthcare personal; nurse-to-patient and patient safety ratio; • Digitisation; • Exposure to toxic and biological agents, risk prevention; • Professional development and retention of staff; • Validation of studies and professions.	• Implementing technology; * • Legislation on recognition of some health specialist, such as embryologists; • A long waiting list for screenings.

*Source: Survey on social dialogue in the hospital and healthcare sectors*Based on the desk-research*

Highest rated topics by employers differ slightly from those of trade unions; Employers need to focus on vocational education and training (weighted average 4,8), continuing professional development and life-long learning (4,6) and the ageing workforce. Trade unions want to address working conditions (4,5), safety and health at work (4,5), Reconciliation of work and family (4,3).

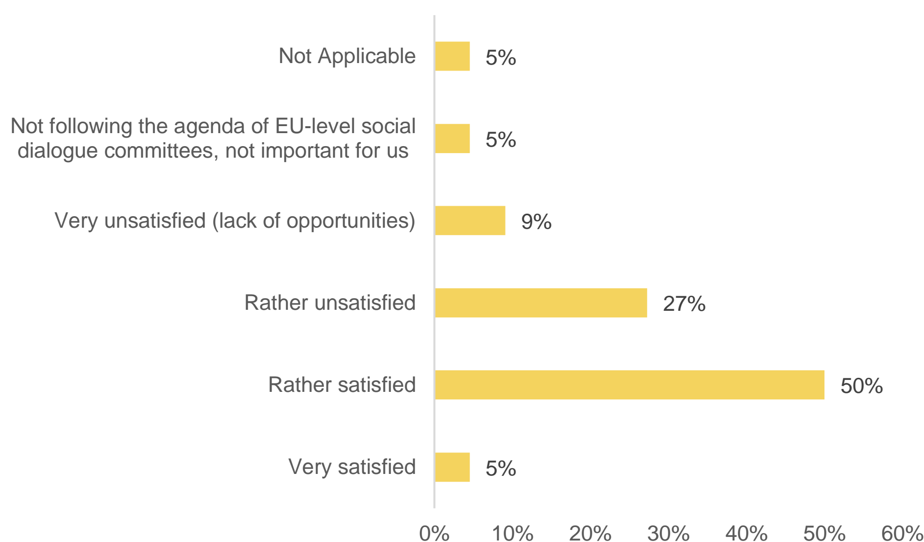
Table 5: The organisations' priorities with the highest rating (in %, N = 22)

Priority	Rating at 4	Rating at 5	Weighted average
Recruitment and retention policies for all health workers	50%	27%	4,0
Safety and health at work	27%	55%	4,3
Working conditions	14%	59%	4,2
Ageing workforce	23%	27%	3,6
The attractiveness of the sector for young workers	41%	23%	3,8
Vocational education and training	32%	41%	4,1
Recognition of skills at the national level	45%	32%	4,0
Continuing Professional Development and Life-long Learning	36%	50%	4,3
Mobility of health professionals in the EU	36%	9%	3,2
Cross-border recognition of professional qualifications	32%	32%	3,8
Digitalisation of workplace / digital skills	41%	32%	4,0
Reconciliation of work and family	36%	41%	4,2

Source: Survey on social dialogue in the hospital and healthcare sectors
Note: The question was "Do you consider any of the topics listed below priority for your organisation? Please rate each option from 1 to 5, where 1 represents the lowest priority and 5 the highest priority."

More than half of the respondents are satisfied (very or rather) with the opportunities to address the highest rated priorities in the EU level social dialogue committee in hospital and healthcare. 36% were unsatisfied and 5% are not following the EU level agenda.

Graph 5: Satisfaction with the opportunities to address the priorities at the EU level social dialogue (in %, N= 22)



Source: Survey on social dialogue in the hospital and healthcare sectors
Note: The question was: "How satisfied are you with the current opportunities to address the topics you rated as the highest priority (mark 4 and 5) in question 16 in EU level sectoral social dialogue committee in hospitals and healthcare? Select one option."

