

## Belgium: The representativeness of trade unions and employer associations in the hospital sector

[Correspondent:] Please change the title to: '<Country>: The representativeness of trade unions and employer associations in the hospital sector'.

### [Correspondent:] Length and format

The responses of the national centres should be no longer than 2,500 words.

**Important: Please use this EIRO template questionnaire to respond, filling in the answer to each question underneath that question. Please also be reminded to fill in the metadata.**

Please retain all headings in the document. Do not change the text of the headings. You may add sub-headings if necessary. Please retain any text appearing in blue, which uses the 'Comment Text' paragraph style, as this will be automatically removed prior to publication. All other text (not in headings or in comments) will be retained and published online, so please ensure that it is suitable for publication.

If you have any queries on administrative issues (deadlines, submission etc), please contact Alexandra Gryparis in the first instance. If you have any queries on the content of the information requested, please contact Franz Traxler ([franz.traxler@univie.ac.at](mailto:franz.traxler@univie.ac.at)) and Georg Adam ([georg.adam@univie.ac.at](mailto:georg.adam@univie.ac.at)) who are coordinating the study.

### [Correspondent:] Timing

The deadline for the submission of responses by national centres is **4 December 2007**.

**In order to fill in this questionnaire it is absolutely necessary to carefully read the accompanying guidelines (i.e. briefing note).**

*Based on fragmented information provided by the involved social partners, the representativeness of the Belgian collective bargaining system in the hospital sector is presented in a concise way. Hospitals are a key factor in the high-quality Belgian health system. Collective bargaining is organised differently, but coordinated for the private (mainly not-for-profit) hospitals and public hospitals. The bargaining takes place with well-established rules and actors. However, compared to other sectors, especially the employers' side has on the one hand a fragmented organisational character, but on the other hand a coverage of 100%.*

[Correspondent:] In the abstract, summarise the quantitative relevance of the hospital sector in your country's economy and the sector's characteristics with respect to collective bargaining and the national actors' representativeness. The length should be no more than **100 words**.

## 1. Sectoral properties

Please provide the following data:

	1995	2005**
Number of employers: hospitals (general and psychiatric) (Note: if the number of employers is not available, please indicate the form of the unit (e.g. companies, establishments, etc.) the number refers to	284	215

Aggregate employment*	n.a	n.a
Male employment*	n.a	n.a
Female employment*	n.a	n.a
	1997	2004
Aggregate employees	145,732	165,437
Male employees***	30,752	32,742
Female employees***	114,954	132,646
Aggregate sectoral employment as a % of total employment in the economy		
Aggregate sectoral employees as a % of the total number of employees in the economy	3.5%	3.8%

\* *employees plus self-employed persons and agency workers*

\*\* *or most recent data*

\*\*\* *1997 26 missing; 2004: 49 missing; employee data are provided by the Cross Roads Bank Social Security and combine data from public and private sector*

Source: Federal Public Service Public Health, Food Chain Safety

A common categorisation is to divide the hospitals in general and psychiatric ones. The general category is itself divided into acute care hospitals (80%), geriatric hospitals (4%) and specialist hospitals (16%). Some general hospitals have psychiatric departments but these can treat psychiatric cases for short stays only. A specific category of general hospitals are the university hospitals, which are large hospitals combining very specialist treatments with research and education. However, care is not only provided in hospitals, but also in rest homes, combined rest and nursing homes and psychiatric care houses. This latter category is not taking into account for the study. Finally, Belgium also counts a number of military hospitals. Unlike the other hospitals, military hospitals do not fall under the Hospital Law. This last category of hospitals falls under the Ministry of Defence. Again, these military hospitals are excluded from the study.

About 60 per cent of all Belgian hospitals are non-profit private institutions, and the remainder are public institutions. Most of the private hospitals are owned by non-profit organisations which originally had links with religious charitable orders, some 5 per cent are owned by the mutual funds, and a small number by doctors (specialists). A public hospital, on the other hand, can be run by an OCMW, a public law association, an inter-municipal association,<sup>4</sup> a province, a regional community or by the State. OCMW hospitals are the most common type of public law hospitals. OCMW hospitals are, however, not necessarily of public law nature. Most hospitals are non-profit institutions. There are only a very limited number of for-profit hospitals (in 1999 there were two for-profit hospitals).

General employment figures are difficult to calculate for the hospitals specifically. Doctors are in Belgium self-employed as 'free profession' and need an accreditation. Specialists combine very often an appointment in a hospital together with a private practice. In other words, data exist on the number of people working as self-employed or employee in the health sector, but not for the hospital sector concretely. Figures from the Ministry of Health state that hospitals employed in 2001 168,645 people (self-employed and employed).

The employee figures are based on a merger of social security administrative data of the private sector (RSZ) and public sector (RSZPPO).

## 2. The sector's unions and employer associations

This section includes the following unions and employer associations:

1. unions which are party to sector-related collective bargaining (In line with the conceptual remarks outlined in the accompanying briefing note, we understand sector-related collective bargaining as any kind of collective bargaining within the sector, i.e. single-employer bargaining as well as multi-employer bargaining. For the definition of single- and multi-employer bargaining, see 4.2)
2. unions which are a member of the sector-related European Union Federation (i.e. EPSU – European Federation of Public Service Unions)
3. employer associations which are a party to sector-related collective bargaining
4. employer associations which are a member of the sector-related European Employer Federation (i.e. HOSPEEM – Hospital and Healthcare European Employers' Association)

For the notion of 'sector-related', see the conceptual remarks in the accompanying background briefing note. Please be reminded that trade unions and employer associations should be excluded where their domain covers, for instance, only medical practice activities according to NACE 85.12, but not any part of hospital activities according to NACE 85.11!