The reasons for non-satisfaction are lack of financial resources, lack of personnel resources (54%) and other priorities evenly per 63%. Lack of interaction with the EU level organisation is a reason for dissatisfaction for 38% of the organisations.

Table 6: The organisations' expectations from the EU level social dialogue structures (%, N= 22)

Expectations	Per cent
Support domestic collective bargaining (e.g. wage-related bargaining)	64%
Greater acknowledgement of our organisation's interests and incorporation into the EU level agenda of social dialogue	45%
Support of EU level social partners to our organisation in order to make a stronger impact on the policies in the health sector in our country	73%
To provide space for networking and exchange of experiences	55%
Capacity building – providing specific guidance on how to strengthen social dialogue and collective bargaining in our country's hospitals and healthcare	59%
Other	5%

Source: Survey on social dialogue in the hospital and healthcare sectors
Note: the question was - What are your expectations from the EU level social dialogue structures in the hospital and healthcare sector? Please select the three most relevant expectations from the options below.

The social partners expect the following from the EU level: support in making a stronger impact on the polices (73%), support in domestic collective bargaining (64%), capacity building (59%) and provide space for networking and exchange of experiences (55%). Even though some of the expectations are out of EU level social partners' competencies (for example, wage negotiating), the revealed aspects might be relevant for future discussion in order to involve the social partners from the Southern EU countries to EU level more intensively.

Conclusion

The report shows how the six Southern EU countries under analysis – Greece, Cyprus, Spain, Malta, Italy and Portugal are challenged by their healthcare underfunding and lack of staff in different professional categories. Despite some undergoing reforms the working conditions, brain drain, staff shortages and increase of precarious work hamper the reform implementation and the sustainability of the healthcare systems.

The role of social partner became a relevant and strategic issue. The structure of the social partners in the targeted counties is fragmented along the lines of subsectors and occupation challenging thus the representativeness of the social partnership and social bargaining. On the other hand, in some countries, only one cross-sectoral organisation is operating together with state bodies as employers in the public sector.

In light of the multiple challenges in the sector, the relevance of the European social dialogue is increasing. Also, the new European Commission perceives the strengthening of the European social dialogue as one of its priorities. Most of the social partners participating in the survey are represented by EPSU or HOSPEEM. The covering of the employers' organisations by HOSPEEM is, however, limited so far by the current insufficient presence of independent employers' organisations in the analysed countries.

The survey findings reveal that the social partners are informed but not sufficiently involved. Additionally, the information and understanding of the European Semester procedure are not sufficient among social partners. To get more involved and be active actors in the mechanism, social partners need not only to be informed but to be consulted as the Swedish case shows. For this reason, it is essential to use social dialogue, in particular at the national level to design and support the implementation of policies

Common and country-specific priorities have been identified by the survey and workshop discussion. The social partners, predominantly trade unions, wish to address working conditions, particularly the health and safety issues and labour rights. Another common topic to be communicated through the EPSU and HOPSEEM at the EU level is the improvement of social bargaining. Nevertheless, the perspective of employers needs to be more taken into account. They focus more on the topics of vocational training and long-term development of the professional skill, in the interconnection to the ageing of the workforce.

Annex

A. Methodology

A combined methodology design was used:

a) Desk research conducted from July to November 2019 focusing on identification of the social partners in the hospital and healthcare sector, their characteristics and studies on the national social dialogue and European Semester,

b) Tailored online survey dedicated to social dialogue in the healthcare sector consisted of 23 questions and structured in four areas:

(1) Identification of the organisations;
(2) Involvement in the national and EU level social dialogue, and European Semester;
(3) Priorities and topics to be communicated at the EU level;
(4) Satisfaction with the opportunities to address priorities and expectation from the EU level social dialogue structures.

The survey was translated into the four national languages (Greek for EL and CY, Spanish, Portuguese and Italian; for MT the English version was available) and distributed online via the Survey Monkey systems from July to November 2019. Approximately 27 different organisations, both trade unions and employers' organisations have been repeatedly invited to complete the survey. The structure of the respondents participating in the survey was as follows:

	Per cent	Number
Total number of respondents	100%	30
Country		
Cyprus	10,00%	3
Greece	30,00%	9
Italy	20,00%	6
Malta	13,33%	4
Portugal	10,00%	3
Spain	16,67%	5
Type of organisation		
Employers' organisation	23,33%	7
Trade union	73,33%	22
Other	3,33%	1
Position of the respondent within the organisation		
President	20,00%	6
Vice-President	10,00%	3
General Secretary	6,67%	2
Member of the Presidium	26,67%	8
Member of staff	16,67%	5
Other		

c) Analysis of the discussion at the Regional Workshop in Rome in November 2019
The discussion at the workshop was facelifted by structure prepared in advance; notes have been taken and consolidated into summary findings, complementing the survey and desk-research results.

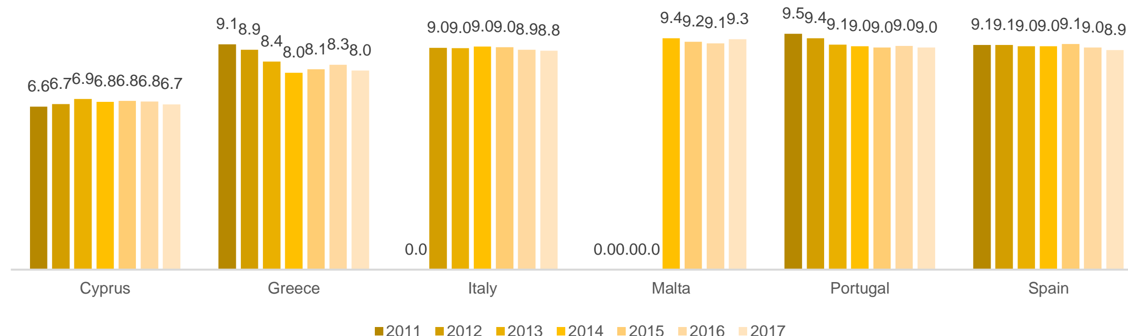
B. Statistical annexe

Table 7: Evolution of the healthcare expenditure – all financial schemes (% of GDP)

Country	2011	2012	2013	2014	2015	2016	2017
Cyprus	6,6	6,7	6,9	6,8	6,8	6,8	6,7
Greece	9,1	8,9	8,4	8,0	8,1	8,3	8,0
Italy	:	9,0	9,0	9,0	9,0	8,9	8,8
Malta	:	:	:	9,4	9,2	9,1	9,3
Portugal	9,5	9,4	9,1	9,0	9,0	9,0	9,0
Spain	9,1	9,1	9,0	9,0	9,1	9,0	8,9

Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]
Note: ":" means that the data are not available

Graph 6: Evolution of the healthcare expenditure – all financial schemes (% of GDP)



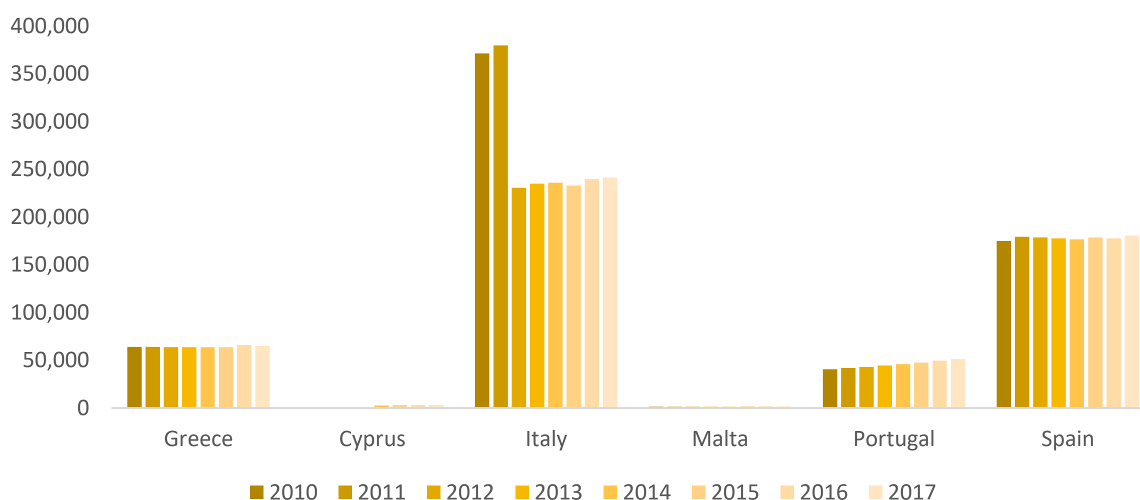
Source: Eurostat, Healthcare expenditure by financing scheme [online conde: hlth_sha11_hf]
Note: 0" means that the data are not available