### 2a Data on the unions

*2a.1 Type of membership (voluntary vs. compulsory)*

*2a.2 Formal demarcation of membership domain (e.g. blue-collar workers, private-sector workers, service sector employees, etc.)*

*2a.3 Number of union members (i.e. the total number of members of the union as a whole)*

*2a.4 Number of union members in the sector*

*2a.5 Female union members as a percentage of total union membership*

*2a.6 Density with regard to the union domain (see 2a.2)*

*2a.7 Density of the union with regard to the sector*

*2a.8 Does the union conclude collective agreements?*

*2a.9 For each association, list their affiliation to higher-level national, European and international interest associations (including cross-sectoral associations)*

Please document these data union by union.

Union density is defined as the ratio of union members to potential union members, as demarcated by the union's domain and by the sector.

If the domain of a union embraces only part of the sector, then the data on density should refer to this part.

### *Introductory remarks*

Unions, participating in collective bargaining, are sectoral federations of the three, traditional, representative union confederations in Belgium. Different sector federations are involved for the public sector (approx. 1/4<sup>th</sup> of the employee population) and private sector hospitals. Within the Christian trade unions, these organisations are also split by a language divide (Flemish/Walloon).

Besides these unions, there are also occupational associations for nurses active in the sector. However, they don't participate in the system of collective bargaining. These associations cover most of the time also self-employed nurses. The umbrella organisation of these nursing associations is the General Union of Nursing personnel in Belgium (Algemene Unie Van Verpleegkundigen België, AUVB). Recently, these nursing associations created also an umbrella organisation on the Flemish side, called the Flemish Nursing Union (Vlaamse verpleegunie). These occupational associations are involved in some of the sectoral concertation bodies, mainly to do with accreditation, planning and skill issues in the sector.

Doctors are in Belgium self-employed. They also have their own interest groups and associations.

### *ACV-Public Services (ACV-Openbare diensten/CSC Services Publics)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all public service workers

in the sector, public hospitals, all personnel

3 Number of union members (i.e. the total number of members of the union as a whole): 148,908

4 Number of union members in the sector: n.a.

5 Female union members as a percentage of total union membership: 46% of the total membership in general

6 Density with regard to the union domain (see 2a.2):

7 Density of the union with regard to the sector: 30% in the sector of public hospitals

8 Does the union conclude collective agreements? The unions signs protocols with the government, which are afterwards implemented by the government; Negotiations take place within Committee A and C of the public sector.

9 National, European, international membership: ACV/CSC; Eurofedop; EPSU; Infedop and ETUC, ITUC,

### *General Federation of Public Services (Algemene Centrale der Openbare Diensten, Centrale Générale des Services Publics ; ACOD/CGSP)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all public service workers

in the sector, public hospitals, all personnel

3 Number of union members (i.e. the total number of members of the union as a whole): 284,576

4 Number of union members in the sector: 11,423

5 Female union members as a percentage of total union membership: n.a.

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: 25% in the sector of public hospitals

8 Does the union conclude collective agreements? The unions signs protocols with the government, which are afterwards implemented by the government; Negotiations take place within Committee A and C of the public sector.

9 National, European, international membership: ABVV/FGTB; EPSU; PSI, ETUC, ITUC

*Free trade union of the Public Service (Vrij Syndicaat voor het Openbaar Ambt – Groep Lokale en Regionale Besturen/Syndicat Libre de Fonction Publique - Groupe Administrations Locales et Régionales VSOA-LRB/SLFP-ALR)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all public service workers

in the sector, public hospitals, all personnel

3 Number of union members (i.e. the total number of members of the union as a whole): n.a.

4 Number of union members in the sector: n.a. (a minority in the sector)

5 Female union members as a percentage of total union membership: n.a.

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: n.a.

8 Does the union conclude collective agreements? The unions signs protocols with the government, which are afterwards implemented by the government; Negotiations take place within Committee A and C of the public sector.

9 National, European, international membership: ACLVB; EPSU; ETUC

*National Employee Federation (Landelijke Bediende Centrale – Nationaal Verbond van het Kaderpersoneel; LBC-NVK)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all white-collar workers (including professional and managerial staff) in Flanders and Brussels and working in the private sector.

in the sector: private hospitals, all personnel (white-collars and blue-collars), Flanders and Brussels

3 Number of union members (i.e. the total number of members of the union as a whole): 297,449

4 Number of union members in the sector: n.a. (considered as the majority union in the sector for Flanders; they obtained more than 80% of the seats in local works councils; )

5 Female union members as a percentage of total union membership:59% (of the total membership, not only the sector).

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: n.a.

8 Does the union conclude collective agreements? Yes, joint committee 330

9 National, European, international membership: ACV; EPSU (for this sector); ETUC, ITUC

*National Employee Federation (Centrale Nationale des Employés - Le Groupement National des Cadres, CNE-GNC)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all white-collar workers (including professional and managerial staff) in Wallonia and Brussels and working in the private sector.

in the sector: private hospitals, all personnel (white-collars and blue-collars); Wallonia and Brussels

3 Number of union members (i.e. the total number of members of the union as a whole): 145,415

4 Number of union members in the sector: n.a. (considered as the majority union in the sector for Wallonia)

5 Female union members as a percentage of total union membership:64% (of the total membership, not only the sector).

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: n.a.

8 Does the union conclude collective agreements? Yes, joint committee 330

9 National, European, international membership: CSC; EPSU (for this sector); ETUC, ITUC

*Federation Employees, Technicians and Cadres (Bond Bedienden, Technici en Kaderleden/Syndicat des Employés, Techniciens et Cadres ; BBTK-SETCA)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all white-collar workers (including professional and managerial staff) working in the private sector.

in the sector: private hospitals, all white-collar personnel

3 Number of union members (i.e. the total number of members of the union as a whole): 356,912

4 Number of union members in the sector: approx. 10,000

5 Female union members as a percentage of total union membership:n.a.

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: approx. 10%.

8 Does the union conclude collective agreements? Yes, joint committee 330

9 National, European, international membership: ABVV; EPSU (for this sector); ETUC, ITUC

*General Federation (Algemene Centrale/Centrale Générale ; AC-CG)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: blue-collar workers in a range of industry and service sectors.

in the sector: private hospitals, only blue-collars (minority in the hospital sector)

3 Number of union members (i.e. the total number of members of the union as a whole): 350,764

4 Number of union members in the sector: n.a.

5 Female union members as a percentage of total union membership:n.a.

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: n.a.

8 Does the union conclude collective agreements? Yes, joint committee 330

9 National, European, international membership: ABVV; ETUC, ITUC

*ACLVB-Liberal trade union (ACLVB-Liberale Vakbond/CGSLB-Syndicat Liberal ; ACLVB-CGSLB)*

1. Type of membership: voluntary

2. Formal demarcation of membership:

in general: all personnel in the private sector.

in the sector: private hospitals, all personnel

3 Number of union members (i.e. the total number of members of the union as a whole): +/- 220,000

4 Number of union members in the sector: 2089

5 Female union members as a percentage of total union membership:n.a.

6 Density with regard to the union domain (see 2a.2): n.a.

7 Density of the union with regard to the sector: 2 to 3% (private sector hospitals)

8 Does the union conclude collective agreements? Yes, joint committee 330

9 National, European, international membership: ETUC, ITUC

Remarks on all the provided union data: general union data are from 2005; sector, if provided by the organisation, current figures; Union figures include always inactive members (unemployed, retired). General union data:ACV/CSC without historic upgrading factor; ABVV/FGTB with historic upgrading factor.

## **2b Data on the employer associations**

*2b.1 Type of membership (voluntary vs. compulsory)*

*2b.2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.)*

*2b.3 Number of member companies (i.e. the total number of members of the association as a whole)*

*2b.4 Number of member companies in the sector*

*2b.5 Number of employees working in member companies (i.e. the total number of the association as a whole)*

*2b.6 Number of employees working in member companies in the sector*

*2b.7 Density of the association in terms of companies with regard to their domain (see 2b.2)*

*2b.8 Density of the association in terms of companies with regard to the sector*

*2b.9 Density in terms of employees represented with regard to their domain (see 2b.2)*

*2b.10 Density in terms of employees represented with regard to the sector*

*2b.11 Does the employer association conclude collective agreements?*

*2b.12 For each association, list their affiliation to higher-level national, European and international interest associations (including the cross-sectoral associations).*

Please document these data employer association by employer association.

Employer density in terms of companies is defined as the ratio of member companies to the potential member companies, as demarcated by the employer associations' domain and by the sector.

Employer density in terms of employees is defined as the ratio of the number of employees working in the member companies to the number of employees working in the potential member companies, as demarcated by the employer associations' domain and by the sector.

If the domain of an employer association embraces only part of the sector, then the data on density should refer to this part.

### *Introductory remark*

Employers (from a collective bargaining point of view mainly a concept relevant in the private sector) were traditionally organised according to:

- Statute: private for-profit, i.e. run by doctors; private not-for-profit run by ‘pillarised’ organisations (mainly catholic, but also socialist and to a lesser extent liberal); public (ownership by communal or to a lesser extent provincial authorities).
- Within the dominant not-for-profit segment by ‘pillarised’ ownership: catholic and socialist and within the catholic sector between the hospitals owned by religious charities (caritas catholica) and the christian health fund (mutualistic fund).
- A third ‘divide’ has been region: for some of the mentioned segments a further division in employers’ organisations exist by region: Flanders, Wallonia and/or Brussels.
- Finally, the large academic hospitals – which have a special statute in the Belgian hospital system - also have created an additional interest group, although they are most of the time also member of another employers’ organisation.

Furthermore, a lot of the employers’ organisations are not only covering hospitals, but also other parts of the supply-side in the health care system (elderly care; mental care; day care; ...).

Finally, a lot of mergers have been happening in the Belgian hospital sector. It means that the formerly ‘clear’ statute of hospitals (for example: public owned by the local authorities, or private not-for profit owned by a catholic organisation) is now more confused. Conglomerates exist now that can be ‘yes’ or ‘no’ a merger of hospitals with a different background.

These situations lead on the one hand to the fact that probably a lot of the hospitals are members of more than one employers’ organisation. On the other hand, it means that the employers’ organisations, presented in this report and which are the hospital-related employers’ organisations present in the key bargaining joint committee 330 of the private hospital sector, cover all together the whole hospital sector on the employers’ side (coverage of 100%).

All the employers’ organisations participate in a general council of dialogue between the employers, called the National Confederation of Care Institutions (Nationaal Verbond van Verzorgingsinstellingen/Confederation Nationale des Etablissements de Soins; NVVI/CNES). However, as this is only a concertation body to prepare common opinions and positions, we do not consider this Confederation as a ‘real’ employers’ organisation.

A last technical remark: these employers’ organisations are used to count their ‘representativity’ in how many (hospital) beds the member-institutions represent. These ‘beds’ are (traditionally) a crucial factor in the accreditation and financing of hospitals. Based on these ‘bed’ figures, mandates are distributed in the key concertation bodies in the planning system of the sector by the Ministry of Health (for example the Council for Hospital Services). As a result: the organisations have difficulties to count in ‘number of employees’ in relation to their representativity.

Anyhow, presented figures are based on self-reporting of the organisations or consultation of their websites.