Table 8: Evolution of the number of physicians (number)

Country	2010	2011	2012	2013	2014	2015	2016	2017	2018
Cyprus	:	:	:	:	2 880	3 046	3 209	3 325	:
Greece	64 032	64 145	63 838	63 736	63 906	63 866	65 972	65 240	:
Italy	371 450	379 930	230 621	234 918	235 889	233 102	239 642	241 512	241 136
Malta	1 279	1 319	1 381	1 466	1 566	1 636	1 743	1 855	1 925
Portugal	40 672	42 054	43 123	44 555	46 036	47 792	49 541	51 241	:
Spain	175 033	179 267	178 833	177 665	176 665	178 600	177 731	180 633	:

Source: Eurostat, Physicians by sex and age [online conde: hlth_rs_phys]

Graph 7: Evaluation of the number of physicians (all ages)



Source: Eurostat, Physicians by sex and age [online conde: hlth_rs_phys]

Table 9: Number of practising nurses, midwives, healthcare assistants and home-based personal care workers (all ages)

Country	2010	2011	2012	2013	2014	2015	2016	2017	2018
Cyprus	:	:	:	:	:	:	:	:	:
Greece	49 043	48 776	46 582	45 245	44 231	43 308	43 547	44 175	:
Italy	:	:	:	851 779	910 950	948 713	975 802	991 361	:
Malta	:	:	:	6 029	6 628	6 687	6 990	7 059	7 489
Portugal	:	:	:	:	:	:	:	:	:
Spain	:	:	:	:	:	:	:	:	:

Source: Eurostat, Nursing and caring professionals online conde: [hlth_rs_prsns]

C. European Semester Country-Specific Recommendations

The table below outline the four targeted countries' CSRs and other in-text recommendations in regard to health and social policy areas. It has to be noted that the information below is excerpts of the country's recommendations, adopted in July 2019.

Areas of recommendation	Cyprus	Greece	Italy	Malta	Portugal	Spain
Health policy						
Healthcare system and infrastructure	Progress made on healthcare by adopting legislation to establish the new National Health System: • seeks to improve access; • introduce universal health coverage; • reduce the high level of out-of-pocket payments; • increase the efficiency of care delivery in the public sector; • ensures the financial and operational autonomy of public hospitals. **CSR**: Take measures to ensure that the National Health System becomes operational in 2020, as planned while preserving its long-term sustainability.	A far-reaching reform of the primary healthcare system initiated in 2017: • relevant to ensure access; • continued investment through the deployment of local healthcare unit required. **CSR**: Focus on investment-related economic policy on sustainable healthcare, taking into account regional disparities and the need to ensure social inclusion;	Overall good outcome but the various providers of healthcare across regions; impact on: • access; • equity; • efficiency; Potential to be improved by: • better administration • monitoring the standard levels of services. **Recommendations:** • More home and community-based care and long-term care to people with disabilities and other disadvantaged groups; • Geographical disparities to be taken into account in health and long-term care availability of services **CSR:** Improve effectiveness, accessibility and sustainability of health care	Current situation: • Increase of the age-related public spending in healthcare systems; • Risk of rising debt in the long term; • Ongoing measures to decentralise services from hospitals to primary care; • Tackling long waiting time by expanding the capacity of public-hospital outpatient care; • Increasing demand for long-term care; • Introduction of new types of community-based and home services; • No impact of the measures taken on fiscal sustainability so far. **CSR**: Ensure the fiscal sustainability of the healthcare system, including by • restricting early retirement; • adjusting the statutory retirement age in view of expected gains in life expectancy.	• Continuous pressure on public finances from the adverse demographic trends; • Promotion of the cost-effectiveness by increased centralised purchasing and use of generics; • Inadequate budgetary planning and accounting control resulting in high hospital arrears; • introducing a new governance model for public hospitals to structurally addressing arrears in 2019. **CSR**: Improve the quality of public finances by prioritising growth-enhancing spending while strengthening overall expenditure control, cost efficiency and adequate budgeting, with a focus in particular on a durable reduction of arrears in hospitals.	
Social policy						
Skills	Access to quality education and training with a life-long perspective taking into account future needs. **Recommendations:**	Rising skills shortages and mismatches and a changing world of work. **Recommendations**:	Consider the future-oriented acquisition of skills, including measures to promote adult learning. **Recommendations**:	Additional efforts to improve quality and inclusiveness of education and training systems, with particular attention to disadvantaged groups.	Skills levels remain low for several population groups. Improving employability and social mobility by investing in education, training and infrastructure.	Skills shortages and mismatches hamper the development and use of advanced technologies, in particular by small and medium-sized firms.