### *Federation of Caring Institutions (Vereniging van Verzorgingsinstellingen, VVI)*

1 Type of membership (voluntary vs. compulsory): voluntary

2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Flemish, private-catholic institutions, active in the care sector (including the hospitals)

3 Number of member companies (i.e. the total number of members of the association as a whole): 566

- 4 Number of member companies in the sector: 82 (48 general hospitals and 34 psychiatric hospitals)
- 5 Number of employees working in member companies (i.e. the total number of the association as a whole): appr. 80,000
- 6 Number of employees working in member companies in the sector: n.a.
- 7 Density of the association in terms of companies with regard to their domain (see 2b.2): +/-38%
- 8 Density of the association in terms of companies with regard to the sector: +/-38%
- 9 Density in terms of employees represented with regard to their domain (see 2b.2): +/-22%
- 10 Density in terms of employees represented with regard to the sector: n.a.
- 11 Does the employer association conclude collective agreements? Yes, under the umbrella of Caritas Catholica 4 seats in joint committee 330.
- 12 Membership to higher-level national, European and international interest associations: Confederation of social profit companies (CSPO); Flemisch social profit companies (Verso); Caritas International, HOPE, IHF

*Federation of Public care institutions (Vereniging van Openbare Verzorgingsinstellingen/Association des Etablissements Publics de Soins ; VOV-AEPS)*

- 1 Type of membership (voluntary vs. compulsory): voluntary
- 2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): hospitals with a (partly) ownership by public authorities (most of the time local or provincial).
- 3 Number of member companies (i.e. the total number of members of the association as a whole): 48
- 4 Number of member companies in the sector: 48
- 5 Number of employees working in member companies (i.e. the total number of the association as a whole): appr. 50,000
- 6 Number of employees working in member companies in the sector: appr. 50,000
- 7 Density of the association in terms of companies with regard to their domain (see 2b.2): 100%
- 8 Density of the association in terms of companies with regard to the sector: +/-25%
- 9 Density in terms of employees represented with regard to their domain (see 2b.2): 100%
- 10 Density in terms of employees represented with regard to the sector: +/-30%
- 11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); one mandate in joint committee 330.
- 12 Membership to higher-level national, European and international interest associations: Confederation of social profit companies (CSPO); Flemisch social profit companies (Verso); Confederatie van Social Profit Ondernemingen (CSPO) op het federale niveau, Brussels Confederation of Social Profit Companies (BCSPO); French-speaking federation of not-for-profit companies (UFENM); HOPE

*Belgian Confederation of Private Health Care Institutions (Belgische Confederatie voor Private Inrichtingen/Confédération Belge des Etablissements Privés de Soins de Santé ; BECOPRIVE –COBEPRIVE)*

1 Type of membership (voluntary vs. compulsory): voluntary

2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Private health care institutions, i.e. not run by one of the 'pillarised' organisations, but especially in the hospital sector set-up by doctors. The organisation is a confederation of four employers' organisations (VGBM, BSK, FERUBEL, SENIORENUNIE). Two of these organisations are particularly relevant for the hospital sector: Federation of doctor-administrators and doctors-governors of care companies (Vereniging der Geneesheren Bestuurders en Mandatarissen van verzorgingsondernemingen; VGBM) and the Belgian Syndical Chamber of Care Institutions (Belgische Syndicale Kamer der verzorgingsinstellingen; BSK). These two associations are federated in the Union of Private Hospitals in Belgium (Vereniging van Private Ziekenhuizen in België; VPZB/FHPB). In 1978 this VPZB confederated with the other non-hospital federations (cf. FERUBEL, SENIORENUNIE). BSK and VGBM under the umbrella of VPZB have always represented the private-for-profit hospitals in the sector. In joint committee 330, they are represented by BECOPRIVE, because the bargaining committee has a broader domain description than only hospitals.

3 Number of member companies (i.e. the total number of members of the association as a whole): 900

4 Number of member companies in the sector: +/-20

5 Number of employees working in member companies (i.e. the total number of the association as a whole): +/-14,0000.

6 Number of employees working in member companies in the sector: n.a.

7 Density of the association in terms of companies with regard to their domain (see 2b.2): 100%

8 Density of the association in terms of companies with regard to the sector: +/-10%

9 Density in terms of employees represented with regard to their domain (see 2b.2): 100%

10 Density in terms of employees represented with regard to the sector: n.a.

11 Does the employer association conclude collective agreements? Yes

12 Membership to higher-level national, European and international interest associations: European Union of Private Hospitals (UEHP)

*National Federation of Medico-social associations (Nationaal verbond van medisch-sociale verenigingen/ Fédération nationale des associations médico-sociales; NVMSV-FNAMS)*

1 Type of membership (voluntary vs. compulsory): voluntary

2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Care institutions (including hospitals) with a (partly) ownership by the Christian health fund; the organisation has several cooperation agreements with other employers' organisations (FIH-W, VVI).

3 Number of member companies (i.e. the total number of members of the association as a whole): n.a.

- 4 Number of member companies in the sector: 20
- 5 Number of employees working in member companies (i.e. the total number of the association as a whole): n.a.
- 6 Number of employees working in member companies in the sector: n.a.
- 7 Density of the association in terms of companies with regard to their domain (see 2b.2): 100%
- 8 Density of the association in terms of companies with regard to the sector: +/-10%
- 9 Density in terms of employees represented with regard to their domain (see 2b.2): 100%
- 10 Density in terms of employees represented with regard to the sector: n.a.
- 11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); one seat in joint committee 330.
- 12 Membership to higher-level national, European and international interest associations: Confederation of social profit companies (CSPO); Flemish social profit companies (Verso); Confederation van Social Profit Ondernemingen (CSPO) at the federal level, Brussels Confederation of Social Profit Companies (BCSPO); French-speaking federation of not-for-profit companies (UFENM).

*Belgian association of hospitals (Belgische Vereniging van Ziekenhuizen/Association belge des Hôpitaux; BVZ/ABH)*

- 1 Type of membership (voluntary vs. compulsory): voluntary
- 2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Hospitals
- 3 Number of member companies (i.e. the total number of members of the association as a whole): n.a.
- 4 Number of member companies in the sector: n.a.
- 5 Number of employees working in member companies (i.e. the total number of the association as a whole): n.a.
- 6 Number of employees working in member companies in the sector: n.a.
- 7 Density of the association in terms of companies with regard to their domain (see 2b.2): n.a.
- 8 Density of the association in terms of companies with regard to the sector: n.a.
- 9 Density in terms of employees represented with regard to their domain (see 2b.2): n.a.
- 10 Density in terms of employees represented with regard to the sector: n.a.
- 11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); one seat in joint committee 330.
- 12 Membership to higher-level national, European and international interest associations: HOPE.

*Federation of Walloon Hospital Institutions (Fédération des Institutions Hospitalières de Wallonie ; FIH-W)*

- 1 Type of membership (voluntary vs. compulsory): voluntary
- 2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Care institutions, private, not-for-profit, Christian, Walloon region

3 Number of member companies (i.e. the total number of members of the association as a whole): 145

4 Number of member companies in the sector: 31 (general, specialised and psychiatric).

5 Number of employees working in member companies (i.e. the total number of the association as a whole): n.a.

6 Number of employees working in member companies in the sector: n.a.

7 Density of the association in terms of companies with regard to their domain (see 2b.2): 100%

8 Density of the association in terms of companies with regard to the sector: 14%.

9 Density in terms of employees represented with regard to their domain (see 2b.2): 100%

10 Density in terms of employees represented with regard to the sector: n.a. (around 45% in the Walloon region).

11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); two seats in joint committee 330.

12 Membership to higher-level national, European and international interest associations: Confederation van Social Profit Ondernemingen (CSPO) at the federal level, French-speaking federation of not-for-profit companies (UFENM), Caritas Catholica International, HOPE, IHF

### *French-speaking Association of Health Care Institutions (Association Francophone d' Institutions de Santé ; AFIS)*

1 Type of membership (voluntary vs. compulsory): voluntary

2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Care institutions, private and public, Brussels region and Walloon region, historic links with the socialist pillar

3 Number of member companies (i.e. the total number of members of the association as a whole): 67

4 Number of member companies in the sector: +/-20 (general, specialised and psychiatric).

5 Number of employees working in member companies (i.e. the total number of the association as a whole): n.a.

6 Number of employees working in member companies in the sector: n.a.

7 Density of the association in terms of companies with regard to their domain (see 2b.2): 100%

8 Density of the association in terms of companies with regard to the sector: +/-10%.

9 Density in terms of employees represented with regard to their domain (see 2b.2): 100%

10 Density in terms of employees represented with regard to the sector: n.a.

11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); two seats in joint committee 330.

12 Membership to higher-level national, European and international interest associations: Confederation van Social Profit Ondernemingen (CSPO) at the federal level, French-speaking federation of not-for-profit companies (UFENM), HOPE.

*Brussels' Confederation of Social and Health Care Institutions (Confédération Bruxelloise des Institutions Sociales et de Santé/ Coördinatie van Brusselse Instellingen voor welzijnswerk en gezondheidszorg, CBI)*

- 1 Type of membership (voluntary vs. compulsory): voluntary
- 2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Care institutions, private, not-for-profit, Christian, Brussels
- 3 Number of member companies (i.e. the total number of members of the association as a whole): 31
- 4 Number of member companies in the sector: 8 (general, specialised and psychiatric).
- 5 Number of employees working in member companies (i.e. the total number of the association as a whole): n.a.
- 6 Number of employees working in member companies in the sector: n.a.
- 7 Density of the association in terms of companies with regard to their domain (see 2b.2): 100%
- 8 Density of the association in terms of companies with regard to the sector: 4%.
- 9 Density in terms of employees represented with regard to their domain (see 2b.2): 100%
- 10 Density in terms of employees represented with regard to the sector: n.a.
- 11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); one seat in joint committee 330.
- 12 Membership to higher-level national, European and international interest associations: Confederation van Social Profit Ondernemingen (CSPO) at the federal level, Brussels Confederation of Social Profit Companies (BCSPO/CBENM), Caritas Catholica Belgium and International.

*Socialist Federation of Flemish health services (Socialistische vereniging van Vlaamse gezondheidsvoorzieningen; SOVERVLAG)*

- 1 Type of membership (voluntary vs. compulsory): voluntary
- 2 Formal demarcation of membership domain (e.g. SMEs, small-scale crafts/industry, health services, etc.): Care institutions, private, not-for-profit, socialist, Flanders
- 3 Number of member companies (i.e. the total number of members of the association as a whole): n.a.
- 4 Number of member companies in the sector: n.a..
- 5 Number of employees working in member companies (i.e. the total number of the association as a whole): n.a.
- 6 Number of employees working in member companies in the sector: n.a.
- 7 Density of the association in terms of companies with regard to their domain (see 2b.2): n.a.
- 8 Density of the association in terms of companies with regard to the sector: n.a.
- 9 Density in terms of employees represented with regard to their domain (see 2b.2): n.a;
- 10 Density in terms of employees represented with regard to the sector: n.a.
- 11 Does the employer association conclude collective agreements? Yes (for the private sector hospitals); one seat in joint committee 330.