	• Increase the capacity of vocational education and training; • Increase employers' engagement and learners' participation in vocational education and training. **CSR**: Improve labour market relevance of their education and training systems.	• Increase the capacity of vocational education and training • Strengthen and modernise education and training systems.	• Strengthen the attractiveness of the teaching profession; • Upskilling is particularly needed for digital skills. **CSR:** Improve educational outcomes, also through • adequate and targeted investment; • foster upskilling in digital skills.		**CSR**: Improve the skills level of the population, in particular, their digital literacy, including by making adult learning more relevant to the needs of the labour market	Stalled efforts to reform the education system. **CSR**: Reduce early school leaving and increase cooperation between education and businesses to improve the provision of labour market-relevant skills and qualifications, in particular for information and communication technologies.
Wage		**Recommendation:** completion of more comprehensive reforms of welfare benefits.	Income inequality and risk of poverty are high, with wide regional and territorial disparities. The gender employment gap remains one of the highest in the Union. A comprehensive strategy to promote women's participation in the labour market is still missing.		Despite decreased income inequality, still significantly higher than the Union average. The adequacy of the minimum income scheme is among the lowest in the Union. **Recommendation:** Improve the coverage, adequacy or effectiveness of the social safety net, including minimum income schemes	Regional disparities presented in regional minimum income schemes; Limited portability between regions reduces incentives for labour mobility. **Recommendations:** • Integrate territorial development strategies, including actions promoting entrepreneurship, digitalisation and the social economy. • Address coverage gaps in regional minimum income schemes.
Social dialogue		Effective social dialogue and responsible social partnership can support • the environment for the implementation; • ownership of sustained reforms.	The initially envisaged reform of the collective bargaining framework aimed to bring wages and salaries more in line with economic conditions at the regional and firm-level. A framework agreement signed with the three major Italian trade unions in order to • expand second-level bargaining; • increases legal certainty by setting more precise rules for the representation of social partners at negotiations; • establishment of an improved algorithm for setting wage minima.			While the setting-up of tripartite round tables is a good step towards more significant involvement by the social partners in policy design, there is room for more in-depth and more timely consultations.

Source: Overview compiled by CELSI team based on Country-Specific Recommendations within the European Semester 2019