12 Membership to higher-level national, European and international interest associations: n.a.

### **3. Inter-associational relationships**

#### **3.1. Please list all unions covered by this study whose domains overlap.**

Public hospitals: the public sector unions of the confederations (ACV-CSC; ABVV-FGTB) and VSOA-SLFP compete for membership in these hospitals. They all cover the whole domain of the public sector.

Private (mainly not-for-profit) hospitals: mainly the white-collar sector unions of the three confederations (ACV-CSC; ABVV-FGTB and ACLVB-CGSLB) compete for membership in these hospitals. They all cover the whole domain of the private sector.

#### **3.2. Do rivalries and competition exist among the unions, concerning the right to conclude collective agreements and to be consulted in public policy formulation and implementation?**

No, bargaining is structured by the joint committee 330 and the power relations in this bargaining committee for the private sector. In the public sector recognition is organised by the trade union statute of 1974 (several times amended).

#### **3.3. If yes, are certain unions excluded from these rights?**

No

#### **3.4. Same question for employer associations as 3.1.**

Overlap exists and is growing due to an increase of hospital mergers. Typical organisational borders between hospitals – public/private not for profit or catholic/non-catholic – have been dispersed to a certain degree as a result of these mergers into large hospital conglomerates (most of the time situated in a local area). For example: a hospital, which is a merger of 4 hospitals (2 of religious charities, 1 of the christian health fund and 1 public hospital) is member of several employers' organisations (VVI, NMSV and VOV).

#### **3.5. Same question for employer associations as 3.2.**

No, bargaining is structured by the joint committee 330 and the power relations in this bargaining committee for the private sector.

#### **3.6. Same question for employer associations as 3.3.**

No

### **4. The system of collective bargaining**

Collective agreements are defined in line with national labour law regardless of whether they are negotiated under a peace obligation.

## 4.0 General overview

### *a) Private (not-for-profit) hospitals*

The Belgian hospital law requires that private hospitals have a not-for-profit statute. Collective bargaining for these hospitals takes place in joint committee 330. This is a new committee set-up since 2003, but only recently activated by the necessary Royal decrees. This sector committee 330 covers all the Federal Health Services (i.e. not only the hospitals) and replaces for the hospital sector the activities and agreements of joint committee 305 (which has been split up). The social partners have the Minister of Labour advised in the summer of 2007 to set up a specific subcommittee 330.1, which will focus only on the hospitals.

### *b) Public hospitals*

The employment relationship is organised by legislation. Bargaining takes the form of both negotiation or consultation. Negotiation can lead to agreements that are laid down in protocols. These protocols are morally or politically binding for the government, but are not legally binding. Government can act unilaterally. However, the trade union statute states that negotiations and consultations – i.e. the processes itself - are a legal pre-condition for measures to be valid. The topics, where an obliged and prior negotiation or consultation is needed, are defined in the trade union statute.

The main feature of the collective bargaining system in the Belgian public sector is its tiered structure, from federal state down to the local level. There are three negotiating levels:

- **Committee A:** representatives of the federal government, the communities and regional governments negotiate with the 3 representative trade unions protocols for all public sector workers in Belgium. The activity of Committee A is in this regard comparable with the intersectoral private sector bargaining in the National Labour council. Any matters that are dealt with by Committee A can no longer be dealt with in the committees.
- **Committee B:** the bargaining partners involved here are the Minister for the Federal Civil Service, the ministers for the departments concerned, the officials in charge of the public bodies concerned and the trade unions. At this level the bargaining is done in 15 different bargaining committees, known as Sectoral Committees.
- **Committee C:** provincial and local administrations.

From the bargaining perspective of the public hospital personnel, committee A and C are very important. Most of the public hospitals are run by local Public Centers of Social Welfare (Openbare Centra voor Maatschappelijk Welzijn, OCMW).

Trade unions and public authorities conclude collective agreements (protocols) at national level which are complemented by additional agreements at regional and local level. Unions have been making a plea to create a specific sector committee for the public care sector, but until now this has not been realised.

### *c) Coordination in practice*

Since 2000 and under trade union pressure, bargaining in the hospital sector has altered seriously. Agreements have been set for 5 years and were/are based on a tripartite dialogue, between employers' organisations, government (partly employer, partly subsidizing actor) and trade unions. The dialogue covered both private and public and not only hospitals, but also other care sector. These talks resulted already two times (2000-2005; 2005-2010) in a final agreement,

which afterwards has/had to be implemented in the different formal bargaining committees and has/had to be finalised in legally-binding texts of the private sector (mutual binding collective agreement, which are extended) and the public sector (protocols translated in governmental official decisions at different policy levels). Key aspects of these agreements were:

- Involvement of the subsidizing government, which could guarantee the necessary financial funds to implement the agreement;
- ‘Solidarity’ bargaining: wage settlements that created a catch-up process in earnings for care workers in other sectors than the hospitals (for example nursing personnel in elderly care facilities).
- Specific measures to keep ‘older’ care workers at the job

#### *d) Semi-collective bargaining doctors*

Doctors are in Belgium self-employed. As a free profession they can have a private practice and/or can be linked to a hospital. In any case they keep their independent statute (although they need an accreditation). The Belgian health system combines this type of independent medical practice with a compulsory health insurance. Payment is mainly fee-for-service and patients have a large degree of freedom in their choice of provider. Each year representatives of the sickness funds and the health care providers (including doctors’ organisations and the federations of hospitals) negotiate a detailed fee schedule for each type of service, the so-called nomenclature. In all these negotiations the sickness funds act as a cartel and are seen as a kind of representative for patients. As the government has veto power over the fee levels, the whole process resembles a bilateral bargaining monopoly supervised by the central government. During the year, health expenditures are closely monitored, and if there is a danger of transgressing the a priori budget, negotiations begin between the government, the providers and the sickness funds to find solutions, which may include a change in the fee schedule and the co-payments. If necessary, the government can impose measures unilaterally.

#### **4.1. Estimate the sector’s rate of collective bargaining coverage (i.e. the ratio of the number of employees covered by any kind of collective agreement to the total number of employees in the sector).**

Private sector hospitals

100% Every hospital is member of a signing employers’ organisation. Furthermore: agreements are normally always extended by royal decree and so they apply legally to all employers and their employees of the sectors concerned.

Public sector hospitals

100%; When protocols are transposed into legal texts, which can take some time.

#### **4.2. Estimate the relative importance of multi-employer agreements and of single-employer agreements as a percentage of the total number of employees covered. (Multi-employer bargaining is defined as being conducted by an employer association on behalf of the employer side. In the case of single-employer bargaining, it is the company or its subunit(s) which is the party to the agreement. This includes the cases where two or more companies jointly negotiate an agreement.)**

Sector bargaining most important

**4.2.1. Is there a practice of extending multi-employer agreements to employers who are not affiliated to the signatory employer associations?**

Private sector: yes (but hospitals are anyhow member of one or more of the signing parties).

Public sector: not relevant, statutory regulation of employment relationship. However, it can sometimes take a while before the agreed protocols are implemented in the different hospitals.

**4.2.2. If there is a practice of extending collective agreements, is this practice pervasive or rather limited and exceptional?**

Private sector: pervasive

Public sector: not relevant; protocols only have legal power when they are transposed into governmental decrees.

**4.3. List all sector-related multi-employer wage agreements\* valid in 2005 (or most recent data), including for each agreement information on the signatory parties and the purview of the agreement in terms of branches, types of employees and territory covered**

\* Only wage agreements which are (re)negotiated on a reiterated basis. For the notion of ‘sector-related’, see the conceptual remarks in the accompanying briefing note. Please be reminded that agreements should be excluded where their purview covers, for instance, only medical practice activities according to NACE 85.12, but not any part of hospital activities according to NACE 85.11. In case of regionally differentiated, parallel agreements, an aggregate answer explaining the pattern may be given.

Private sector (joint committee 330, previously 305.01)

In the table, most important ones, not included agreements on end of the year premium, additional sector-related social benefits (for example pension fund or early retirement), employment measures for specific target groups.

**Sector-related multi employer wage agreements**

Collective agreement of 10/09/2007 which prolonged all the still in existence agreements of the former 305.1 joint committee			
Bargaining parties	Purview of the sector-related multi-employer wage agreements		
	Sectoral	Type of employees	Territorial
Joint Committee 330	x	White and blue-collar	National
Wage agreement of april 2005; pay rise for specific categories and night/shift work			
Bargaining parties	Purview of the sector-related multi-employer wage agreements		
	Sectoral	Type of employees	Territorial
Joint Committee 330 (former 305)	x	White and blue-collar	National
Automatic indexation of wages			
Bargaining parties	Purview of the sector-related multi-employer wage agreements		

	Sectoral	Type of employees	Territorial
Joint Committee 330 (former 305)	x	White and blue-collar	National
Sectoral job and wage classification (agreement of 1982, several times changed)			
Bargaining parties	Purview of the sector-related multi-employer wage agreements		
	Sectoral	Type of employees	Territorial
Joint Committee 330 (former 305)	x	White and blue-collar	National

### *Public sector*

#### **Sector-related multi employer wage agreements**

Agreement on the federal health sectors – public sector 2005-2010 (protocol afterwards implemented)			
Bargaining parties	Purview of the sector-related multi-employer wage agreements		
	Sectoral	Type of employees	Territorial
Government and public sector trade unions in coordination with the private sector bargaining	x	Public sector hospital workers (statutory and contractual)	National, need to be implemented at different levels by statutory arrangements

## **5. Formulation and implementation of sector-specific public policies**

### **5.1. Are the sector's employer associations and unions usually consulted by the authorities in sector-specific matters? If yes, which associations?**

Yes, all of the mentioned organisations in point 2. Form and content of the consultation depend on the matter. Furthermore, other associations (of nurses, doctors and patients) are involved in this type of consultation, again depending on the matter and advisory body.

### **5.2. Do tripartite bodies dealing with sector-specific issues exist? If yes, please indicate their domain of activity (for instance, health and safety, equal opportunities, labour market, social security and pensions etc.), their origin (agreement/statutory) and the interest organisations having representatives in them:**

#### **Main sector-specific concertation bodies within the field of industrial relations**

Name of the body and scope of activity	Bipartite/tripartite	Origin: agreement/statutory	Unions having representatives (reps)	Employer associations having reps.
<a href="#">Social sector fund</a>	Bi	Agreement	Yes	Yes

<a href="#">for the private hospitals</a> (Fonds voor bestaanszekerheid )				
Intersectoral fund for the health sector	Bi	Agreement	Yes	Yes
<a href="#">Fund social maribel</a>	Bi	Agreement	Yes	Yes
Sectoral saving fund (pension fund)	Bi	Agreement	Yes	Yes
<a href="#">Institute for job classification</a>	Bi	Agreement	Yes	Yes
National council of Nursing	Tri	Statutory	Yes	(Yes)**
Technical commission Nursing	Tri	Statutory	Yes	(Yes)**

\* Sector-specific policies specifically target and affect the sector under consideration.