D. Participant list of Regional Workshop: Southern Europe

Last name	First name	Organisation	Affiliation	Country
Andronikos	Andronikou	PASYDY	EPSU	Cyprus
Antoniou	Zoyia	PASYDY	EPSU	Cyprus
Barlet	Celine	HOSPEEM	HOSPEEM	Belgium
Bartolini	Antonio	ARAN	HOSPEEM	Italy
Bergendorff	Sandra	SALAR	HOSPEEM	Sweden
Bonvicini	Riccardo	UIL	EPSU	Italy
Bossart	Patrice	CGT Santé et Action Sociale	EPSU	France
Boudhan	Mounia	EPSU	EPSU	Belgium
Branca	Marta	ARAN	HOSPEEM	Italy
Bugeja	Lawrence	General Workers' Union	EPSU	Malta
Ciociola	Filomena	UIL FPL	EPSU	Italy
Dahlstrom	Tore	Norwegian Nurses Organisation	EPSU	Norway
De Carli	Gabriella	INMI Spallanzani	HOSPEEM	Italy
Di Lorenzi	Stefano	FIALS	Other	Italy
Di Pasquale	Flavia	FIASO	HOSPEEM	Italy
Duch	Cyrille	Cfdt Sante Sociaux	EPSU	France
Fasoli	Sara	HOSPEEM	HOSPEEM	Belgium
Gae	Razvan	Sanitas	EPSU	Romania
Gaglio	Christian	INMI Spallanzani	HOSPEEM	Italy
Galanti	Costanza	University College Dublin	Other	Ireland
Gentile	Elvira	ARAN	HOSPEEM	Italy
Grieco	Nicoletta	FP CGIL	EPSU	Italy
Griskonis	Sigitas	Lithuanian National Association of Healthcare organizations	HOSPEEM	Lithuania
Grudev	Krasimir	National Union of Private Hospitals	Other	Bulgaria
Holubová	Barbora	CELSI	Other	Slovakia
Kahancová	Marta	CELSI	Other	Slovakia
Kalejs	Jevgenijs	Latvian Hospitals Association	HOSPEEM	Latvia
Koutsioumpelis	Stavros	ADEDY	EPSU	Greece
Krivmane	Kristine	European Commission	Other	Belgium
Leso	Davide	FIALS	Other	Italy
Librandi	Michelangelo	UIL FPL	EPSU	Italy
Ling	Kathleen	NHS Confederation	HOSPEEM	United Kingdom
Lozano	Jesus	FeSP-UGT	EPSU	Spain
Malapitan	Christopher	Graphic designer	Other	Belgium
Mathiopoulos	Georgios	ADEDY	EPSU	Greece
Michelutti	Paolo	AGE.NA.S	Other	Italy
Mohrs	Simone	HOSPEEM	HOSPEEM	Belgium

Monastero	Viviana	FIASO	HOSPEEM	Italy
Muscat	Arthur	Malta Employers' Association	Other	Malta
Naughton	Mary	University College Dublin	Other	Ireland
Neuhauser	Ulrike	Observer	Other	Austria
Øst-Jacobsen	Kim	FOA	EPSU	Denmark
Passri	Vingillo	INMI Spallanzani	HOSPEEM	Italy
Pena Costa	Manuel Marcelino	Portuguese Commerce and Services Confederation	Other	Portugal
Pinelli	Nicola	FIASO	HOSPEEM	Italy
Rabben Asbjornsen	Anita	Norwegian Nurses Organisation	EPSU	Norway
Ripa di Meana	Francesco	FIASO	HOSPEEM	Italy
Rossini	Gianfranco	AGE.NA.S	Other	Italy
Sarafianos	Grigorios	Panhellenic Union of Private Hospitals	Other	Greece
Scarpiello	Luca	EPSU	EPSU	Belgium
Stivala	Mireille	CGT Santé et Action Sociale	EPSU	France
Tolsá	Desiderio Rodrigo	FeSP-UGT	EPSU	Spain
Travaglini	Michaela	ARAN	HOSPEEM	Italy
Tripodina	Matteo	FIASO	HOSPEEM	Italy
Vannini	Michele	FP CGIL	EPSU	Italy
Vestergaard Sørensen	Malene	Danish Regions	HOSPEEM	Denmark
Weinreich-Jensen	Eva	HOPE	Other	Belgium
Welz	Christian	Eurofound	Other	Ireland
Zambujo Boieiro	Emanuel António	Nurses' Union - Sindicato Dos Enfermeiros	Other	Portugal
Zettergren	Göran	Swedish Confederation of Professional Employees	EPSU	Sweden