\*\* Associations of doctors are member of the council, not the hospital organisations

## 6. Statutory regulations of representativeness

**6.1. In the case of the unions, do statutory regulations exist which establish criteria of representativeness which a union must meet, so as to be entitled to conclude collective agreements? If yes, please briefly illustrate these rules and list the organisations which meet them.**

### *Private sector hospitals*

The Collective Agreements Act 1968 lays down the criteria to be fulfilled by representative organisations, namely:

- Inter-occupational organisations of workers and employers established at national level and represented on the Central Economic Council and the National Labour Council; these workers' organisations shall furthermore have at least 50,000 members;
- The occupational organisations affiliated to, or forming part of, an inter-occupational organisation.

These criteria determine the external representativeness of trade unions. When a trade union meets these criteria, it can conclude collective agreements and apply for representation in a joint committee (here 316).

At present, three trade unions have the status of a representative workers' organisation namely the FGTB/ ABVV , CSC/ACV, the CGSLB/ ACLVB and their member federations

### *Public sector hospitals*

Only representative unions can have seats in the negotiation and consultation committees. These unions have subsequently the freedom to choose and assign their own delegates (also at the workplace level in the staff committees, which in the private sector are elected by the whole workforce).

Representative public service unions must on the national level be affiliated to a trade union confederation represented in the National Labour Council. Further (vague) criteria are that they must have their activities organised on the national level and represent the interests of all categories of public service staff. These unions are representing civil servants at the general committees (A, B and C).

Representativeness in a sector committee requires a trade union to have 10 per cent of the total workforce of that sector as a member. The representativeness is examined by an independent control commission. However, the unions presented at the general committees don't have to fulfil this 10 per cent quorum. With this recent measure, the liberal union VSOA/SLFP obtained seats in all sector committees, besides the socialist and christian union.

Some organisations are only registered. When they are registered, they are allowed, for example, to intervene with the authority covering the services for which they have obtained registration, assist employees, and post opinions in workplaces; they also sometimes take part informally in negotiations and concertation exercises. However, they don't have legal rights to be involved in negotiation and consultation activities.

Besides the 3 representative unions, no registered public sector unions are active in the hospital sector.

### **6.2. In the case of the unions, do statutory regulations exist which establish criteria of representativeness which a union must meet, so as to be entitled to be consulted in matters of public policy and to participate in tripartite bodies? If yes, please briefly illustrate these rules and list the organisations which meet them.**

In general, trade unions, meeting the aforementioned criteria, can be represented in consultative bodies. As such the trade unions, mentioned in point 2, are involved in a range of bipartite and tripartite funds, commissions and working groups related to the industrial relations matters of the sector. Nevertheless, the occupational associations, which don't act as a trade union in collective bargaining, are involved in the bodies, which are involved in the accreditation and occupational (skills-related) regulation of the nursing personnel in hospitals. For example. Representatives of the National Federation of Catholic Flemish Nurses and Midwives (Nationaal Verbond van Katholieke Vlaamse verpleegkundigen en vrouwvrouwen, NKVV) have seats in the following councils and commissions, which play an advisory role to the Minister of Health:

- National council of Nursing (de Nationale Raad voor de Verpleegkunde)
- National council for Midwives (de Nationale Raad voor de Vroedvrouwen)
- Technical Commission Nursing (de Technische Commissie Verpleegkunde)
- The National Council for Hospital care (de Nationale Raad voor Ziekenhuisvoorzieningen)
- Commission Patient rights (Comissie Patientenrechten)

**6.3. Are elections for a certain representational body (e.g. works councils) established as criteria for union representativeness? If yes, please report the most recent electoral outcome for the sector.**

*Private sector*

A trade union recognised as a representative organisation in the external sense can apply for a mandate in a joint commission. In that case, the internal representativeness of the organisation for that sector in particular will be examined. In general, trade unions accord reciprocal recognition to their representativeness in a sector. If they do not, then the Minister of Employment will base his decision on the results of the national elections for the works councils, held every 4 year.

The division of mandates in the newly established 330 is based on an agreement between the unions.

*Public sector*

Here, the principle works the other way round. National representative unions (cf. the big '3') can use this status to claim seats in the local employee representation, namely the basic concertation committee (basisoverlegcomité).

**6.4. Same question for employer associations as 6.1.**

*Private sector hospitals*

The Collective Agreements Act 1968 lays down the criteria to be fulfilled by representative organisations, namely:

- the employers' occupational organisations which, in any given branch of activity, are declared to be representative by the Crown on the advice of the CNT/NAR;
- the national inter-occupational and occupational organisations approved under the Act of 6 March 1964 concerning small and medium-sized enterprises and self-employed persons carrying on a liberal profession.

The Minister of Labour assigned by Royal Decree the members of the joint committee 330 (see point 2)

*Public sector hospitals*

Government is the employers' side.

**6.5. Same question for employer associations as 6.2.**

Rules depend on the type of established consultation body. Employers' organisations, together with health funds (mutualities) and doctors' associations, are strongly involved in a lot of concertation bodies (consultation and control) related to hospital care (on the federal, but also at the regional level).

**6.6. Are elections for a certain representational body established as criteria for the representativeness of employer associations? If yes, please report the most recent outcome for the sector.**

No; For your information: membership fees of employers' organisations are mainly based on the accredited beds a hospital represents. Nevertheless, the composition of the employers' faction in joint committee [330](#) gives insights into the 'representativity' of the different employers' organisations. However, the committee covers a broader domain than hospitals.

## **7. Commentary**

Please give your views on the issue of representativeness in the sector, especially on jurisdictional disputes and recognition problems, and indicate any specificities or other problems which refer to representativeness in this sector in your country.

The employers' representation has a complicated structure, especially in the private sector (not-for-profit). However, all the federations participate in the bargaining of joint committee 330. On the union side, we see that the traditional unions are the recognised players of the collective bargaining. They are complemented by other occupational associations in regulatory bodies of the hospital sector. In this regard, these two types of employee interest groups seem to have found a 'modus vivendi'.